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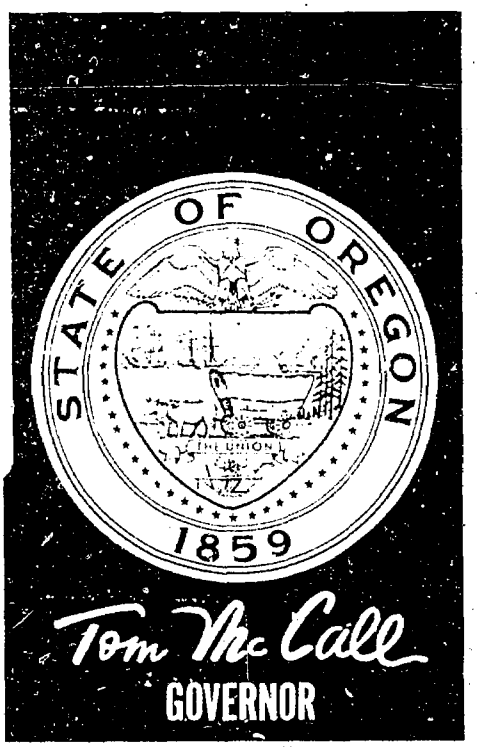
ABSTRACT

After seeking data from public, private, and voluntary health-related agencies, associations, and activities in the State, the committee reports on the following areas: health delivery system problems, health services, target groups (aged, medically indigent, migrants, newborns, infants, preschool children, and school-age children), personal health problems (mental health, communicable disease, non-communicable disease), and environmental health problems. For each area the following factors are provided when applicable: title of study or problem area, goals, statement of condition/problem, current programs and activities, authorities, objectives, recommendations and methods, operational problems, evaluation criteria, and priorities/recommendations. The document also includes a five-section appendix, a section of charts and graphs (in addition to those in the body of the report), a matrix for reference to organizational responsibility for problems noted, an organization index, and a subject index. (AG)



STATE OF OREGON COMPREHENSIVE HEALTH PLAN

Prepared by the

EXECUTIVE DEPARTMENT

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GOVERNOR'S HEALTH PLANNING COMMITTEE

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TOM McCALL
GOVERNOR

LLOYD G. HAMMEL, JR.
Chairman

January 27, 1971

The Honorable Tom McCall
Governor of the State of Oregon
State Capitol
Salem, Oregon 97310

Dear Governor McCall:

On May 24, 1967, by Executive Order No. 67-14, in response to the "Partnership for Health Act of Congress", Public Law 89-749, you appointed the Governor's Health Planning Committee. You charged the Committee with responsibility to implement Oregon's participation in the partnership for health legislation.

The Emergency Board in October of 1967 approved a federal grant of $72,500 to hire staff and commence work on the planning process. Subsequently, federal and state funds were appropriated in the amount of approximately $258,500 to date.

In June 1970 the Governor specifically challenged the Committee to produce the nation's first State Comprehensive Health Plan by January of 1971. Despite what has been described as "nationwide uncertainty" as to what the parameters, processes, and format of comprehensive health planning are--and we in Oregon have struggled nightly with these questions--your Committee accepted the challenge. The difficulty of the task has been exceeded only by the enormity of the charge of continuous comprehensive health planning and the variety of problems in health which cry out for attention and solution.

Should we gather all available data on all health related problems into a health information system, define the problems in terms of the data and develop solutions and plans based upon such data? Or, should we accept the health problems the people believe to exist, propose solutions, and develop plans to address those problems and solutions?

The absence of any data in some fields and the very skimpy and oftentimes unusable data in other areas of concern militated against an affirmative answer to the first question. The lack of objectivity

and the general absence of scientific analysis implicit in a positive answer to the second question cautioned the Committee against that as an ideal approach.

However, your Committee chose the practical rather than the endlessly idealistic in developing its solution. We chose to have confidence in a strongly "consumer oriented" and "grass roots" approach to the development of the Comprehensive Health Plan. We asked the people what they thought were the health problems in their area of the state. We fashioned the Plan toward solutions to those problems.

The Plan is not complete. It will never be complete. The Plan is not up to date. It will never be up to date. Because the health needs and problems are dynamic, the Plan cannot be static. Because the health needs and problems are changing, the data collected to describe them is continuously evolving.

Your Committee submits this Comprehensive Health Plan for the State of Oregon as a viable document. The Plan represents the contributions of hundreds of consumers, voluntary health associations, health professionals, public health and welfare agencies, health institutions, health insurance carriers, and a highly dedicated and professional staff which has worked tirelessly in preparing this document for publication.

Your Committee is convinced that having distilled so much information and thought into this organized Plan for attacking selected health problems, that the job of planning comprehensively has truly begun. Now is not the time to relax or lessen the state's efforts. We urge your strongest support for increased effort and commitment on the part of the state to coordinate the implementation of the many recommendations included in the Plan.

The Plan must continue to be objective in coordinating the health activities of not only state agencies, but those of the private and voluntary sectors as well. It is imperative that this continuous planning process be kept free of entanglements with state agencies involved in health services and responsibilities.

In preparing the Plan we are indebted to a great many individuals, institutions, and associations who have assisted by submitting drafts of material and expressions of opinions. They have given unselfishly of their time and talent. While those whose names are enumerated hereinafter should bear no responsibility for statements or recommendations included in the Plan, without their contribution the staff and the Advisory Council would have been unable to produce this Plan.

Very truly yours,

LLOYD G. HAMMEL, JR.
Chairman, Comprehensive Health Planning
Advisory Council

COMPREHENSIVE HEALTH PLAN
STATE OF OREGON

EXECUTIVE DEPARTMENT
PROGRAM PLANNING DIVISION
HEALTH PLANNING SECTION

January 1971

Tom McCall
Governor

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PREFACE

This document has been developed in such a fashion as to utilize several alternative mechanisms for developing plans and recommendations. It incorporates into a composite plan, reports by the Comprehensive Health Planning staff, as well as reports from ad hoc committees, professional organizations, voluntary organizations, and state agencies who administer the wide variety of health and health-related programs. Additional valuable input was received from the broad array of public, voluntary, and private health organizations, as well as local citizen planning committees and subject matter experts who were sent copies of reports and asked to review and comment on the various elements of the proposal.

The Governor's Health Planning Committee chose this method as an obvious way of "tapping" these many sources of valuable and current information and providing an expeditious means of assembling an initial version of a comprehensive health plan for Oregon. But, of equal importance, the technique demonstrated -- in a real way -- how a rich source of data and information could be made available to guide decision makers, and the potential rewards to be attained through the cooperative efforts of existing resource and service agencies and organizations dedicated to the concept of the "Partnership for Health."

We, of the Governor's Comprehensive Health Planning Committee and staff, fully appreciate the limitations of this first attempt at evolving a comprehensive health plan. The imperfections are in part due to the limitations of time and in part due to the constraints imposed by a grossly inadequate health information system. The former problem will be dealt with in a continuing effort by the Comprehensive Health Planning staff to refine plans relative to selected priority areas during the next biennium on the basis of continued input. The second problem is one being felt across the nation by all planning and decision-making authorities. Studies to determine the feasibility of central data banks have served primarily to point out the high cost of maintaining such a management tool.

There will undoubtedly be instances where the stimulus provided by the description of the problem and the recommendations contained in this Plan will result in not only correction and updating of information and data, but also will disclose compelling reasons for taking immediate remedial action. We strongly recommend that such information and proposals be submitted to the Governor's Health Planning Committee for review. We emphasize that the implementing action phase of this planning effort must be accomplished with the same cooperative attitude and optimum communications that were achieved during this initial phase -- this is essential if we are to succeed.

The Health Planning Committee has, in the process of its discussions, repeatedly reaffirmed its prerogative, intention, and its determination to correct, revise, or add to this Plan at any of its meetings. It is our belief that such flexibility is essential.

With this Plan, it is our intention that the Governor and Legislators have available for their consideration a useful collection of information, data, and recommendations compiled and subscribed to by the partnership of our total health care community, which gives impetus and direction toward the attainment of a high level of health for all Oregonians.

The rapid scientific advances in the field of medicine have dramatically upgraded the effectiveness of today's health care services. Concomitant with technological advances and increasing affluency, we have experienced an unprecedented increase in the demand and expenditures for health services.

As one would expect, the financing of costs of medical care -- especially for the poor and those requiring extended care because of a major illness -- has become a problem of critical proportions which the President has called a "Crisis in Health Care."

The financial elements of the health care crisis are several and varied. Comparing medical care expenditures to 1950, today's expenditures have increased three-fold (from $11 billion to over $67 billion). This rise is attributable to several factors which include the population increase, general inflation, medical inflation, more accessible facilities, an increase in the aged population, new services, and greater utilization.

Oregon, if it is to contribute to the control of increasing health costs, must bring the total health costs into focus. A coordinated approach to preventive health care, better utilization of existing health care facilities, services, and knowledge, a free flow of information between components of the delivery system and its beneficiaries, and an intelligent use of all resources (in summary, comprehensive health planning) may represent the only way in which costs can be kept in their proper prospective and services optimized without sacrificing the quality of medical care.[1]

With the enactment of Public Law 89-749, the Comprehensive Health Planning Act, Oregon was afforded the rare opportunity to merge the strengths and capabilities of government, the private and the voluntary sector in a unique partnership to bridge the gap between public expectations and accomplishment in health care.

Comprehensive Health Planning is still new. It is barely beyond the organizational phase. State and areawide planning should be given broad-base support from all segments of the community. It is becoming increasingly evident that planning is our best solution to developing principles and methods for expanding the capacity of the present delivery system and meeting the challenges before us.

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1. For current information on the costs and financing of medical care, see Charts and Graphs Section of this Plan.

ACKNOWLEDGEMENTS

Publication of this Comprehensive Health Plan, possibly the first such attempt in the nation, represents the joint efforts of public, private and voluntary health-related agencies, associations and activities throughout the state of Oregon. The great number of individual contributors who have provided input, advice, and assistance in the preparation, review, and editing of the various sections of the Plan precludes individual acknowledgement. Acknowledgement of these active participants, who gave generously of their time and energies without compensation and who joined hands in this planning process in a true "Partnership for Health", is made through their organizational affiliations listed below. Recognizing that there are undoubtedly some inadvertant omissions because of the magnitude of the statewide involvement, we can only apologize to these unacknowledged sources and hope that they will be called to our attention for future correction.

Governmental Organizations

Board of Education
Community Action Programs (CAP)
Conference of Local Health Officers
Cooperative Area Manpower Planning System (CAMPS)
Councils of Governments (COG)

County Health Departments
Department of Agriculture
Department of Commerce
Department of Environmental Quality
Department of General Services
Department of Transportation
Motor Vehicles Division

Division of Emergency Services
Division of Vocational Rehabilitation
Educational Coordinating Council
Employment Division

Governor's Advisory Committee on Chicano Affairs
Governor's Advisory Committee on Medical Assistance for the Underprivileged
Law Enforcement Council
Mental Health Division
[illegible]on Regional Medical Program

Professional Licensing Boards:
Board of Chiropractic Examiners
Board of Dental Examiners
Board of Medical Examiners
Board of Nursing
Board of Pharmacy
Board of Optometry

Public Welfare Division
State Board of Health
State Office of Economic Opportunity
State Program on Aging

State System of Higher Education:
University of Oregon Dental School
University of Oregon Medical School
Crippled Children's Division
School of Nursing
Oregon State University Cooperative Extension Service

Traffic Safety Commission
Valley Migrant League
Veterans' Administration Hospital (Portland)

Private - Voluntary Organizations

Allergy Foundation
American Cancer Society - Oregon Division
American Red Cross
American Social Health Association

Areawide Comprehensive Health Planning Agencies
Arthritis and Rheumatism Foundation
Arthur Young and Company
Associated Home Health Services, Inc.

Association of Oregon Counties
Association of Voluntary Health Agencies (Portland)
Blue Cross
Diabetes Association of Oregon

Easter Seal Society
Emanuel Hospital
Epilepsy League of Oregon
Kidney Association
Health Manpower Intelligence Facility

League of Oregon Cities
Motorola Communications and Electronics, Inc.
Multnomah County Medical Society
Myasthenia Gravis Association

National Foundation - March of Dimes
National Multiple Sclerosis Society
Oregon Ambulance Association
Oregon Association of Hospitals

Oregon Association for Retarded Children
Oregon Chapter - American College of Surgeons - Committee on Trauma
Oregon Dental Association

Oregon Cystic Fibrosis Research Foundation
Oregon Dairy Council
Oregon Dental Assistants Association
Oregon Dental Service

Oregon State Dental Hygienists Association
Oregon Dietetic Association
Oregon Heart Association
Oregon Home Economics Association

Oregon Medical Association
Oregon Mental Health Association
Oregon Chapter of the National Rehabilitation Association
Oregon Nurses Association

Oregon Nutrition Council
Oregon Osteopathic Association
Oregon Pharmaceutical Association
Oregon Physicians' Service
Oregon Speech and Hearing Association

Oregon Tuberculosis and Respiratory Disease Association
Oregon Thoracic Society
Oregon Women's Christian Temperance Union
Planned Parenthood Association, Inc.

Portland Retail Druggists Association
Portland Orthopedic Clinic
Shriners' Hospital
St. Vincent's Hospital
Tri-County Community Council

The Visiting Nurse Association
United Cerebral Palsy

Special acknowledgement is extended to the Chairmen and members of the three Comprehensive Health Planning ad hoc committees listed below who voluntarily devoted innumerable hours of their time to conduct in-depth studies and develop the reports for their respective areas of concern.

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INTRODUCTION

The Comprehensive Health Planning Act of 1966 (P.L. 89-749) and the Partnership for Health Amendments of 1967 (P.L.90-174) revise and initiate several programs of health services grants to states and committees. These programs -- state comprehensive health planning; areawide health planning; comprehensive public health services support; and health services development projects are all health-related in their operation and in their goal of assuring comprehensive health services of high quality for every person.

National policy has been clearly expressed by the Congress in the following excerpt from the Law:

> "Sec.2.(a) The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshaling of all health resources -- national, State, and local -- to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts.
>
> (b) To carry out such purpose, and recognizing the changing character of health problems, the Congress finds that comprehensive health planning for health services, health manpower, and health facilities is essential at every level of government; that desirable administration requires strengthening the leadership and capacities of State health agencies; and that support of health services provided people in their communities should be broadened and made more flexible."

The Federal Comprehensive Health Planning Act (P.L. 89-749) was derived directly from the concepts and recommendations of the task force of the National Commission on Community Health Services. Public Law 89-749 and the "Partnership for Health" amendments of 1967 establish mechanisms for comprehensive areawide and statewide health planning, identifying health problems and establishing priorities in the allocation of resources. The purposes of this legislation are to establish comprehensive planning for

health services, health manpower, and health facilities essential at every level of government; to strengthen the leadership and capabilities of state health agencies; and to broaden and make more feasible and relevant Federal support of health services provided people in their communities.

The Partnership for Health asserts that these objectives will be attained through an effective partnership involving close intergovernmental collaboration, a working relationship between government, professional organizations, voluntary agencies, and providers with participation by consumers and consumer organizations. The Act establishes a new mechanism to relate varied planning and health programs to each other and to other efforts in the achievement of a total health goal.

It needs to be understood that comprehensive health planning was never meant to supplant vertical or specialized planning which has been, and is currently engaged in by each and every health care organization in varying degrees. Comprehensive health planning does attempt to relate this type of planning or activity to a broader range of health problems and needs, and, in general, to overall needs.

The Law has five major sections:

1. It authorizes formula grants to the states to conduct comprehensive health planning at the state level. The Oregon Comprehensive Health Planning Program has been organizationally placed in the Program Planning Division of the Executive Department.

2. The Act provides for grants for comprehensive health planning at the district level. Three grants have been awarded to district comprehensive health planning organizations in Oregon. The largest of these grants has been awarded to the Metropolitan Portland C.H.P. Association. The other two funded organizations include the Lane County Council of Governments and the Southwestern Oregon C.H.P. Association of Coos and Curry Counties.

3. Section (c) of the Act authorizes the funding of training for health planners and citizen participants in comprehensive health planning.

4. Section (d) of the Act authorizes the distribution of bloc grants to each state to be allocated to the State Board of Health (85% of total allocation) and the Mental Health Division (15% of total allocation) for use as the State Comprehensive Health Plan dictates. The legislation further states that 70% of the State Board of Health's and the Mental Health Division's (d) monies must be spent for providing direct services at the local level.

5. In addition there is a provision for funding special demonstration projects through Section (e) of the Act. These grants are intended to explore new and innovative methods of delivering health services as well as encouraging comprehensive health services for the poor, the

rural populations, and minority ethnic groups. Grant funds are available to test new concepts and methodologies for improving the present health delivery system.

State Level Response to the Partnership for Health Act

Comprehensive Health Planning was implemented in Oregon by Governor McCall on May 24, 1967, with the issuance of Executive Order 67-14 (see Appendix) and the appointment of a Health Planning Committee. The original committee consisted of 12 members appointed by the Governor (the administrators of the State Health Department, the State Mental Health Division, and the State Welfare Division; the Dean of the University of Oregon Medical School; a representative of the Budget Division; a representative of the Governor's Office; a representative of the State Medical Association, a county commissioner representing local government; representatives of the public, one from each of the four congressional districts) and the Chairman, also a consumer representative.

On June 10, 1968, the Governor's Committee was expanded to include 17 members. The new members included a hospital administrator, a dentist, an insurance executive, and two representatives of the poor and ethnic groups.

The program became operational shortly before January of 1968 and soon thereafter the committee instructed the staff to give top priority to the development of district (areawide) planning committees. Consistent with this charge, cooperative organizational efforts were initiated with the main provider organizations and local government in each district.

The second task the committee dedicated itself to was the development of priorities for allocating health resources and the obvious concomitant, a State Comprehensive Health Plan.

Community Response to the Comprehensive Health Planning Law

Many communities in Oregon responded to the health planning challenge with enthusiasm and commitment. It became obvious early in the development of comprehensive health planning that without appropriate funding for staff, office space, travel, and supplies, health planning could not be fully effective. The hope of federal funding waned early as the federal health budget was observed to be obviously inadequate to sustain the level of activity dictated by the comprehensive health planning concept. Counties such as Coos and Curry, Douglas, Washington, Columbia, Clackamas, Multnomah, and Lane supported the planning for health concept and expressed the priority they gave to health problems by allocating funds to match federal monies. These counties are to be complimented for their foresight and perserverance to plan for the future health of their citizens.

Oregon must continue to strive for the goal of having each district achieve the capability of identifying their health problems, assigning priorities to its resources, and moving ahead to efficient solution of these problems.

The organization of district (areawide) comprehensive health planning organizations took various forms; however, in most instances, the original impetus came from a steering committee composed of representatives of voluntary health organizations, the medical society, the dental society, the hospitals, elected county and city officials, local health office, nursing profession, and consumer leaders of the community.

After the basic organizational tasks of preparing by-laws; filing of articles of incorporation (when appropriate); completing the necessary information to acquire non-profit status with the Internal Revenue Service; and assuring the representation of a broad range of community leaders and interests on the planning committee, the organization qualified to request the Governor's Health Planning Committee to recognize the organization as the sole comprehensive health planning authority for that state administrative district.

District planning has made significant strides during the past two years. This is reflected only partially by the federal grant funds awarded under the 314(b) section of the Law to four funded areawide comprehensive health planning organizations.

District 7's (Coos and Curry Counties) Southwestern Oregon Comprehensive Health Planning Assoc ation was awarded a second year grant of $24,806. The Lane County Planning Council received their first year developmental grant of $14,324. The Metropolitan Portland Comprehensive Health Planning Association for District 2 (Columbia, Clackamas, Washington, and Multnomah Counties) were recently awarded their first year operational grant of $70,495.

Malheur and Harney Counties, as part of Idaho's Treasure Valley Comprehensive Health Planning Association, parti ipate in the benefits of a $24,334 grant made to that organization.

Comprehensive health planning organizations that are not funded, but nevertheless recognized by the Governor's Health Planning Committee, include District 4's Linn, Benton, and Lincoln Comprehensive Health Planning Association; Douglas County Comprehensive Health Planning Association; District 3's Marion, Polk, and Yamhill Comprehensive Health Planning Association; District 1's Clatsop and Tillamook Counties; and District 8's Josephine and Jackson Comprehensive Health Planning Council.

District 10 (Deschutes, Crook, and Jefferson Counties), District 9 (Hood River, Wasco, and Sherman Counties), and District 11 (Klamath and Lake Counties), are currently developing the organizational base for health planning committees and it is expected that these district committees will receive official recognition from the Governor's Health Planning Committee during the early part of 1971.

Relationship of Comprehensive Health Planning with the Hill-Burton and Oregon Regional Medical Programs

Two programs that are often confused in purpose with comprehensive health planning are the Hill-Burton Planning and Construction Program (P.L. 91-296, as amended), administered by the State Board of Health, and the Oregon Regional Medical Program (P.L. 89-239), located on the campus of the University of Oregon Medical School.

Regardless of the stated operational objectives of these two programs, there are certain basic differences in operational philosophies between them and comprehensive health planning.

The Hill-Burton Program was implemented in Oregon in 1945 and is administered as a program of the Oregon State Board of Health. Its budget approximates $5,000,000 per biennium, $4,800,000 devoted to subsidizing the construction and modernization of health and health care facilities. The allocation of federal monies among construction and modernization projects in Oregon is based upon a priority system developed by applying a formula reflecting bed needs by hospital service areas. Hill-Burton funds are provided for a priority project on a one-third federal - two-thirds local matching basis. Counsel and guidance is provided to the State Board of Health by a 16-member Hospital and Medical Facility Survey and Construction Advisory Council. The Governor's Health Planning Committee has contracted with the Oregon State Board of Health to perform the facility review function of comprehensive health planning.

The Oregon Regional Medical Program one of the 55 Regional Medical Programs in the country, was implemented in Oregon in April, 1968. The University of Oregon Medical School was selected as the fiscal agent for the program and it followed that the program offices were located on the University of Oregon Medical School campus. This arrangement has facilitated a close administrative relationship between the program and the Medical School. The current annual budget of $837,328 has been largely (75%) devoted to financing continuing education courses and seminars for professionals and allied health personnel training in the broad areas of heart, cancer, stroke, and diabetes, and for financing demonstration projects aimed at improved patient care in selected hospitals throughout Oregon and the University of Oregon Medical School. Special studies including patient origin studies have been conducted and have contributed significantly to planning data utilized by many organizations doing health planning. Policy is determined by a 41-member advisory board, representing various health organizations and the public.

The Comprehensive Health Planning Committee's functions differ from either of these programs in the scope of the health problems considered (from mental health to diseases, to environmental sanitation), and in its concern for longer-range comprehensive planning as it addresses specific problem areas of the medical care delivery system. The 17-member Governor's Health Planning Committee represents both providers and consumers of health services but the consumers must remain in the majority, as dictated by the federal law. Comprehensive health planning, to a greater degree than others of the afore-mentioned programs, relies upon a working relationship with district areawide planning committees composed of consumers and providers. Grass roots participation in the planning process has been a prime policy consideration of the Governor's Health Planning Committee. The Comprehensive Health Planning Program is designed as an umbrella program to coordinate the

mechanisms for defining roles among the many health providers and groups. Its operational scope, as contrasted to its overall purpose, has been obviously limited by the size of its staff.

Although there has been considerable discussion at the national level regarding the feasibility of administratively merging these three programs, at the present time in Oregon the programs complement each other functionally and provide needed focus on critical problems of the health care delivery requiring immediate and expert attention.

Both the Oregon Regional Medical Program and the Hill-Burton programs are examples of specialized programs necessary to the successful implementation of goals and objectives determined by Comprehensive Health Planning.

Purposes of Comprehensive Health Planning

Section 314(a) of the Act provides for assisting the states in developing and sustaining comprehensive health planning programs. Comprehensive health planning is intended to enable states to identify problems and needs; to set and periodically revise objectives toward which private medicine, voluntary health organizations, and non-governmental health and related agencies and groups can strive cooperatively; to promote the efficient utilization of resources, to develop and expand resources where needed; and to assure that current and future health manpower, services, and facilities for the prevention of disease and injury and for health care will be coordinated with one another and with those welfare, education, vocational rehabilitation, and other activities that affect environmental, physical, and mental health.

Comprehensive health planning neither negates nor diminishes the need for continued or expanded functional or specialized planning. Operating State and local agencies and private and voluntary organizations should continue to plan for specialized programs -- the construction of health facilities, the development and expansion of community mental health programs, regional medical programs, programs in environmental control, services for the mentally retarded, etc. -- and to plan for increasing the supply and effective utilization of trained manpower. Comprehensive state health planning provides a framework for strengthening such efforts by relating objectives in these specialized areas to each other and to the overall needs and resources of the state.

Specialized health planning and functional planning not only contribute to comprehensive planning but also increase their own potential when they are conducted within the state health planning agency's comprehensive, integrated, long-range framework.

The Scope of Comprehensive Health Planning

The term "comprehensive" as applied to state health planning is envisioned in the Act to mean that such planning will be concerned with the entire population and territory of the state; with all health and associated problems that affect the well-being of all persons; and with all types of health services, facilities, and manpower existing in the state or developed to meet needs throughout the State.

Comprehensive health planning should include a variety of informational, consultative, and promotional activities, including recommendations for action by both public and voluntary agencies, institutions and individuals to meet needs for preventive and health care services, facilities, and manpower. Comprehensive health planning is characterized by its comprehensive scope, integrated nature and long-range viewpoint.

The comprehensive state health planning agency, which will henceforth be referred to as "the Agency," will provide an immediate organizational focus for identifying health problems in the state and recommending policies and programs to improve the health status of the population. While it is recognized that an agency may not be able at any one time to direct its attention to such a comprehensive scope of planning as described, the Agency should schedule its activities in such a manner as to encompass this scope of planning within a reasonable period of time.

The Agency should establish and maintain a continuing planning process for developing and adopting recommendations to guide the organization, financing, and provision of health services, facilities, and manpower. Over a period of time, these recommendations, as revised and inter-related within a comprehensive framework of study, problem identification, goal establishment, and priority determination, will form the basis for a comprehensive state health plan.

The following are some of the functions that we believe should be performed by the comprehensive state health planning agency. They are listed neither in order of importance nor in order of time. All are continuing and interrelated and each builds upon and contributes to the other.

A. Development and Periodic Revision of a Comprehensive State Health Plan

1. Selecting and applying measures for evaluating the health of the population and for assessing the impact on health status of environmental, social, economic, and other related factors.

2. Undertaking studies to define the scope, nature, and location of health problems and to identify and assess the resources available and necessary to solve them.

3. Selecting goals and priorities for solving identified health problems through the use of available resources or through the development of new resources.

4. Developing both current and long-range policy and action recommendations for meeting the health needs of the people of the state through public, voluntary, and private efforts.

5. Developing criteria for evaluating health programs and their contribution to attaining the goals established through comprehensive health planning.

B. Provision of Information and Consultation

1. Providing information that will serve as a basis for responsible public decision making in the development of new or additional health resources to serve health needs.

2. Undertaking, either directly or by arrangement with other agencies, special studies and continued gathering and analysis of data on health problems and resources.

3. Promoting the development of areawide health planning organizations and assisting them in their work.

4. Providing information to, consulting with, and generally assisting specialized health planning agencies and public and voluntary operating health organizations in the development of their plans and programs.

C. Promoting Coordination of Health and Other Programs

1. Providing channels of communication among public, voluntary, and private agencies and groups with health and related concerns.

2. Recommending measures for the assignment and coordination of health functions in the state which promote maximum efficiency and minimize overlap and duplication of functions and resources.

3. Recommending measures for more effective coordination of health activities with related activities in such areas as welfare, education, and vocational rehabilitation.

4. Working with counterpart agencies in other states to identify and suggest possible approaches for handling health problems that cross state boundaries.

In fulfilling its planning responsibilities, the Agency will necessarily work closely with other planning and operating governmental and non-governmental agencies at state, regional, and local levels. It is not expected to exercise administrative authority over such agencies. The recommendations adopted by the comprehensive state health planning Agency and the plan it develops, however, will be useful to such agencies in their program planning and development; and to state and local executive and legislative bodies and federal granting agencies in decision making with respect to the development, coordination, and funding of health programs.

A close relationship should exist between the Agency and areawide health planning organizations. Applications for federal grant support of areawide health planning may be approved by the federal Health Services and Mental Health Administrator only after prior approval by the state health planning agency (or agencies, in the case of interstate areas).

Formal and informal relationships between the Agency and prospective areawide organizations should address such questions as the geographic relationship of areas to state planning regions, mutual assistance in utilizing planning resources and techniques, the establishment of planning priorities within each area, and the development of appropriate areawide planning activities to complement the objectives and efforts of comprehensive state health planning. The Agency may consider incorporating in the state's comprehensive health plan parts or all of the plans developed by areawide planning organizations as well as by other groups and agencies engaged in planning.

REPORT FORMAT

A standard report format was adopted to facilitate information gathering and the presentation of data in a logical and orderly form. The following explanatory information detailing the conceptual basis for each of the section headings of the individual reports is provided to assist the reader in understanding these various report areas. An outline of the format is presented below followed by a detailed explanation of each of the subject headings.

TITLE OF STUDY OR PROBLEM AREA

GOAL FOR PROGRAMING RELATIVE TO THIS PROBLEM AREA

STATEMENT OF CONDITION/PROBLEM

CURRENT PROGRAMS AND ACTIVITIES

AUTHORITIES

OBJECTIVES

RECOMMENDATIONS AND METHODS

OPERATIONAL PROBLEMS

EVALUATION CRITERIA

PRIORITY ASSIGNED TO PROBLEM AREA/RECOMMENDATIONS*

TITLE

Self explanatory

Examples:

COMPREHENSIVE HEALTH PLANNING; REHABILITATION; HEALTH MANPOWER, ETC.

GOAL

A general long-range statement focusing on a goal which may be somewhat idealistic but attainable at some future point in time. It represents the broad mission of programs addressed to this particular health problem area. It answers the questions of "what are we trying to achieve with respect to the existing problems" and "what is the ultimate purpose of resource expenditures in this health problem area."

*To be determined by Governor's Health Planning Committee

Examples:

Promoting and assuring an optimum level of health for all Oregonians; reduction of illness and disability; eradicate tuberculosis; prevent and control venereal disease; provide and make accessible quality medical care to all migrants; insure to all Oregon residents and visitors prompt accessibility to emergency medical services; insure adequate health facilities distributed throughout the state to meet the needs of Oregon's people; attain and maintain a healthy environment conducive to optimum individual, family, and community living.

CONDITION

The condition reflects the severity of the problem and its extent. The problem or condition is stated in terms of morbidity, mortality, prevalence, trend, disability days, and reduced productive life.

Other important descriptive data and information identify target groups, state of the art (technology), law (outmoded statutes), resources, attitude of the public, geographic factors, etc.

The questions that this particular section addresses itself to are "what is the problem", "how bad is it", "what needs to be ameliorated", and "why".

CURRENT PROGRAMS AND ACTIVITIES

Describes briefly the significant programs focusing on this problem area and most important, the agency or organization having jurisdiction. Covers public (federal, state, local), private, and voluntary sectors. Identifies who conducts which program. Includes fiscal, personnel, and facility data when readily available as an indicator of the size of the effort or program.

AUTHORITIES

Identifies the authority under which the agencies have responsibility in the applicable problem area. Indicates whether the agency having jurisdiction has it by statute, legislative mandate, Governor's Executive Order, tradition, fiat, etc. Refers to Oregon Revised Statutes (ORS), legislative resolutions, legislative committee minutes or other documentation, executive orders, organization charts, policies of boards and commissions, etc.

OBJECTIVES

Objective statements reflect accomplishments desired within a certain time frame. They can be best formulated by conceptualizing "what are the

impediments to goal attainment and what needs to be done to overcome the impediments." Whenever possible, the objective is stated in quantified terms, and within a practical time frame.

Objective statements are sometimes called sub-goals. They generally answer the question, "what is going to be done that will contribute to the achievement of the goal and by when." Objectives should be specific enough to permit the evaluator to apply a measure or index of accomplishment or progress. The objective, obviously, should be related to the goal. It should not be confused with an activity. ("Inspection of a nursing home" is an activity. "The upgrading of care or reduction of violations" is an objective. "Establishing a tuberculosis case registry" is an activity. "Assuring continued surveillance of all tuberculosis patients for five years after discharge" is an objective.) An objective should be output oriented, and subject to evaluation.

Examples:

By July 1971, have identified the major health problems in Oregon and have assigned a priority to the nine most serious; by January 1971, insure that all health construction, projects, and programs proposed for execution are in conformance to the State Plan; establish local health planning capability in each of the State Administrative Districts by July 1971; reduce tuberculosis cases from 5/100,000 to 3/100,000 by 1975; provide emergency medical care services in every city in Oregon over 20,000 population by 1975; have established a health information system for Oregon by 1975.

RECOMMENDATIONS AND METHODS

The recommendations and methods section is directed to answering who is to do what, when, where, and how. Recommendations may or may not be directly related to achievement of any particular objective, but are pertinent to the problem and its solution.

Recommendations may propose reorganization or realignment of authority or may address themselves to the fragmentation of responsibility and authority. Statutory revisions may be included as recommendations. Recommendations must be specific. The methods propose the "how" for implementing the recommendation(s). Several methods are provided when appropriate or applicable.

Examples (Recommendations):

1. Comprehensive Health Planning evaluate morbidity and mortality data obtained from the State Board of Health, voluntary agencies, Oregon Association of Hospitals, Oregon Medical Association, and Kaiser Research Foundation and array diseases in order of severity.

2. Review all applications submitted to State Board of Health for Hill-Burton funds and for licensing.

3. Review all notices of intent (A-95) applying for planning and/or construction funds.

4. Establish a Comprehensive Health Planning Committee in each State Administrative District.

Examples (Recommendations and Methods):

1. Discontinue use of University of Oregon Tuberculosis Hospital as a special treatment hospital.

   Method

   Support a special task force of representatives from University of Oregon Medical School, Tuberculosis and Respiratory Disease Association of Oregon, State Board of Health, Oregon Medical Association, and Oregon Association of Hospitals to present recommendations for implementing this recommendation.

2. Expand Maternal and Infant Care Project at Emanuel Hospital in Portland.

   Methods

   a. Oregon State Board of Health request additional funding for project grant #11111.

   b. Emanuel Hospital apply to Health, Education, and Welfare for funding assistance.

3. Install telephones approximately every two miles on major interstate highways in Oregon.

   Method

   State Highway Commission arrange with Northwest Bell Telephone for installation of phones at points designated by the State Highway Commission.

4. Consolidate authority for venereal disease control in the State Board of Health.

   Method

   State Board of Health submit bill to Legislature revising ORS 510.620 to exclude Department of Education.

OPERATIONAL PROBLEMS

This section identifies existing operational problems which impede progress to accomplishing the recommendations. Insufficient staff, need for improved procedures, outdated equipment, fragmented responsibility, ambiguity in the policy or statute, and generally inadequate budget or resources (including lack of skilled people) are all operational problems that need to be corrected to assure accomplishment of the recommendations and progress toward objective.

EVALUATION

This section delineates responsibility for evaluating progress toward objectives and lists criteria for measuring success of the programs.

RECOMMENDED PRIORITY

The priority assigned the problem areas will be considered and determined at future meetings of the Governor's Health Planning Committee. The Committee, with assistance from Portland State University, is developing a system by which specific health problems can be assigned priorities on the basis of the many and diverse variables.

HEALTH DELIVERY SYSTEM PROBLEMS

EMERGENCY MEDICAL SERVICES

GOAL MINIMIZE PERSONAL INJURY AND LOSS OF LIFE BY PROVIDING ADEQUATE EMERGENCY MEDICAL CARE AND RELATED SERVICES TO ACCIDENT AND ILLNESS VICTIMS.

CONDITION

In 1968 emergency room facilities in Oregon treated over 400,000 patients, of which 12% were medical emergencies such as cardiovascular arrests, heart, asthma, allergic reactions, etc., and 35% were accident-injury victims. (See Table 1)

Motor vehicle accidents are the leading cause of accidental deaths. Oregon's motor vehicle death rate per 100,000 population was the highest in the western United States. In 1966, Oregon's rate was 36; Alaska 22; California 28; and Washington 29. In 1967, the rates were 34, 20, 27, and 29 respectively. In the past 15 years, the rate of motor vehicle deaths has climbed dramatically from a low of 25 in 1955 to a high of 36 in 1965 and has remained high: 34 in 1967; 33 in 1968; and 35 in 1969.[1] It is impossible to ascertain the number of motor vehicle accident-injury victims that could have been saved with improved emergency medical facilities and procedures. It will suffice to say that the potential for reducing loss of life in this area is significant.

This report addresses itself specifically to five major topics in emergency medical services: personnel, communications, facilities, transportation, and financing. In recent years more and more people have become concerned with the availability and quality of these services. Frequently, the care provided is critical in terms of stabilizing the vital processes of the individual. The following are some of the problems that have emerged from studies reviewing the spectrum of emergency medical services.

Communications. The entire system of caring for traffic casualties is inadequate. Rapid communication is often unavailable. For example, out of 143, 18% of the ambulance services operate without radios or mobile telephones. Of the 82% with radio equipment, only 32% can contact local hospitals, only 42% can call their local police, and only 14% can communicate directly with another ambulance base station. In addition, only 4 out of 79 hospitals are able to radio an ambulance service. The 11 rest areas along Interstate 5 have telephones. Most of these can be operated without a coin for emergency calls. According to the State Highway Department, there are 58 additional rest areas throughout the state, but only one has a telephone. In addition, there are 61 truck scale locations throughout the state, five of which have telephones.

1. U.S. Bureau of the Census, Statistical Abstract of the United States: 1969 (90th edition) Washington, DC, 1969; and the Oregon State Board of Health, Vital Statistics Section, Oregon Public Health Statistics Report for Calendar Year 1969.

Table 1

Types of Cases Handled by Emergency Departments in 1968

	Number	Percent
Exams and Miscellaneous (foreign bodies, burns, infections, upper respiratory infections, etc.)	95,781	29
Other Injuries (limbs, abdomen, chest, face, back, etc.,	51,881	16
Lacerations	50,490	15
Medical Emergency (cardiovascular arrest, heart, asthma, allergic reactions, etc.)	39,199	12
Patients Examined in Emergency Room by Their Own Physicians	26,726	8
Medications, Injections, Transfusions	23,262	7
Fractures	13,531	4
Patients Examined as a Result of Motor Vehicle Accidents	10,687	3
Cast Room	8,702	3
Minor Surgery (lesions, cysts, lipomas, etc.)	5,388	2
Overdoses	3,067	1
Unspecified (many hospitals did not keep records on the type of cases handled in the Emergency Room)	71,785	-
TOTAL	400,499	100%

Source: Oregon State Board of Health, Emergency Medical Services Evaluation and Master Plan Development, May, 1969. (Note: Unless otherwise noted, the remaining data in this report has been taken from the Emergency Medical Services Plan.)

Oregon has no statewide coordinated radio communication system for hospitals. Such a system would be critically need d during a crisis, disaster, and/or power failure.

Hospital routes are poorly marked and emergency vehicles often must travel streets clogged with traffic. Provisions for ambulances to change direction on freeways are very rare.

Transportation and Personnel. Ambulance equipment and/or staffing standards are inadequate to either treat victims at the accident scene or to prevent aggravation of injuries during transit. Less than 50% of the ambulance personnel providing direct care to the sick and wounded have had Advanced Red Cross training or its equivalent. Only 45% of the ambulances services met the minimal equipment standards recommended by the American College of Surgeons Committee on Trauma (ACSCT); 48% did not have oropharyngial airways; 45% did not have short or long spine boards; 45% did not have a hand-operated bag-mask resuscitation unit; 40% did not have padded mouth gags; and 21% lacked a leg-shaped hinged, half-ring splint. In addition, 11% reported that their vehicles were not equipped to care for burns. Staff training and experience was at a level where 26% were unable to handle emergency treatment of poisonings, 30% were unable to handle emergency births, and 85% were unable to handle radiation victims.

Financing. Inadequate mechanisms for financing quality emergency medical services represent one of the most significant problems retarding the improvement of emergency medical services. The question of who should pay for these services is a fundamental one. Should the burden be carried by the users themselves or should society, as a whole, bear more of the costs because of the widespread demand for high-quality and readily-available services by an educated public?

The financial situation as it now exists can best be described as precarious. One of the most significant reasons for this is the inability of many ambulance services to make a profit. High costs of equipment, vehicles, adequate personnel coverage, and poor patient-payment ratios have all contributed to the increasing number of ambulance companies closing down. Of the providers of ambulance services in 1968, only 22% showed a profit, 41% broke even, and 22% showed a loss (15% did not respond).

A particularly serious income problem reported by ambulance services is the inability to collect accounts receivable. This is further complicated because there is no lien law including ambulance services in Oregon.

Features of certain insurance policies also result in financial difficulties for ambulance services. Most insurance policies provide only minimal coverage (usually limited to $25) for ambulance transportation. In addition, a significant number of insurance companies pay the insured directly and not the vendor. Ambulance companies have complained that it is difficult to collect from the insured party and that insurance companies should pay directly to the vendor.

Few areas in the state have ambulance districts that are defined and honored. In the vast majority of areas having two or more ambulance services, no districts have been defined, with ambulance services competing with each other on calls to the detriment of all.

Over the years, city and county governments have assumed increasing responsibility for providing or partially subsidizing emergency medical transportation. In 1968, 71% of the 143 services were operated as non-profit services; at least 45% were governmentally operated and 15% were operated by volunteers. Approximately 40% of the services were privately operated as ambulance companies, funeral homes, hospitals, and other non-specified organizations. Less than 9% of the privately operated services reported that they received some form of subsidy from local government.

While several local government officials have expressed concern over the existing mechanisms for financing ambulance services, there is general consensus on the need for establishing statewide personnel and vehicle standards (as recommended by Oregon State Board of Health report: Emergency Medical Services Master Plan and Evaluation.) The concern of a few in local government is most clearly expressed in the following excerpt from a letter written by Donald L. Jones, League of Oregon Cities, dated April 10, 1970, to Comprehensive Health Planning:

> ...Most cities in the state are directly involved in the problems of ambulance service, either through regulation of private ambulance operators or through direct city operation of ambulance services. Over the past few years, a number of cities have been forced to take over the operation of ambulance services after private operators have abandoned them. This has been apparently the only way to keep any ambulance service in these communities. The city-operated ambulances have become significant burdens for the cities that have assumed them, and in almost all cases, require some sort of a general government subsidy inasmuch as they cannot be financed from service charges.
>
> The League executive committee asked to be placed on record as reminding the health planning agency, that a serious problem exists in financing adequate ambulance service throughout the state. The League will be very much interested in development of programs that give adequate consideration to financing needed services in all areas of Oregon. City officials are especially concerned that some existing public ambulance services will have to be discontinued if present plans to establish standards are pursued without also developing financing and operator training programs to help cities meet these standards.

It becomes apparent that a form of state-level funding as a subsidy is essential if Oregon is to provide requisite, quality emergency medical services to its citizenry.

Emergency Hospital Facilities. Many Oregon hospitals do not have specific service units: 60% do not have an intensive care unit; 28% do not have blood banks; 40% have no pathology lab; 74% have no X-ray therapeutic section; and 25% have no pharmacy.

Many emergency facilities in Oregon are understaffed, particularly during the second and third shifts. Sixty-seven percent of the 77 hospitals with emergency rooms have no full-time nurses or doctors in the emergency room, but are operated by surgery nurses or nurses from other departments. Four hospitals (5%) have no physician call lists. On-site inspection by Oregon State Board of Health revealed that in only 58% of the facilities were there prior arrangements for calling in specialists.

Thirty-four percent of the hospitals reported that not all emergency room patients are seen by physicians. Ambulance personnel universally complain about the length of time it takes for a physician to arrive at the emergency room. Many times a registered nurse in the emergency room waits until she sees the patient before calling a doctor to the emergency room, even though the ambulance company has telephoned ahead to the hospital relaying the nature of the emergency and requesting a doctor.

Only 24 hospitals had a basic medical emergency room physician's fee listed. Others state the physician makes his own charge. The fees among the 24 averaged $7.67, ranging from $3.00 to $10.00. Seventy-six reported a basic hospital emergency room fee. The average fee was $6.30, ranging from $2.00 to $13.00.

CURRENT PROGRAMS AND ACTIVITIES

Oregon State Board of Health, Emergency Medical Services Section, is responsible for the planning and coordination of a statewide program of emergency medical care and transportation. In May, 1969, they published the first comprehensive report on the status of emergency medical services in Oregon. All hospitals with emergency facilities, ambulances and rescue services, police departments, and officials representing city and county governments were surveyed by questionnaires and personal interviews. Since the completion of this study, Emergency Medical Services' staff has proceeded to develop community councils for emergency medical services.

The Section has developed, and is now implementing, a statewide training program for emergency care personnel through the community colleges in Oregon. This is a 72-hour course (similar to the one designed by the Multnomah County Medical Society), including advanced initial care of the sick and injured, accident scene management, extrication of accident victims, and training in the use of all equipment used in providing emergency medical services.

Their biennial budget for 1969-71 was $42,000 in Comprehensive Health Planning 314(d) monies and $55,000 in Highway Safety funds.

Oregon Traffic Safety Commission is responsible for the coordination and upgrading of emergency medical transportation and communication. They had a biennial budget of $150,000 for 1969-71, and disbursed $1,671,178 in federal highway safety funds from 1967 to 1970.

Recently, the Commission contracted with a consultant engineering firm to develop a statewide emergency medical radio communications plan. The plan will be concerned with frequency allocation, the establishment of emergency radio dispatch centers, and preparations for the eventual implementation of a single statewide phone number (911) for all emergencies. The plan should be completed early in 1971.

Several additional projects have been funded. The Washington County project (the first of its kind in the United States) establishes a single emergency communications center (central dispatch) connected to one universal emergency telephone number. Dialing the emergency number (911) connects the caller to dispatchers for the police, sheriff, fire department, ambulance companies, and Emergency Services.

The Lane County project will place under one radio dispatch center the various public, private, and voluntary ambulance operators. The central dispatch center links the ambulance to the hospital and has the capability of hooking up with police and fire. A reserve generator to power the radio, in case of power failure, is planned. In addition, a radio, interfaced with this system and funded by Traffic Safety, has been installed in a helicopter/ambulance owned by Bohemia Lumber Company. When this system becomes operative, Lane County will be the only county in the United States that has incorporated into its emergency service network a private industry-owned helicopter/ambulance to serve critically injured traffic victims.

The Malheur and Harney County project is the first in the United States to use solar batteries to power roadside radio-telephones where electricity is unavailable or undependable. In addition, five transmitters will be built on mountain peaks to transmit emergency communications in areas where previous emergency communications have always been limited or non-existent. The roadside telephones will be connected with an areawide radio network, tying into the Idaho and Nevada network.

The Portland Council of Hospitals Community Disaster Coordination Committee has been instrumental in organizing approximately 13 hospitals and over 5 ambulance companies in the Portland service area to install the Motorola system "HEAR" (Hospital Emergency Administrative Radio). The system operates on a high-band radio frequency allowing the interfacing of other non-Motorola high-frequency equipment. The "HEAR" system uses two radio frequencies and is designed to handle both day-to-day emergencies on 155.340 MH_Z and community or regional disasters on 155.280 MH_Z.

The Local System is a single frequency radio unit designed for day-to-day local emergencies. By lifting the handset on the radio unit, hospital staff can communicate to all other units on that hospital's (PL) "private line" (their mobile units, radio-equipped personnel, radio-equipped rooms, etc.). By dialing other "private line" codes, contact can be made with other hospitals and ambulance services within radio range.

The Regional System uses a two-frequency radio unit designed for communication at both the local community and regional levels. These units are operated only by designated "regional hospitals." Regional hospitals are responsible for coordinating hospital emergency activities at both the local and regional level in the event of a disaster.

An integral part of this plan is the designation of regional hospitals in strategic locations throughout the state. An inter-regional hospital communication network would enable the selected hospitals to communicate the extent of needed supplies, equipment, and manpower, regardless of power failure.

The Portland area is the only one in Oregon organizing an areawide radio communication system between hospitals and between hospitals and ambulances. Multnomah County Hospital was chosen by the Portland Council of Hospitals as the most ideal location for the "regional 'backbone' hospital" in the Portland area; the hospital intends to apply for federal funds to subsidize the $4,500 cost of the necessary equipment. However, it is waiting for the outcome of the statewide emergency services radio communication plan, contracted by the Traffic Safety Commission, before they submit the request. One of the next goals is to connect a Red Cross Mobile Unit and other rescue-emergency agencies with the regional hospital.[1] It should be noted that the "HEAR" system is primarily a hospital communication system and has limited utility as an ambulance communication network.

Nowhere in the state are any of the emergency medical services tied to the Communications Center and Command Post of the State Office of Emergency Services (Civil Defense). This means that in the event of disaster, there is no communication and no participation in the decision-making process between emergency medical services and the Emergency Services Agency. The only exception to this is the Oregon Nuclear Emergency Organization Plan, which calls for the participation of the State Health Officer, the Director of Emergency Services in the State Board of Health, and the Director of the Department of Environmental Quality to advise the Governor during a nuclear crisis at the command post.

1. Minutes of Portland Council of Hospitals Meeting held November 18, 1969.

The Department of State Police is planning to purchase and operate four helicopters beginning in the 1971-73 biennium. These vehicles will be used for a wide variety of purposes, including traffic control and surveillance, Driving Under the Influence of Liquor (DUIL) enforcement, emergency medical transportation, highway debris removal, criminal investigation, search and rescue, fish and game enforcement, and commercial fisheries enforcement.

Although its primary purpose will be traffic control and surveillance, the helicopter will be available for rescue operations and removal and evacuation of seriously injured individuals - especially in situations where ambulance access is difficult.

Air Transportation. In the Medford area, Mercy Flights offers a unique air ambulance service. For an annual family membership of $8, they will provide air transportation to members as far away as Portland, Seattle, or San Francisco. Flight services in Burns, Portland, Albany, and Joseph offer charter flights, but lack emergency equipment or personnel.

Air Ambulance, Inc. of Eugene offers charter air ambulance service to anywhere in the United States and the Eugene-Springfield Ambulance Service will provide the needed technicians and equipment.

At the time of the Emergency Medical Services survey, there were three helicopters in Oregon available for emergency transportation and rescue operations. The helicopter/ambulance owned by Bohemia Lumber Company in Cottage Grove is available to traffic accident victims throughout Lane County. The other two helicopters are owned by Ramblin Rotors, a private unsubsidized transportation service in LaGrande (Union County). They are equipped with only a torch and flares. Rental costs for the LaGrande helicopters are $140/hour. Recently, through an agreement with the Traffic Safety Commission, a Coast Guard helicopter/ambulance based in Astoria is providing rapid transportation to critically injured traffic victims within a 55-mile radius of Astoria.

AUTHORITIES

Oregon Traffic Safety Commission

ORS 484.520 - Creates the Traffic Safety Commission and lists the officials that shall serve by virtue of their office.

ORS 484.570 - Outlines the duties of the Commission, including "organize, plan, and conduct a statewide highway safety program."

ORS 484.590 - Governor to apply for, receive, and disburse federal highway safety funds to carry out approved state highway safety programs conducted under the Federal Highway Safety Act of 1966.

Oregon State Board of Health - Emergency Medical Services Section - administrative mandate.

PERSONNEL

OBJECTIVES

1. Upgrade the educational level of emergency medical services personnel so that all emergency medical technicians have completed the Oregon State Board of Health sponsored community college training program or its equivalent by 1973.

2. Upgrade the staffing level of ambulance services so that there will be two trained emergency medical technicians on at least 95% of emergency calls by 1973 (34% at present time).

RECOMMENDATIONS AND METHODS

1. *DESIGNATE A SINGLE STATE AGENCY RESPONSIBLE FOR CONSOLIDATING AND INTEGRATING INTO ONE STANDARD COURSE, THE TRAINING PROGRAMS CURRENTLY BEING CONDUCTED BY THE DEPARTMENT OF EDUCATION, STATE FIRE MARSHAL, COMMUNITY COLLEGES, BOARD ON POLICE STANDARDS AND TRAINING, RED CROSS, HOSPITALS, MEDICAL SOCIETIES, AND AMBULANCE ASSOCIATIONS. THIS INTEGRATED COURSE TO BE MADE AVAILABLE TO ALL EMERGENCY MEDICAL SERVICES PERSONNEL, PUBLIC SAFETY OFFICIALS (FIRE, POLICE, ETC.), AND THE GENERAL PUBLIC.*

   Method

   The Governor or Legislature designate the Oregon State Board of Health the sole State agency responsible for the consolidation of all emergency medical services training programs.

2. *REQUIRE EMERGENCY MEDICAL TECHNICIANS (AMBULANCE TECHNICIANS) TO BE LICENSED BY THE OREGON STATE BOARD OF HEALTH TO ASSURE THAT A MINIMUM TRAINING STANDARD HAS BEEN ATTAINED.*

   Method

   Oregon State Board of Health to prepare and submit legislation in 1971 to require emergency medical technicians to be licensed. Successful completion of minimum training standards (as defined by the State Board of Health) be a prerequisite to licensure.

3. *STAFF AMBULANCES ON ALL EMERGENCY CALLS WITH TWO TRAINED PERSONS.*

   Method

   Oregon Ambulance Association and Oregon Voluntary Ambulance Association adopt this staffing standard and urge their members to comply

4. *BROADEN THE GOOD SAMARITAN STATUTE (ORS 30.800) SO THAT NO QUALIFIED PROFESSIONAL/PARAPROFESSIONAL SHALL BE LIABLE FOR CIVIL DAMAGES RESULTING FROM THE ADMINISTRATION OF EMERGENCY CARE IN GOOD FAITH AT THE SCENE OF ANY EMERGENCY, UNLESS SUCH ACTS ARE WILLFULLY, WANTONLY, OR GROSSLY NEGLIGENT.*

Method

Oregon State Board of Health submit legislation to broaden ORS 30.800 to include all qualified medical professionals. Paraprofessionals, firemen, and policemen who have successfully completed the Oregon State Board of Health sponsored community college course on emergency medical care or its equivalent, should also be included in the law.

OPERATIONAL PROBLEMS

1. Licensed emergency medical services personnel may command higher salary rates, which will increase the cost of some services.

2. The cost of staffing ambulances on emergency calls with two trained persons may be prohibitive.

3. Local governments are currently encountering financial problems in operating emergency medical transportation services; higher standards for emergency personnel will increase the financial burden.

COMMUNICATIONS

OBJECTIVE

3. Broaden and upgrade the emergency medical services communications network:

   a) Develop a coordinated statewide emergency medical radio communication system with related networks appropriately integrated and interfaced.

   b) Develop and implement an integrated statewide emergency medical services communication plan so that by 1975 at least 75% of the providers of emergency medical services will be operating equipment compatible with and interfaced on the statewide network.

   c) Implement centralized dispatching centers responding to all emergency calls in the major metropolitan areas of the state by 1975.

d) Implement the universal (for all emergency calls - fire, emergency medical services, police, etc.) emergency telephone system (dial 911) in ten state administrative districts by 1980.

e) Install dial-tone (911) phones connecting to central dispatching centers at proper intervals on all primary highways by 1977.

RECOMMENDATIONS AND METHODS

Radio

5. *BROADEN THE RESPONSIBILITIES OF THE DIVISION OF EMERGENCY SERVICES TO DEVELOP A STATEWIDE PLAN FOR COMMUNICATION SYSTEMS AND TO PROVIDE CONSULTATION DURING THE INITIAL PLANNING, COORDINATION, AND REVIEW OF REGIONAL AND STATEWIDE COMMUNICATION SYSTEMS DEVELOPED BY PUBLIC AND PRIVATE AGENCIES AND ORGANIZATIONS.*

Methods

a. *Governor, through executive order, direct the Division of Emergency Services to:*

1) *Develop a state plan for radio communication systems.*

2) *Provide technical assistance and insure conformance with the state plan by all public or private agencies or organizations applying for state or federal funds and by any agency or organization requesting technical assistance.*

b. *Governor appoint an advisory council to the Division of Emergency Services including representatives of those public and private agencies and organizations that have a functional interest in the planning and operation of regional and statewide communication systems.*

c. *The advisory council to the Division of Emergency Services review all statewide and regional communication plans and make recommendations to the Division of Emergency Services.*

6. *DIVISION OF EMERGENCY SERVICES ASSUME RESPONSIBILITY FOR THE STATEWIDE PLAN FOR EMERGENCY MEDICAL RADIO COMMUNICATIONS DEVELOPED BY THE OREGON TRAFFIC SAFETY COMMISSION AND ASSURE THAT IT REPRESENTS THE BEST COLLECTIVE JUDGEMENT OF THE OREGON ASSOCIATION OF HOSPITALS, OREGON AMBULANCE ASSOCIATION, OREGON VOLUNTARY AMBULANCE ASSOCIATION, AND OREGON STATE BOARD OF HEALTH.*

Methods

a. *Oregon Traffic Safety Commission submit the prepublication draft of the statewide plan for emergency medical radio communications to the Oregon Association of Hospitals (OAH),*

the Oregon Ambulance Association (OAA), Oregon Voluntary Ambulance Association (OVAA), and Oregon State Board of Health for review and comment and the Division of Emergency Services for approval.

b. Ambulance services and hospitals be encouraged to give high priority to implementing the recommendations of the plan applicable to their organizations.

c. Oregon State Board of Health be authorized to assist hospitals and ambulance services participating in the emergency communications network in fully utilizing the communications equipment and to design standard operating procedures for emergencies.

d. Oregon Association of Hospitals designate regional hospitals by the end of 1971 which would also serve as "regional hospitals" for communication purposes.

e. Major metropolitan areas be encouraged to implement a central dispatching center for transmitting emergency calls to ambulances, fire, police, sheriff, or civil defense.

f. Centralized ambulance dispatching should be supervised and operated by qualified emergency medical technicians.

Telephone

7. *ESTABLISH THE UNIVERSAL TELEPHONE NUMBER SYSTEM (911), FOR EMERGENCY CALLS THROUGHOUT THE STATE. (PUBLIC TELEPHONE SHOULD BE REPLACED WITH TELEPHONES DESIGNED SO THAT THE EMERGENCY NUMBER CAN BE DIALED WITHOUT COIN.)*

8. *LOCATE PUBLIC TELEPHONES IN REST AREAS AND PARKS.*

9. *LOCATE DIAL-TONE (911) TELEPHONES AT PROPER INTERVALS ON PRIMARY HIGHWAYS. THEY SHOULD CONNECT DIRECTLY TO THE CENTRAL EMERGENCY DISPATCHING UNIT IN THE AREA.*

Method

Division of Emergency Services, together with the telephone companies and Public Utility Commissioner, implement the telephone systems within a reasonable time frame.

10. *INTERFACE THE DIVISION OF EMERGENCY SERVICES COMMAND POST WITH THE CENTRAL DISPATCHING UNITS AND "REGIONAL HOSPITALS" FOR COORDINATION DURING DISASTERS.*

Method

The Division of Emergency Services apply for federal funds to interface the command post with the central dispatching units and "regional hospital" communications system throughout the state.

Signs

11. *THE HIGHWAY DIVISION OF THE DEPARTMENT OF TRANSPORTATION INSURE APPROPRIATE DIRECTIONAL SIGNS TO EMERGENCY FACILITIES.*

Methods

a. *Highway Division of the Department of Transportation adopt the national hospital sign for highway use, developed by the American Association of State Highway Officials.*

b. *The Highway Division install informational signs in all rest areas, state parks, and wayside coffee shops and gas stations to identify available emergency facilities and how to get to them.*

12. *EMERGENCY ROOM SIGNS SHOULD BE CLEARLY VISIBLE ON THE OUTSIDE OF THE HOSPITAL AND AT THE EMERGENCY ROOM ENTRANCE.*

Method

Hospital administrators determine if the emergency room signs are adequate throughout the hospital area, and install additional signs where required.

OPERATIONAL PROBLEMS

4. Some ambulance services have recently purchased incompatible equipment and would find it economically infeasible to replace it immediately. (The cost of purchasing compatible radio equipment in ambulance services is estimated to be approximately $1,150 -- $1,500 per ambulance; for those services without radio equipment now, an additional $3,000 receiver at headquarters will be necessary. The cost of transmitters is not included because it is so variable, depending on location, height needed, and distance from base station.)

5. Police and fire agencies are reluctant to participate in central dispatching units until the emergency medical service field has implemented some sort of communications system and is on one frequency.

6. The installation of the "911" emergency phone system at proper intervals on primary highways is expensive.

7. Ambulance companies have expressed concern over who will man the dispatching equipment in the central dispatching unit. It is considered vital that ambulance companies control ambulance dispatching: to determine the legitimacy of the call, the type of service that is required, and instruct the caller in emergency care procedures.

AIR AND GROUND TRANSPORTATION

OBJECTIVES

4. By 1973, upgrade all ambulance services to comply with the 1968 minimal equipment standards of the Committee on Emergency Medical Services, Division of Medical Sciences, National Academy of Sciences.

5. By 1973, expand emergency helicopter transportation so that 90% of the state's population has helicopter service available (presently 13%).

RECOMMENDATIONS AND METHODS

13. *REQUIRE LICENSING OF AMBULANCE SERVICES OR OTHER ORGANIZATIONS THAT PROVIDE AMBULANCE TRANSPORTATION FOR THE ILL OR INJURED.*

Method

Oregon State Board of Health submit appropriate legislation to license those ambulance services whose ambulances meet the standards for vehicles and equipment, as established by the Committee on Emergency Medical Services.[1] *Vehicles used for transporting non-emergency cases should not be required to meet the above standards.*

14. *OREGON STATE HIGHWAY DIVISION TO DESIGN AND CONSTRUCT MEDIAN STRIPS ON FREEWAYS SO AS TO PERMIT EMERGENCY VEHICLES TO REVERSE THEIR DIRECTION AT POINTS SEPARATED BY NO MORE THAN TEN MILES.*

15. *ESTABLISH AMBULANCE SERVICE DISTRICTS TO ASSIGN GEOGRAPHIC AREAS OF PRIMARY RESPONSIBILITY TO AVOID OVERLAP OF SERVICES AND TO SERVE AS A TAXING AUTHORITY TO BROADEN THE BASE OF FINANCIAL SUPPORT FOR AMBULANCE SERVICES.*

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1. *Division of Medical Sciences, National Academy of Sciences booklet, Medical Requirements for Ambulance Design and Equipment (September 1968). The total cost for completely equipping an ambulance, according to this standard, is less than $300, excluding oxygen tanks -- 98.6% of the ambulances now have oxygen tanks.*

Method

Association of Oregon Counties submit legislation providing for the establishment of ambulance districts. Districts should be established by Councils of Government, with the advice of the areawide health planning committees.

16. *STANDARDIZE WARNING LIGHTS ON ALL AMBULANCES.*

Method

Oregon Ambulance Association and/or Oregon Voluntary Ambulance Association submit legislation standardizing ambulance warning lights.

17. *PUBLIC AND PRIVATELY OWNED HELICOPTERS SHOULD BE LOCATED IN A STATEWIDE CAMPAIGN TO RECRUIT HELICOPTERS CAPABLE OF AND AVAILABLE TO PROVIDE EMERGENCY TRANSPORTATION (PRIMARILY FOR SERIOUS EMERGENCIES REQUIRING RAPID TRANSPORT OR WHERE ACCESSIBILITY OF AN AMBULANCE IS IMPEDED).*

Methods

a. *Oregon State Board of Health negotiate with corporations and flight services owning helicopters to provide on-call emergency medical transportation.*

b. *Oregon State Board of Health request the cooperation of other governmental agencies to utilize existing helicopters for emergency medical transportation.*

c. *Oregon State Board of Health develop and circulate to all hospitals with emergency facilities, ambulance services, law enforcement agencies, and the medical societies, current lists of helicopters and charter planes available for emergency medical transportation.*

d. *Oregon State Board of Health should purchase emergency equipment and lend it to participating private, charter, and governmental helicopters.*

OPERATIONAL PROBLEMS

8. There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EMERGENCY HOSPITAL FACILITIES

OBJECTIVE

6. By 1973, develop a network of emergency hospital facilities to provide the full spectrum of emergency medical services.

RECOMMENDATIONS AND METHODS

18. *EVALUATE AND CLASSIFY ALL HOSPITAL EMERGENCY DEPARTMENTS IN TERMS OF THEIR FACILITIES, PERSONNEL, AND SERVICES, AS WELL AS THE TYPE AND SCOPE OF EMERGENCY MEDICAL CARE RENDERED.*[1/] [2/]

Methods

a. *Designate a limited number of "Major Emergency Facilities" in metropolitan areas with 24-hour full-time physician coverage and with the emergency-related equipment and physical plant capability of handling any emergency.*

b. *Designate other hospitals where a doctor is always on call within the hospital as "Standard Emergency Facilities." Such hospitals will be capable of handling "normal emergencies."*

c. *Designate other facilities as "Limited Emergency Facilities."*

d. *Oregon State Board of Health, in cooperation with areawide comprehensive health planning committees, Oregon Association of Hospitals, and county medical societies, inventory existing emergency facilities in their area and classify them into three types, according to the level of service they offer. This classification should be made public and utilized by the ambulance services.*

1) *"Major Emergency Facilities" provide:*

a) *Full-time coverage by a licensed physician on the premises of the hospital.*

b) *Twenty-four hour capabilities for rapid X-ray, laboratory, EKG, pharmacy, operating and admitting room services.*

c) *Twenty-four hour coverage by registered nurses in the emergency unit.*

d) *Adequate physical plant with appropriate backup system to handle any likely emergency situation.*

e) *Adequate backup personnel (professional and clerical) for unusual emergency situation.*

f) *Centers should be operated under the direction of an Emergency Department committee of the hospital medical staff.*

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1. *For more detailed information and procedures for classifying emergency facilities, see Journal of American Medical Association (JAMA) September 7, 1970, Vol. 213, No. 10, pp. 1647-1651.*
2. *Hospitals may limit their emergency facilities according to the availability of nearby major emergency centers. Hospitals not set up to handle emergencies will not be considered as emergency qualified.*

g) *A heliport shall be available in close proximity to emergency entrance.*

h) *There should be no more than one "Major Emergency Facility" in each city under 100,000 population.*

2) *"Standard Emergency Departments" provide: (a) physicians available on premises of hospital 24 hours per day; (b) registered nurses available on the premises of the hospital 24 hours per day; and (c) twenty-four hour capability of X-ray and laboratory.*

3) *"Limited Emergency Facility" maintain 24 hour-a-day capability to meet any emergency situation that might reasonably arise.*

19. *ESTABLISH THE UNIVERSITY OF OREGON MEDICAL SCHOOL POISON CONTROL CENTER AS THE CENTER FOR POISON INFORMATION FOR ALL EMERGENCY FACILITIES IN THE STATE.*

Method

University of Oregon Medical School submit a request for funds from the 1971 Legislature to operate poison control center.

20. *MORE EMPHASIS SHOULD BE PLACED ON RECOGNITION OF PSYCHIATRIC EMERGENCIES AND THE ROLE OF THE PSYCHIATRIST IN THE EMERGENCY DEPARTMENT.*

21. *STANDARDIZE SPLINTS, STRETCHERS, OXYGEN, AND OTHER EQUIPMENT FOR EXCHANGE PICKUP BETWEEN HOSPITALS AND AMBULANCES.*

22. *URGE IN ALL NEW CONSTRUCTION OR REMODELING OF HOSPITAL FACILITIES THAT THE SPACE ALLOTTED TO EMERGENCY FACILITIES BE DETERMINED ON THE BASIS OF THE ACTUAL AND POTENTIAL PATIENT LOAD OF THE EMERGENCY DEPARTMENT. ALL FACILITIES MAKING UP THE EMERGENCY DEPARTMENT SHOULD BE LOCATED ON THE GROUND FLOOR IN ADJACENT AREAS -- THIS WOULD INCLUDE X-RAY, LABORATORY, AND OPERATING ROOMS.*

OPERATIONAL PROBLEMS

9. The University of Oregon Medical School Poison Control Center is presently an unfunded operation. If it were used extensively throughout the state, serious burdens would be placed on the personnel now donating their time to it.

FINANCING COSTS OF EMERGENCY MEDICAL SERVICES

OBJECTIVE

7. By 1975, develop methods of financing emergency medical services so that ambulance services and emergency facilities will be financially sound and capable of providing a high level of care.

RECOMMENDATIONS AND METHODS

23. DEVELOP METHODS FOR FINANCING HIGH QUALITY EMERGENCY MEDICAL SERVICES.

Methods

a. The Emergency Medical Services Advisory Council to the Oregon State Board of Health study and make recommendations to the Governor's Health Planning Committee on improved methods of financing emergency medical services.

b. The Emergency Medical Services Advisory Council of the Oregon State Board of Health study and make recommendations to the Governor's Health Planning Committee defining the role and responsibility of state and local governments in providing or subsidizing emergency medical services.

24. ALLOW AMBULANCE SERVICES TO FILE LIENS AGAINST PERSONS WITH OVERDUE BALANCES (AS PHYSICIANS ARE ABLE TO DO).

Method

Department of Commerce prepare and submit legislation providing for a "lien law" for ambulance services.

25. PAYMENT BY INSURANCE COMPANIES SHOULD BE MADE DIRECTLY TO THE VENDOR, NOT THE INSURED.

Method

Insurance companies reassess their payment policies and attempt to provide direct payment to the vendor instead of the insured.

OPERATIONAL PROBLEMS

10. There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

VOLUNTARY ORGANIZATIONS

OBJECTIVE

8. By 1972, coordinate all emergency medical services planning at the state and district levels.

RECOMMENDATIONS AND METHODS

26. *EACH AREAWIDE COMPREHENSIVE HEALTH PLANNING COMMITTEE ESTABLISH AN ADVISORY COMMITTEE ON EMERGENCY MEDICAL SERVICES MADE UP OF REPRESENTATIVES FROM RED CROSS, LAW ENFORCEMENT AGENCIES, FIRE DEPARTMENTS, AMBULANCE AND RESCUE SERVICES, MEDICAL SOCIETY, HEALTH DEPARTMENT, CIVIL DEFENSE, HOSPITAL ADMINISTRATOR, ETC. THIS ADVISORY COMMITTEE TO HAVE THE RESPONSIBILITY FOR PLANNING, COORDINATING, IMPLEMENTING, AND REVIEWING THE EMERGENCY MEDICAL CARE SYSTEM IN ITS DISTRICT.*

OPERATION PROBLEMS

11. There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

1. Completion of state-approved community college course by 100% of emergency medical technicians by 1973.
2. Preparation and implementation of state communications plan.
3. Compliance with minimal equipment standards for all ambulances providing emergency transportation by 1973.
4. Establishment of a network of emergency care facilities offering a complete range of services by 1973.
5. Establishment of mechanisms for adequately financing emergency medical services by 1975.
6. Establishment of mechanism for planning and coordinating emergency medical services throughout the state by 1972.

PRIORITY

To be determined.

FACILITIES

GOAL ESTABLISH IN EACH ADMINISTRATIVE DISTRICT, A NETWORK OF COOPERATING HEALTH-PROVIDER ORGANIZATIONS MAKING AVAILABLE TO ALL OREGONIANS (REGARDLESS OF THEIR LOCATION, ECONOMIC CIRCUMSTANCES, TIME OF NEED, RACE, RELIGION, OR NATIONAL ORIGIN) A CONTINUUM OF COMPREHENSIVE HEALTH SERVICES (INCLUDING PREVENTIVE, DIAGNOSTIC, THERAPEUTIC, EMERGENCY, CURATIVE,[1] AND MAINTAINATIVE SERVICES) LOCATED AS CLOSE TO THEIR WORK AND HOME SETTINGS AS IS CONSISTENT WITH THE ACHIEVEMENT OF GENERALLY RECOGNIZED SERVICE QUALITY STANDARDS AND THE ACHIEVEMENT OF OPTIMUM UNIT SERVICE COSTS.[2]

CONDITION

The following "facility" categories are addressed in this report:

a. Neighborhood clinic services
b. Extended care facilities
c. Hospitals
d. Laboratories
e. Outpatient services
f. Rehabiliation facilities

It should be noted that the facility categories listed above are not exclusive of one another, not always easily distinguishable, and not amenable to unambiguous description. Clear-cut definitions simply do not exist because there is a great deal of overlap between each category. As new skills are created and technology advanced, category definitions also change. Certain organizational settings have evolved over the years in order to make services available for people who needed them. Most development has occurred in response to the availability of funds to pay for these services. These artificial boundaries have been fortified by licensing laws, certification requirements, and

1. i.e., Intensive, Acute, Intermediate, Convalescent, Rehabilitative, Home, and follow-up.
2. The health care facility network envisioned in the goal above conceptualizes a system which does not violate the cultural mores of the people or force them to undergo humiliation, extreme cost, or inconvenience in order to obtain needed health services; a system which firmly places decisions on the allocation of resources in the hands of informed and responsible community consumer representatives; a system which features rational cost and quality controls with performance-review feedback to long-range planning at the district and state level; a system which (insofar as is possible, consistent with the goal elements previously outlined) allows for provider competition, self-government and operating autonomy, and plural forms of ownership, organization, and association.

financing mechanisms, and have occasionally been changed by these same mechanisms. Home care and extended care was a Medicare formulation combining certain traditional aspects of hospital and nursing home services. Neighborhood clinic services are an Office of Economic Opportunity formulation of traditional hospital-physicians' office services and social welfare services.

Laboratory and rehabilitation services may be component services of both hospitals and nursing homes, and yet these services have also been provided in many physicians' offices. Exclusive definitions for these services have been attempted, but have never been widely accepted because they have been attempts to define components as if they were the whole rather than parts of the whole. There are no "natural" divisions of the health service provision universe which allow any particular service or service provider to stand alone, out of context with the other services or service providers. The divisions that do exist, exist as a matter of tradition, administrative convenience and licensure. However, for the purposes of this chapter, it may not be important to define each of the above classifications, if when all merged into one category, they form a patient service continuum.

Tradition, administrative convenience, medical politics, community pride and lack of reimbursement controls are powerful factors which, if unchecked, tend to fragment services unnecessarily without providing mechanisms to offset the fragmentation. Oftentimes, the intrinsic similarities among all health provider organizations and their essential relationships with one another are obscured by their surface-level differences. The differences, then, rather than the similarities, become institutionalized. They are embodied in laws, rules, regulations, financing mechanisms, accounting systems, and statistical reports.

Patient service is, and must be, a continuum or continuity of care. Persons require certain services to obtain, maintain, and restore their capacity to function as productive human beings. They need mental, physical, preventive, curative, restorative, supportive, inpatient, outpatient, and home services. There is no "natural" reason for any of these services to be exclusively provided by any particular kind of traditional or newly formulated health provider organizations. Laboratory screening services in a given area, for example, may best be provided by a for-profit, physican-directed multiphasic screening unit affiliated with a nonprofit hospital. In suburban Portland, an identical service may best be provided in private doctors' offices or group practice clinics, while in an urban ghetto it may best be provided in a neighborhood clinic or in the outpatient department of a large hospital. The roles of all provider organizations are undergoing serious review at this time. We simply do not have enough information in 1970 to conclude that one form of organization is always more effective than any other in the provision of a particular

service. We cannot, therefore, rationally conclude that a certain spectrum of services ought to constitute "hospital" services while a distinctly separate and different spectrum of services ought to constitute "nursing home services," and so on.

For the reasons indicated above, this study emphasizes consideration of services and service programs rather than institutions. Where this is not possible and the nature of the text requires a reference to the various categories of organized health providers, we will utilize the following "working" definitions:

a. Clinics (outpatient services; ambulatory services):

   Facilities to enable persons who are ill, injured, or concerned with potential illness to seek the consultation, diagnosis, prescription and/or treatment of licensed medical professionals on a routine (non-emergency), ambulatory (walk-in office-type setting) basis. Clinics may offer far more than physician services (i.e., laboratory, x-ray, minor surgeries, pharmacy, physical therapy, screening, etc.).

b. Hospitals:

   Institutions organized and licensed to enable the combined application of licensed professionals' consultative, diagnostic, prescriptive, and therapeutic services, with the services of a number of supportive professional and technical personnel and with supportive space, equipment and supplies, to provide curative, restorative, and supportive services, on an inpatient (patients in bed) and/or outpatient (walking patients) basis; institutions organized to care for routine and emergency cases for two or more nonrelated individuals on a 24-hour basis; institutions which may provide any of the following levels of intensity of patient service: emergency, intensive, acute, intermediate, convalescent, custodial, rehabilitative (restorative), and home care services.

c. Nursing Homes:

   Institutions providing primarily long-term (at least 30 days or more) convalescent and/or chronic care for a period exceeding 24 hours for two or more ill or infirm patients not related to the nursing home administrator or owner by blood or marriage. Convalescent and chronic care may include, but need not be limited to, the procedures commonly employed in nursing and caring for the sick.

d. Homes for the Aged:

   Institutions providing board, domiciliary, and residential care (for compensation) for three or more aged persons not

related to the operator by blood or marriage. A new name for facilities within this category is also Retirement Apartments.

When we refer to services and service programs, we will use the following "working" classifications and definitions:

a. Environmental Health Services:

Air, water, and noise-pollution controls; sanitation and engineering services; health aspects of urban planning; and occupational health services.

b. Identificative Services:

The testing of apparently well persons to identify latent or potential illness before it results in impairment of functional capacity. This service might also provide a health data bank in the future.

c. Preventive Services:

Health education and information; maternal and child health services; vision conservation; preventive mental health services; fluoridation and other preventive dental health services; vaccination and communicable disease-control services, including tuberculosis and venereal-disease control; annual physical examinations, etc.

d. Outpatient Services:

Non-emergent, consultative, diagnostic, and therapeutic services provided to people who are partially incapacitated or sick but remain ambulatory.

e. Emergency Services:

Services required to assure immediate response at any time to situations believed by ill or injured persons to be emergencies. This category includes disaster medical, ambulance, mobile intensive care, emergency communications, and emergency medical services such as those provided in hospital emergency rooms.

f. Curative inpatient institutional services (normally provided by hospitals):

Including emergency and non-emergent diagnostic, prescriptive and therapeutic, (intensive, acute, intermediate, convalescent, rehabilitative, and home care services).

g. Maintainative inpatient institutional services (normally provided by nursing homes, homes for the aged, and home health agencies):

Including custodial, residential, social, and economic services, as well as controlling drug therapy and nursing services and preservative rehabilitation services.

It will be noted that the service classifications utilized above describe a comprehensive continuum of services that any individual person might require to obtain, maintain, and restore a state of optimum functional health capacity.

By Comprehensive we mean: the delivery of environmental, preventive, diagnostic, curative, restorative (rehabilitative) and maintainative services integrated in such a way that they are brought to bear on the total needs of the individual or family. It is widely believed that this can be accomplished only by 1) a continuing relationship with a central source of care (one person or a team of providers) with responsibility for the health of the patient; and 2) the coordination of the entire range of services through the primary provider. Thus, a full range of uncoordinated services does not constitute comprehensive care, nor does a continuous patient-physician relationship without accessibility to the complete breadth of services.

By Continuum we mean: that persons are treated as whole persons rather than collections of organs, diseases or conditions requiring treatment; and that needed services are coordinated to apply what persons need, when they need them. An uninterrupted ordered sequence of health services (continuity of care).

General Condition

More than 500 organizations provided health care services for the 2,056,171 people[1] of Oregon in 1970. They are owned and operated by all levels of government, for for-profit coporations and proprietors, religious groups and by non-sectarian, non-profit corporations. As individual organizations, they are referred to as general and special, long-term and short-term, convalescent and intermediate care hospitals; extended care facilities and nursing homes; homes for the aged; group care homes; foster homes; home health agencies; halfway houses; infirmaries; psychiatric hospitals; domicillaries; diagnostic and treatment centers; clinics; etc.

Health facilities, often thought of simply as buildings, are in actuality complex social and economic structures. They exist to enable the focus of many diverse technical skills and facilitating

1. Preliminary report of 1970 Census Bureau totals carried on pages 1 and 5, The Oregon Journal, Final Edition, September 2, 1970.

resources (equipment, supplies, and space) on the needs of individuals with impaired functional capacity at specific and difficult to predict points in time. At the present time, individual institutions are primarily organized around predictable levels of intensity of patient service. Thus general hospitals are normally organized to handle acute, short-term spells of illness or injury at a high level of service intensity. General hospitals normally are characterized by high capital investment, large numbers of highly skilled workers, intensive staff/patient ratios (currently averaging about 2.7 employees per patient), short-term services, and high costs per unit of service. Lowest on the service intensity scale are homes for the aged, which usually provide long-term services in a home setting, with a low capital investment requirement, low staff/patient ratios (currently estimated at less than 0.5 employees per patient), and a low cost per unit of service.

Health facilities in Oregon encompass about 10% of the total available facilities in the Pacific States (Alaska, Hawaii, California, Washington, and Oregon), and about 1% of the available facilities in the United States. Quality standards, which have long been applied to hospitals, are not yet uniformly agreed upon for the other categories of health facilities. Eighty percent of our hospitals are accredited by the Joint Commission on Accreditation of Hospitals.[1] This compares favorably with the national average of 82%. Oregon compares less favorably with the Pacific States' average of 95% due to the large number of small hospitals in Oregon which serve large rural areas with low population density. Small hospitals have much greater difficulty matching J.C.A.H. standards than do large hospitals.

As alluded to earlier, there is no uniform acceptance of clear-cut definitions of the various categories of health facilities for utilization in data gathering. Accounting and service statistical reporting systems are not standardized. The asset value of these organizations, their total annual expenditures, the number of persons they employ, the number of persons they serve, and the extent of their capacity to serve, therefore, can only be roughly estimated.

The following examples will point up the nature of the problem: 1) The Health Facilities Planning and Construction Section of the Oregon State Board of Health, on page 203 of its 1971 State Plan, reports a total of 86 general hospitals and 175 long-term care facilities (consisting of 139 nursing homes, 12 hospitals, and 24 long-term units of hospitals) for the State of Oregon as a result of the application of Federal formulae to its base data. It lists three mental hospitals, one tuberculosis hospital, and ten rehabilitation facilities separately. It does not list the Veterans' Administration hospitals at Portland and Roseburg, and the Veterans' Domiciliary Center at White City, 2) the Health Facilities Licensing and Certification Section of the Oregon State Board of Health in its April 1, 1970 list of licensed institutions,

1. J. C. A. H. standards are cooperatively established by the American Medical Association, the American Hospital Association, the American College of Physicians, and the American College of Surgeons.

reports a total of 114 hospitals (including convalescent and intermediate care facilities, but excluding the two Veterans' Administration facilities) and 193 nursing homes; 3) the American Hospital Association lists a total of 88 hospitals in Oregon (including the Veterans' Administration and mental hospitals, but excluding convalescent and intermediate care facilities).

The most recent report by the American Hospital Association lists total value of the assets of its 88 member hospitals at just under $300 million. It reports 1969 expenditures of about $181,500,000, and a total of 20,681 employees. Comparable data is not available for other categories of health service providers. Total institution patient days of care (from the 1971 state Hill-Burton Plan, plus an estimate for homes for the aged) are estimated for 1969 at about 7,850,000. Outpatient services (including home health services) are estimated at about 1,340,000 visits for 1969. Occupancy (or utilization) rates in 1970 have been averaging about 70% for general hospitals, 80% for nursing homes, and nearly 100% for homes for the aged. Utilization of home health services is believed to be less than 70%, but the actual percentage has not been determined.

While efforts (by such organizations as the Oregon Regional Medical Program, the State Comprehensive Health Planning Agency, and the area-wide health planning councils of Portland, Eugene, Coos Bay, and others) have been and continue to be made to evaluate the adequacy of existing health facilities and to objectively determine unmet needs, actual needs cannot be accurately determined for the state as a whole from currently available data. It would appear, however, that there are substantial unmet needs for additional homes for the aged, as well as for more health facilities offering comprehensive services in sparsely populated rural areas, and a substantial need for modernization of nursing homes and hospitals.

The difficulty illustrated above in reporting the status of health facility development in the State of Oregon is compounded by the absence and/or fragmentation and lack of coordination of health facilities planning, financing, and licensing efforts at the district and state levels. Existing health facilities have not always been developed in clear response to demonstrated needs, and clearly demonstrated needs have not always resulted in the establishment of facilities. Health planning agencies capable of identifying facility needs and reviewing development proposals do not yet exist in all areas of the state, nor do those in existence have the requisite authority to function effectively. There is not a single focal point at the state level for total facility planning. There are many state, federal, and local certifying, licensing, accrediting, and financing bodies; each with its own goals and objectives, definitions, limitations, criteria, standards, rules and regulations, and reporting systems.

Though there have been encouraging attempts at the local level to surmount the fragmentation problem (recent mergers of the hospitals in

Astoria and Salem and the planning of a single hospital for Coos Bay-North Bend are examples), most facilities are still not relating their services to one another in such a way as to provide a continuum of services offering continuity of care for individual patients. There are few incentives or planning agencies encouraging them to do so.

A long-standing facilities planning goal has been the development of patient and information flow among the health facilities in each district, and from the districts to and from centers offering wider-scope services of greater specialized complexity. In the absence of incentives or regulations designed to further the realization of this goal, few formal or informal regional networks have been developed. The service provision system operates in response to effective demand for services. Consequently, needs not addressed by financing mechanisms have gone unmet.

The cost of services provided by health facilities in Oregon and elsewhere in the nation is rising faster than most other consumer services (13% in the past year). Many elements of this increase are not subject to the control of the facilities operators, such as lack of adequate payment by government and rapidly changing medical technology, etc. Health facilities have been slow to adopt more sophisticated technological improvements and professional management techniques which might have reduced the rate of increase. In Oregon, this is partially attributable to the small size of our institutions. (The average hospital size in Oregon is 111 beds; the average nursing home is 68 beds; and the average home for the aged is 24 beds.)

Historically, the dominant motivation of health facility development has been charitable and little (if any) income has been generated from operations which could be invested in technological innovation. Automated and industrialized services could be shared in a district if the substantial capital their establishment requires were made available and if management mechanisms were devised which didn't threaten the operating autonomy of the facility owners. In the absence of sufficient capital and an appropriate organizational device, however, little progress has been made to incorporate modern automation technology which might help contain the increasing costs of health facility services.

In other words, it would appear that a little "pump priming" is in order. Technological advances in provision of health care services in a health facility environment would be more rapid if there were:

a. incentives for experimentation;

b. funds to support certain developmental "risk" ventures;

c. long- and short-range planning efforts conducted by the majority of the health facility organizations;

d. incentives to encourage mergers, centralization of services and development of comprehensive health resources on a district basis;

e. a larger number of professionally trained administrators. (Only 69 affiliates (of which number only nine were fellows) of the American College of Hospital Administrators served the 116 hospitals in Oregon in 1969.)

Currently, the Kaiser Foundation (with Federal Health Services Research Center grant assistance) and the University of Oregon Medical School Hospitals (also with federal grant assistance) plus the Physicians' Association of Clackamas County are known to be conducting research efforts in health delivery system improvements. These efforts are minimal and dependent on the vagaries of the federal treasury. Generally, it is believed that some form of providing comprehensive health service on a regional capitation basis must be developed if we are to improve the total system. Other institutions, operating in a negative incentive climate without risk capital, are unwilling or unable to conduct an "on-going critical review" of their operation systems and a systematic program of experimentation with new methods and techniques. The hospitals of Washington, Oregon, and Idaho, with the assistance of Kellogg Foundation and Blue Cross Service Plans of Washington, Oregon, and Idaho, have contracted with Batelle Northwest to assist them in conducting management systems and methods improvement programs during the past year. Insufficient time has elapsed for an evaluation of this program.

Thomas S. Bodenheimer, M.D., in an article entitled "Patterns of American Ambulatory Care," (INQUIRY, Volume VII, No. 3, September 1970, pages 26-37) has attempted to measure the prevailing patterns of American ambulatory care against our stated National Health Care Goals. Dr. Bodenheimer listed the patterns and his estimate of their relative utilization by the American people as follows:

Patterns of Care	Percent
No care	5
Private physician as central and only source with or without referrals	10
Private physician as central source, plus other primary physicians	45
Private physician as central source, plus use of outpatient department, emergency room, and/or non-hospital clinics	10

Patterns of Care	Percent
Group practice as only source	4
Group practice as central source, plus independent physicians	4
Hospital outpatient department as only source	3
Hospital outpatient department as central source, plus other sources, such as private physicians and/or emergency room	5
Emergency room as central or prominent source, with or without other sources	3
Non-hospital clinic as central source, usually with other sources	1/2
No central source; use of variety of independent practitioners, outpatient departments and emergency rooms	10
Neighborhood health center as central source	1/2
	100

In his conclusions, he evaluates the patterns against the nation's stated health care goals. His evaluation is quoted, below.

"The next logical step would be to rank these patterns with respect to comprehensiveness, accessibility, and quality of care. However, the impossibility of measurement even on a semi-quantitative basis makes such an ordering futile. Instead, we will make a few generalizations (each of which has numerous exceptions) about the relation of the patterns to the health care goals.

"1. Patterns with a strong central source are more comprehensive and more accessible than those with weak or no centrality. This is true because comprehensiveness requires the coordination of services through one person or team, and accessibility is enhanced by a clearly defined, single point of entry into the health care system. Furthermore, patterns with a weak central source are an indication of the poor accessibility or narrow

breadth of services of that source; otherwise, the centrality would presumably be stronger.

"2. Patterns centering on group practice, outpatient departments and neighborhood health centers are potentially more comprehensive than patterns involving the independent practitioner network or the emergency room. This is due to the presence at one site of a wide range of services and the easy institutionalization of channels between these services. Emergency rooms deal only with minimal diagnosis and treatment, avoiding all other facets of health care, and the independent practitioner network has weak linkages, both spatially and functionally, among the various services offered. The conclusion cannot be reached, however, that the potential for comprehensiveness of the group practice, outpatient department, and neighborhood health centers has been realized; individual institutions vary widely, as a comparison between traditional and reformed outpatient departments would probably show.

"3. No general statement comparing the health care institutions with respect to accessibility can be made; this varies with the type of accessibility under consideration. Hospital emergency rooms are the most accessible; solo practitioners (in some places) are the most distance-accessible; neighborhood health centers (for some people) are the most accessible financially; and socio-cultural accessibility varies with the cultural group in question. This conclusion points out the impossibility of constructing one ideal pattern for a large heterogeneous population. Different institutions are ideal for different population densities, different economic and social groups, and different diseases. (However, there is a growing interest in Oregon hospitals to provide paid physicians to run emergency rooms. Such a service is already being provided in Klamath Falls, Salem, Portland, and other areas.)

"4. No generalization can be made as to quality, since essentially no comparative studies of quality of care for different patterns have been done. It is generally felt that a supervisory mechanism enhances quality, but the capacity (both human and technical) of each provider is certainly far more important in determining quality than any particular health care pattern."

Regional Health Centers

The 1970 Hospital Guide Issue (August 1, 1970) of Hospitals magazine (pages 463-470) documents a distinct movement on the part of general, community hospitals during the 1960's toward the provision of nearly every type of medical service and predicts the acceleration of that tendency in the 1970's. In most communities in Oregon the community hospital has evolved as the natural focal point for a variety of agencies contributing to the delivery of comprehensive personal health service.

It is the only organization that brings together community leadership, community resources, professional management skills, physicians, and other professional and technical personnel to organize and effectively deliver the entire spectrum of essential health services.

The continued trend toward specialism, together with an accelerated development of complex technological improvements requiring substantial capital investment, high-volume operation, and team utilization tends to support the contention that further conversion of general community hospitals into comprehensive health centers is distinctly in line with the public interest.

If regional health care centers are deemed feasible and this approach is adopted to provide the full continuum of health care services in designated geographic areas, these centers should develop plans outlining:

a. The extent of environmental, identificative, preventive, outpatient, emergency, curative, maintainative, and home services they will seek to make available at the center location;

b. The extent of educational, training, and research and development programs they will seek to conduct at the center location;

c. The extent that they will relate to regional and state centers for clinical and educational services too specialized for location at the district level;

d. The extent that they will provide extended clinical, administrative, educational, and supportive services to other facilities within their district and to population groups not adequately served by existing health facilities within their district;

e. The extent of their involvement in developing a health maintenance organization which might enable care to be delivered on a per capita rather than a fee-for-service basis.

In densely populated districts, two or more centers may be designated, in which case each center would be assigned a geographically circumscribed subdivision of the district.

Community (not-for-profit and for-profit) hospitals may not always be the appropriate organization to fulfill these functions. In some cases, the responsibility to develop a community health center might best be assumed by an educational institution, a group practice clinic, an association of physicians, or a public service corporation formed for this purpose.

Also, the health center organization need not own or merge any particular component part of the complex. The organization does, however, need

to accept the responsibility to provide, establish, advocate, and/or arrange for the availability in their district of the full spectrum of comprehensive health services needed by the residents of the district.

Either by establishment within the district or by means of organized provision arrangements with centers in neighboring districts, the following minimum spectrum of health facility services should be available within each district to all of the residents of the state:

a. Environmental Services: Air, water, and noise-pollution control programs; engineering; sanitation; food-inspection programs.

b. Identificative Services: Automated multiphasic screening programs and health data bank.

c. Preventive Services: Environmental and occupational safety programs; community health information and education programs; community mental health service programs; preventive vision and dental health service (including fluoridated water) programs; vaccination and communicable disease control services; periodic physical examination programs.

d. Outpatient or Ambulatory Services: Physician services in at least the following specialties (the Oregon Medical Association needs to clarify those specialties to be offered):

1. general practice
2. internal medicine
3. general surgery
4. psychiatry
5. opthalmology
6. otorhinolaryngology
7. urology
8. neurosurgery
9. general pediatrics
10. obstetrics
11. orthopedic surgery
12. radiology
13. pathology
14. anesthesiology
15. thoracic surgery
16. dermatology

Dental physician services in at least the following specialties (the Oregon Dental Association needs to clarify those specialties offered):

1. general dentistry
2. orthodontics
3. pedodontics
4. prosthetics
5. oral surgery

Social service (counseling, placement, and referral) programs; organized outpatient service programs:

1. dental
2. laboratory
3. physical therapy
4. orthopedic

5. radiological
6. surgical
7. pre and postnatal
8. family planning
9. prosthetic
10. chronic disease
11. renal dialysis
12. nutrition

e. Emergency Services: Civil disaster program; emergency communication services; emergency transportation services (ambulance service); mobile intensive care services; hospital emergency room services.

f. Curative and Restorative Services available for inpatients, outpatients, and emergency cases:

1. Laboratory Services:

autopsy
bacteriology
bio-chemistry
blood bank
virology
hematology
histology
parasitology
serology
cytology

2. Radiological Services:

diagnostic x-ray
fluoroscopy
diagnostic tracer
radiation therapy
(ortho and super voltage)
(superficial and deep)
radium or cesium

3. Special Services:

intensive care unit
electroencephalogram
electrocardiogram
electromyography
cancer registry
inhalation therapy
orthopedic appliances
pharmacy
coronary care unit

4. Physical medicine and rehabilitative services:

psychological counseling
occupational therapy
physical therapy
speech therapy
corrective therapy
recreational therapy

5. Inpatient care services:

delivery room
newborn nursery
premature infant care
operating room
orthopedic service
long-term care service
obstetrical service
medical service
surgical service
pediatric service
psychiatric service
self-care service

6. Education Facilities

g. Related Extended and Corollary Service Programs: home care program; continuing education program (for all technical and professional personnel); training programs (nurses, technologists, dietitians, etc.); scientific research programs; experimental projects and community educational programs such as maternal-child classes, diabetic classes, first aid, etc.

h. Maintainative inpatient and outpatient services: custodial nursing care; residential services; controlling drug therapy; meals on wheels; foster home service; social and economic assistance services; preservative rehabilitation services; homemaker service; day care home service; recreational service; alcoholic and detoxification.

The scope of service made available in each district by clinics, public health departments, hospitals, nursing homes, homes for the aged, and home health agencies should depend on the traditions and values of the district; the administrative arrangements acceptable to the district; and the economic, managerial, and professional resources of the district. If not available in a district, contractual arrangements with other districts could be made to provide service.

The Map and Chart attached as Exhibit 1 (information extracted from the Oregon Regional Medical Program Patient Origin Study (1967-68)) have been included to show the regional patterns of patient hospital utilization in Oregon. The Maps attached as Exhibit 2 have been included to show the location and bed capacity of hospitals and nursing homes in Oregon.

Exhibit 3 contains a summary of contributions which were solicited from health facility representatives throughout Oregon in an attempt to identify specific conditions which affect the operation and development of health care institutions in the state. These statements represent the considered judgments and opinions of the identified resource agencies, and do not reflect necessarily the position of the Governor's Health Planning Committee or Comprehensive Health Planning in the state of Oregon. Where applicable, some of this input, together with implementing objectives, recommendations, and methodology has been either cross referenced or incorporated into other sections of the Comprehensive Health Plan and deleted from this report (e.g., data relating to health manpower, ambulance service, home health services).

Specific conditions discussed in Exhibit 3 are as indicated below:

1. All health facility roles are under review.

2. Existing laws discourage health facility innovation.

3. High judgment malpractice liability awards have had undesirable side effects.

4. Some Oregon residents have difficulty gaining access to needed services.

5. Hospital outpatient services are not widely available in Oregon.

6. Many hospital emergency rooms are inadequate.

7. Ambulance standards are inadequate.

8. Ambulance service financing mechanisms are inadequate.

9. Many health insurance policies are deceptively inadequate.

10. Rehabilitation services are poorly utilized and provided by all types of facilities without adequate quality controls or widely accepted standards.

11. Rehabilitation services are not integrated with other services.

12. Clinical laboratory technology is changing rapidly.

13. Health worker licensure laws have not always operated in the public interest.

14. The supply of trained health manpower is inadequate.

15. Some hospitals believe that facilities for the care of abortion cases are inadequate.

16. There are inadequate controls on the establishment of new health facilities.

17. Most health facilities do not have formal long-range planning programs.

18. Most facilities do not dispose of wastes in accordance with the state's pollution-control goals.

19. Present methods of determining true needs for health facilities are inadequate.

20. Mechanisms to provide capital funds for facility improvement are inadequate.

21. Nursing home and home for the aged developments are under the primary control of the public financing agencies.

22. Home care services are widely available but poorly utilized.

Exhibit 4 contains an index of source material and references for facilities planning in Oregon.

CURRENT PROGRAMS AND ACTIVITIES

The Governor's Health Planning Committee is responsible, with staff assistance from the Executive Department, to develop a comprehensive statewide health plan and to coordinate health planning activities within the state. The Committee acts in an advisory capacity to the Governor on health-related matters, and is charged with encouraging cooperative planning among all health-related groups in the state.

The Mental Health Division is responsible for administering state facilities and programs for the mentally ill and mentally retarded, as well as coordinating community mental health programs providing a wide range of mental health services to both children and adults.

The Oregon State Board of Health:

Health Facilities Licensing and Certification Section is responsible for licensing, Medicare and Medicaid certification for all of the non-Federal hospitals, nursing homes, and homes for the aged in the state;

Health Facilities Planning and Construction Section is responsible for the administration of the Hill-Burton construction assistance program in the state of Oregon;

Division of Local Health Services is responsible for assistance to, consultation with, and certification of, public health nursing services and home health agencies in the state of Oregon;

Public Health Laboratories Section is responsible for the inspection and licensing of all clinical laboratories in the state of Oregon;

Engineering and Sanitation Section is responsible for furniture and bedding, engineering, plumbing, and sanitation in Oregon.

The Insurance Commission of the State of Oregon licenses nearly 800 companies to sell policies in Oregon, of which 350 are "Life and Health" companies offering various kinds and types of health insurance. About 130 companies are believed to be actively engaged in the sale of health insurance policies.

The Division of Vocational Rehabilitation supports development of improved rehabilitative services in health facilities and improved supportive services for heart-disease and kidney-disease patients throughout the state.

The Crippled Children's Division of the University of Oregon Medical School and the Shriners' Hospital in Portland provide specialized services for crippled children throughout the state.

The Public Welfare Division, through its control of disbursement of Federal and State public-assistance funds for medical care of clients, substantially affects the development of long-term care facilities in the state.

The Oregon Association of Hospitals represents 84 Oregon hospitals before other associations and official agencies. It holds one major educational meeting each year and numerous smaller meetings in many locations within the state. The Association employs a four-member staff officed in Portland; publishes a monthly newsletter; has been active in the sponsorship of many cooperative health facility improvement programs; and provides liaison between hospitals and other health and governmental groups.

The Oregon Health Care Association represents nursing and convalescent homes and seeks to improve standards of care for the elderly and infirm in these facilities.

The Oregon Association of Licensed Homes for the Aged was formed in September, 1970, to cooperatively develop new and more efficient methods of providing comfortable care for home guests and represent its member homes before other associations and agencies.

The Oregon Association of Home Health Agencies was formed September 11, 1970, to represent home health service provider organizations.

A detailed list of other state agencies and statewide non-governmental agencies which actively influence the operation of health facilities in Oregon can be found in "Planning for Health" prepared by and available at the Comprehensive Health Planning office in the Program Planning Division of the Governor's Executive Department.

The Joint Commission on Accreditation of Hospitals contributes to improvement of health facility standards through its voluntary accreditation program for hospitals and extended care facilities. Sixty-four (slightly more than half) of the institutions licensed as hospitals in Oregon were accredited in 1969.

The American Hospital Association and the American Osteopathic Hospital Association - Through their cooperative registration and statistical reporting program (80 hospitals in Oregon participated in 1969) these associations have enabled the compilation of useful information for health facility planning. Attempts by these organizations to develop uniform definitions, standardized accounting systems, and national annual statistical reports, began many years ago. The first American

Hospital Directory was published in 1945. The information now contained in the 26th edition of the annual Administrator's Guide Issue of Hospitals magazine (published each August) represents a valuable tool for rational health facility planning. These organizations also publish numerous technical monographs for health facility administrators and department heads; conduct major continuing education programs for hospital and nursing home trustees, administrators, department heads, and other employees; publish several magazines; and numerous newsletters.

An abbreviated list of other national agencies and associations which have an influence on the operation of health facilities in Oregon can be found in Hospitals magazine, J.A.H.A. (August 1, 1970); Volume 44, Part 2, pages 407-459.

AUTHORITIES

Public Law 89-749, November 3, 1966, authorized planning grants to states for Comprehensive Health Planning. The Governor, by Executive Order in late 1967, placed the administration of Comprehensive Health Planning in Oregon within the Executive Department, and formed the Governor's Health Planning Committee to advise him on the development of Health Planning. His Executive Order 67-14, dated June 10, 1968, contains his detailed charge to the Committee.

Public Law 88-443, governs the operations of the Oregon State Board of Health, Health Facilities Planning and Construction Program, which is authorized to perform the functions of the program by ORS 441.105 through ORS 441.150.

ORS 438.010 through 438.990 require the Oregon State Board of Health to issue and renew licenses for all clinical laboratories in Oregon which serve 5 or more practitioners.

ORS 441.005 through 441.100 require the State Board of Health to issue and renew licenses for all hospitals in the state.

ORS 441.055 authorizes the Oregon State Board of Health to license and establish rules, regulations and standards for all nursing homes in the state.

ORS 442.005 through 442.990 require the State Board of Health to issue and renew licenses for all homes for the aged in the state.

ORS 443.210-443.330 deal with group care homes.

ORS 419.002-419.740 deal with child-care institutions.

ORS 678.510-678.620 deal with nursing home operators.

ORS 401.010 establishes the Oregon State Civil Defense agency which performs numerous health services in times of disaster.

ORS 146.005 establishes the Medical Investigative Program (for sudden deaths) and local, county, and state electrical, fire, plumbing, and sanitary control authorities.

ORS 430.020-430.820 establish and delineate the authority and responsibilities of the State Mental Health Division. Certain aspects of health facility operations are also under the supervision of the State Insurance Commissioner, the State Fire Marshall, and corresponding local, county, federal, and special district official agencies too numerous to list here.

Veterans' Administration facilities are authorized by Federal law.

OBJECTIVES

1. By 1973, establish uniform definitions for all health facility services and service units.

2. By 1974, establish a uniform accounting and reporting system for all health facilities.

3. By 1975, establish uniform standards for all health facilities and services.

4. By 1973, develop and implement procedures to provide for the licensing of all health facilities based on scope of services performed.

5. By 1975, establish an integrated, coordinated, statewide system providing for the central coordination of all health facility planning, licensing and health care financing.

6. By 1973, develop reliable indicators of need for health care facilities, and determine facility requirements for Oregon communities based on these indicators.

7. Devise mechanisms to provide capital to meet existing and anticipated needs, as well as to provide for new forms of health facility organizations.

8. Remove constraints and provide incentives to encourage adoption of improved management and health care service systems by health facilities in Oregon.

9. Expand research and development activities aimed at developing innovative methods of providing health care services in Oregon.

RECOMMENDATIONS AND METHODS

(Objective #1)

1. *THE STATE BOARD OF HEALTH, UTILIZING THE SUBSTANTIAL PRELIMINARY GROUNDWORK OF THE AMERICAN HOSPITAL ASSOCIATION, THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, THE AMERICAN NURSING HOME ASSOCIATION, AND THE CERTIFICATION REQUIREMENTS OF THE FEDERAL SOCIAL SECURITY ADMINISTRATION, ESTABLISH AN OREGON STATE GUIDEBOOK OF UNIFORM DEFINITIONS OF HEALTH FACILITY SERVICES AND SERVICE UNITS BY 1973, AND PROMULGATE REGULATIONS PRESCRIBING USE OF STANDARD NAMES IN ADVERTISING.*

(Objective #2)

2. *BASED ON THE UNIFORM DEFINITIONS RECOMMENDED ABOVE, OREGON ASSOCIATION OF HOSPITALS, TOGETHER WITH COMPREHENSIVE HEALTH PLANNING, THE STATE BOARD OF HEALTH, AND OTHER INTERESTED AGENCIES, DEVELOP AND IMPLEMENT A UNIFORM ACCOUNTING AND STATISTICAL REPORTING SYSTEM FOR ALL HEALTH FACILITIES IN OREGON BY 1974.*

(Objective #3)

3. *ESTABLISH STATEWIDE MINIMUM QUALITY STANDARDS FOR THE PROVISION OF SERVICES DEFINED BY RECOMMENDATION #1. (INTERIM STANDARDS BASED ON PROCESS SPECIFICATIONS AND THE FACILITIES AND PERSONNEL REQUIRED BY THE SPECIFIED PROCESSES SHOULD BE ESTABLISHED BY 1973; PROCESS STANDARDS BASED ON PROCESS SPECIFICATIONS AND THE FACILITIES AND PERSONNEL REQUIRED BY THE SPECIFIED PROCESSES SHOULD BE ESTABLISHED BY 1975; PROCESS STANDARDS SHOULD BE REPLACED BY RESULTS STANDARDS BY 1980.)*

Method

The Governor's Health Planning Committee appoint a task force with representation from the Oregon Association of Hospitals, the Oregon Health Care Association, the Oregon Medical Association, the Oregon Association of Licensed Homes for the Aged, and the Oregon Association of Home Health Agencies, to direct a specially selected staff of health care administration experts working in close collaboration with the University of Oregon Medical School to develop standards, as well as to advise and assist in establishing definitions and an accounting and statistical reporting system referenced in Recommendations #1 and #2 above.

(Objective #4)

4. *STATE BOARD OF HEALTH DEVELOP AND INTRODUCE AN AMENDMENT TO EXISTING FACILITY LICENSING LAWS (O.R.S. 441 and O.R.S. 442) IN THE 1973 LEGISLATURE AUTHORIZING AND REQUIRING THE DEVELOPMENT OF A BODY OF LICENSING STANDARDS TO BE IMPLEMENTED JANUARY 1, 1976, PROVIDING FOR THE LICENSING OF THE DIFFERENT CATEGORIES OF HEALTH FACILITIES ON THE BASIS OF THE SCOPE OF SERVICES THEY ARE QUALIFIED TO PERFORM AT THE SPECIFIED MINIMUM STANDARD. CENTRALIZE THE ADMINISTRATION OF LICENSING STANDARDS IN ONE ORGANIZATION AT THE STATE LEVEL.*

5. *AMEND THE STATE BOARD OF HEALTH RULES AND REGULATIONS TO LIMIT THE TITLE "HOSPITAL" TO THOSE INSTITUTIONS ACTUALLY PROVIDING HOSPITAL SERVICES.*

Method

The Oregon State Board of Health hospital rules, regulations, and standards are seriously deficient. By definition a great many institutions other than those which the general public consider to be "hospitals" are licensed under the act and are, therefore, at liberty to use the word "hospital" in their corporate name on their letterhead, in their advertising, and in the telephone directory classified pages. There is proposed legislation to classify health care institutions into inpatient and outpatient facilities, and further classify inpatient institutions as hospitals (both general and special) extended care facilities, long-term care facilities, and other inpatient care facilities. Early passage of this legislation should be encouraged.

(Objective #5)

6. *PROVIDE FOR THE COORDINATION OF PLANNING, LICENSING, AND FINANCING AUTHORITIES AT THE STATE LEVEL.*

Methods

a. *Provide for the central coordination of health facility planning, licensing, and financing authorities by one organization at the state level through legislation or administrative mandate (e.g., Comprehensive Health Planning or a new organization formed by the combination of the Hill-Burton agency and the licensing authority).*

b. *The Governor's Health Planning Committee appoint a task force* ***to identify*** *and analyze the present health facility planning, licensing, and financing activities currently being conducted by the State Comprehensive Health Planning Agency, the State*

Board of Health, the Department of Human Resources, the Mental Health Division, the State Insurance Commissioner, the health personnel licensing boards, and other state-level organizations during 1971; prepare a reorganization proposal containing several coordinative alternatives during 1972; assure widespread consideration of the proposal preparatory to a 1973 legislative revision or administrative order; arrange systematic and orderly organizational change during 1974; implement coordinated operation January 1, 1975.

7. *CERTIFICATION OF NEED LEGISLATION SHOULD BE DEVELOPED BY 1973.*[1]

Method

Comprehensive Health Planning develop "Certificate of Need" legislation to include: 1) demonstration of a need for the facility and services in the community; 2) availability of trained personnel without proselyting from other on-going institutions; 3) evidence of financial capability and stability; 4) evidence of professional capability to operate a facility in the community; 5) public rate disclosure and rate setting; and 6) appeal mechanism. The determination should be based on "true" need determinations made at the areawide (administrative district) level with the assistance of indicators developed at the state level.[1]

8. *ESTABLISH AND FUND AN AREAWIDE COMPREHENSIVE HEALTH PLANNING AGENCY WITH FACILITY PLANNING RESPONSIBILITIES WITHIN EACH ADMINISTRATIVE DISTRICT IN THE STATE BY 1972. (SEE ALSO RECOMMENDATION #16.)*

Method

Comprehensive Health Planning strive to establish and fund areawide comprehensive health planning agencies capable of:

a. *assisting facility operators with the development and maintenance of a long-term program development plan;*

b. *contributing to the development of uniform reporting systems, need indicators, and need-measurement techniques;*

c. *conducting need determination studies from a community and district perspective and with a broad awareness of the economic, social, professional, and political forces that affect the delivery and receipt of health services, as well as from a competent technical perspective;*

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1. *Action on this Recommendation has been deferred by the Governor's Health Planning Committee pending receipt of a report by its ad hoc Delivery Systems Committee and further study of the potential ramifications.*

d. *formulating on a continuous basis a statement of district health facility goals, objectives, and priorities, which represents an effective community agreement on the relative importance of the district's various health problems;*

e. *representing the district at the state level and contributing a written health facility development plan for the district for incorporation in the state plan;*

f. *reviewing the placement of facilities within the district, in the light of population growth, to determine which services can be extended to new populations. For example, in District #10, the new community of Sunriver is being developed and will need health facilities. To avoid duplication, satellite units attached to existing facilities should be encouraged. Coastal development areas are also in need of satellite facilities. Usually an upper income population will reside in these planned new resort areas.*

Health facility planning authority should be centralized and unified in one organization within each district by 1972. Each district health facility planning organization should relate to a single, state-level, planning organization.

9. *DEVELOP MORE ADEQUATE INDICATORS OF TRUE NEEDS FOR HEALTH FACILITIES THAN THOSE CURRENTLY UTILIZED TO APPLY ON A STATEWIDE BASIS FOR PREPARATION OF A DEFINITIVE REALISTIC STATE PLAN OF ACTUAL HEALTH FACILITY NEEDS FOR OREGON COMMUNITIES.*

Methods

a. *By 1973, the State Comprehensive Health Planning Agency, together with the State Board of Health, develop (and review and update annually thereafter) new and more accurate indicators of the true need for health facility developments. These indicators should be based on the "services" required to meet the needs of a geographically circumscribed population rather than on "bed" needs in different categories of health facilities.*

b. *In 1971, the State Comprehensive Health Planning Agency, together with the State Board of Health, sponsor a statewide conference of professional health facility planners to formulate an initial body of "true" need indicators; provide for the pilot testing of the new indicators during 1972 in each state administrative district and a follow-up state-level conference to compare the results of the tests by October, 1972; compile a "first edition" of need indicators by 1973 and implement these indicators through the areawide health facility planning organizations for determining and making recommendations on health facility needs: 1) to the state for preparation of a definitive, realistic state plan of actual health facility needs for Oregon communities;*

as well as 2) to licensing, financing, and rate reviewing organizations at the district and state level. Provide for an on-going statewide exchange of information on the value of selected indicators and an annual review for necessary revisions. Application of these indicators must be coordinated with the Health, Education, and Welfare requirements for administering the State Hill-Burton Program.

10. *ADVOCATE REVISION OF THE HILL-BURTON BED-NEED DETERMINATION FORMULA WHILE DISCOURAGING ITS UTILIZATION OUTSIDE THE HILL-BURTON PROGRAM.*

Method

The Oregon State Board of Health encourage the Secretary of the Department of Health, Education, and Welfare to authorize amendment of the bed-need formula in Oregon as soon as possible to utilize:

a. *up-to-date service statistics (calendar year);*

b. *separate occupancy goals for obstetrical, surgical, pediatric, medical, and surgical services; for urban, suburban, and rural facilities; and for large, medium, and small facilities;*

c. *patient origin studies conducted during the most recent fiscal year as a basis for determining health facility service areas;*

d. *population estimates provided by the Center for Population Research and Census for all years other than the national census years.*

Public and private agencies involved in health-related activities should use every means at their disposal to discourage or prohibit the use of "bed needs" determined by the Hill-Burton program as the basis for "true or actual" facility need determinations to be utilized by H.U.D., F.H.A., or any other public agency.

11. *DURING 1971, THE PORTLAND METROPOLITAN AREA COMPREHENSIVE HEALTH PLANNING AGENCY, IN COOPERATION WITH THE MULTNOMAH COUNTY MEDICAL SOCIETY AND THE PORTLAND AREA HOSPITAL COUNCIL, CONDUCT A DETAILED STUDY TO DETERMINE THE NEED AND DEMAND FOR NEIGHBORHOOD CLINIC FACILITIES IN THE URBAN DISADVANTAGED AREA.*

12. *EXPLORE THE FEASIBILITY OF DESIGNATING ONE OR MORE KEY HOSPITAL FACILITIES IN EACH DISTRICT OR GEOGRAPHICALLY DEFINED REGION AS THE REGIONAL HEALTH CENTER FOR DELIVERY OF SERVICES IN THAT AREA. (whether in its own area or on a contractual basis with some other area, this institution could be charged with responsibility to*

provide or insure avail bility and provision of a full continuum of health services and care as prescribed by attending physicians.)

(Objective #7)

13. *EFFORTS SHOULD BE MADE BY THE STATE BOARD OF HEALTH (HEALTH FACILITIES PLANNING AND CONSTRUCTION SECTION) TO DEVELOP ADDITIONAL MECHANISMS TO PROVIDE CAPITAL FUNDS FOR NEEDED FACILITY CONSTRUCTION, ALTERATION, AND MODERNIZATION (e.g., STATE LOAN CONSTRUCTION INSURANCE).*

14. *DEVISE A MECHANISM TO PROVIDE NEW CAPITAL TO MEET ANTICIPATED NEEDS AND NEW FORMS OF HEALTH FACILITY ORGANIZATIONS.*

Method

Devise new methods to provide funds for the establishment of services to be shared by two or more cooperating health facilities and for the establishment of facilities to meet newly identified needs for which no funding mechanism now exists (such as "itinerant" services for sparsely settled rural areas; establishment of urban neighborhood clinics; mobile multiphasic screening vans; suburban mental health clinics; foster homes; day care centers; home care services; or health maintenance organizations).

Seek the assistance of the attorney general, the insurance commissioner, and the state budget director to meet with representatives of all health insurance carriers operating in the state to ascertain the feasibility of utilizing the contingency reserves required to be maintained by the health insurance carriers for investments in health delivery system improvements rather than in negotiable securities. They should consider, also, the feasibility of the creation of a state insurance fund which could operate like Federal Deposit Insurance Corporation, or Federal Housing Administration, or Housing and Urban Development, to provide "no loss" guarantees to the health insurance companies converting their investments to health delivery system improvement. If health insurance reserves cannot be utilized, the investigating committee should recommend other avenues of investigation which can be explored.

15. *EARMARK NEW FUNDS FOR EMERGENCY ROOM IMPROVEMENT AND AMBULATORY CARE FACILITIES.*

Method

The Oregon State Board of Health, Health Facilities Planning and Construction Section and its advisory council (State

Hill-Burton Agency) should place the highest possible priority on implementation of Title VI of the Medical Facilities Construction and Modernization Amendments of 1970 (P.L. 92-296) which creates a new three-year program of federal project grants to assist in the modernization or construction of emergency rooms of general hospitals.

16. *DEVELOP A MECHANISM TO ADEQUATELY FINANCE STATE AND DISTRICT LEVEL HEALTH FACILITY PLANNING.*

Method

Investigate the feasibility of obtaining funds for the support of state and district level health planning agencies (either primary or matching funds if federal Comprehensive Health Planning funding support is available) from facility and health manpower license fees; a tax levied against health insurance premiums, drug sales, medical equipment and appliance sales; or from "facility proposal consideration" fees, etc. If, by October 1, 1972, no such ongoing service-derived income can be developed for planning agency support, additional funds should be sought from the state's general tax revenues.

17. *DEVELOP A MECHANISM TO ENABLE AND REQUIRE GOVERNMENT PURCHASERS OF HEALTH FACILITY SERVICES TO PAY THE FULL COST OF PROVIDING THE SPECIFIED SERVICES.*

Method

Comprehensive Health Planning establish a task force to conduct a detailed study of cost control and management savings incentives; and possible sources of adequate support for the state and local governments' health service purchase responsibilities to enable all levels of government to pay the full cost of providing services that are:

a. certified by the appropriate planning agency as necessary to meet the needs of the community;

b. licensed by the appropriate licensing agency as meeting the established service standard specifications;

c. prescribed by a licensed medical practitioner and provided in good faith to public beneficiaries by licensed facility operators. Effective utilization review procedures must be established.

Full cost in this context is intended to include a factor for depreciation, a factor for growth certified in the public interest

by the appropriate planning agency, a factor for debt retirement (when applicable), and a factor for research and development. Full cost includes all types of service, including acute, mental, rehabilitative, long term, etc. This recommendation becomes increasingly important as representatives of the public purchase ever larger percentages of the totality of available services. Some source of funds other than general property revenue must be developed; one which will grow with the state's economy so that adequate funds are available to meet the state's obligations (e.g., liquor, cigarette, theater ticket, or gasoline tax). Such a mechanism should be selected or designed for implementation by 1975. Immediately upon implementation of the new mechanism, the attorney general should be empowered to assure that all levels of government purchasing services on behalf of Oregon residents reimburse facility owners and operators no less than the full and complete actual costs incurred in providing the specific services.

18. *THE STATE INSURANCE COMMISSION SHOULD REVISE EXISTING HEALTH INSURANCE COVERAGE STANDARDS.*

Method

The State Comprehensive Health Planning Agency form a task force committee in 1971 to study and draft minimum standards for health insurance policies to be sold in Oregon. After broad exposure and opportunity for public discussion in each administrative district, these standards should be adopted for enforcement in 1973 by the state insurance commissioner. This study should give attention to the provision of certain minimum benefits, including but not limited to: psychiatric coverage, ambulatory coverage, and diagnostic benefits in addition to the usual sickness and accident package.

19. *DEVELOP MEANS OF FORECASTING PUBLIC FINANCING RESPONSIBILITIES IN SUCH A WAY THAT NECESSARY MECHANISMS CAN BE DEVELOPED IN ADVANCE OF THEIR NEED TO REIMBURSE THE PROVIDERS OF NECESSARY SERVICES FOR THE FULL AND TRUE COSTS OF PROVIDING THE SERVICES. (FOR EXAMPLE: FULL PAYMENT FOR INDIGENTS, MIGRATORY WORKERS, INDIGENT MENTAL PATIENTS AND FULL PAYMENT BY STATE ACCIDENT INSURANCE FUND FOR ON THE JOB INJURIES.)*

Method

Require in 1971 by administrative mandate (state agencies) and administrative request (federal agencies) that all those public agencies responsible for the purchase of health services on behalf of public beneficiaries:

a. *Devise means of forecasting at least five years in advance the amount, type, quality, scope, and nature*

of health services they intend to purchase from private sector providers;

b. *Engage in an ongoing dialogue with facility associations to apprise them of changing program requirements and resources;*

c. *Develop means of reimbursing providers the full costs of providing necessary services required by public purchasers.*

(Objective #8)

20. *AMEND THE STATE BOARD OF HEALTH RULES AND REGULATIONS TO ENCOURAGE FACILITY MERGERS.*

Method

Amend State Board of Health Rules, Regulations, and Standards for Hospitals in Oregon (Section 23-116, Paragraph (4) and 23-124, Paragraph(1)) to encourage the merger of two or more hospitals serving the same community by allowing for hospital operations to be conducted in two or more unattached buildings and urge similar revisions in the federal Medicare law.

21. *ENCOURAGE FACILITY INNOVATIONS BY DEVELOPING INCENTIVES AND REMOVING LICENSING IMPEDIMENTS.*

Method

During 1971, the Governor's Health Planning Committee form a task force to identify the licensing, financial, and social impediments to the adoption of innovations which have been proven successful elsewhere; develop a proposal for legislative and administrative revision; and formulate a body of incentive proposals to encourage adoption of improved service provision mechanisms identified in successful R&D projects. Remove by 1973, existing licensing impediments to already identified improved methods of providing facility services.

22. *PLACE LIMITS ON FACILITY AND MEDICAL MALPRACTICE LIABILITY AND PROVIDE FOR IMMUNITY FROM LIABILITY IN EXPERIMENTAL SITUATIONS.*

Method

Prevail upon the attorney general during 1971 to assemble a task force committee of representatives of the Oregon State Bar Association, the Oregon Medical Association, the Oregon Association of Hospitals, the University of Oregon Medical School, and the major carriers of health facility liability insurance, to propose an equitable upper liability limit and to formulate a specific, detailed proposal for tort liability immunity for institutions

engaged in scientific and R&D projects resulting in unanticipated treatment outcomes for informed, consenting adults. Expose these proposals to wide circulation and public hearings in each legislative district by October 31, 1972. Introduce proposals in the 1973 legislative session. An impartial review committee could be established to arbitrate claims.

23. *STUDY THE FEASIBILITY OF ADOPTING NO-FAULT AUTOMOBILE LIABILITY LEGISLATION SIMILAR TO THAT RECENTLY ENACTED IN MASSACHUSETTS. (It has been asserted by advocates that this would greatly speed the payment of patients' medical facilities bills. Many accounts, at the present time, go unpaid for upwards of five years due to pending litigation. This causes facilities to increase operating costs by borrowing otherwise unnecessary operating capital.)*

24. *AMEND THE HOSPITAL LICENSING LAW TO ENCOURAGE THE SHARING OF SERVICES AMONG HOSPITALS AND FREE-STANDING REHABILITATION FACILITIES.*

Method

Certain seldom-used services (such as operating rooms, x-ray and laboratories) should be provided to rehabilitation centers by nearby hospitals without adversely affecting licensure. In addition, rehabilitation facilities should be encouraged to consider leasing or purchasing land immediately adjacent to a general hospital with direct connections between the two plants to enable the rehabilitation facilities to have the full services of a general hospital (see Recommendation #20 above.)

(Objective #9)

25. *EXPAND RESEARCH AND DEVELOPMENT ACTIVITY FOR INNOVATIONS IN DELIVERY OF HEALTH CARE SERVICES.*

Methods

a. *Form a health facility task force during 1971 composed of consumers, facility representatives, group purchase representatives, and experts in health service provision research and development to ascertain the amount of funds that can be prudently utilized for productive research and development, and recommend a plan for the pooling, distribution, management, and accounting of these funds.*

b. *Amend the insurance laws and/or require by administrative mandate in 1973, the levy of a special tax on all health insurance policies to create a fund for the support of research and development activities in the provision of health care services.*

OPERATIONAL PROBLEMS

In addition to the usual operational problems inherent in most new or expanded projects or programs (i.e., normal resistance to change; shortage of money, manpower and materiel), select operational problems to some of the listed objectives and recommendations are given below.

(Recommendations 1, 2, 3, and 4)

Facility operators who see their organizations as independent, private businesses rather than as component parts of a health service delivery system may be reluctant to cooperate.

The effort required to produce a statewide facility status reporting system will require financial support and the services of several highly qualified experts not presently known to be available in Oregon.

(Recommendations 6 and 8)

Most existing state-level organizations might be expected to resist the proposed change. The ability of district comprehensive health planning to undertake the proposed activities might be questionable.

(Recommendation 7)

There may be a tendency to utilize the Hill-Burton Bed Need Determination formula as a basis for need determinations because of its ready availability, and to try to place the responsibility for determinations in the Hill-Burton (or other existing state-level) agency. This would retard both the development of more appropriate indicators and the development of the capacity to make such determinations at the district level.

This legislation will probably function to encourage the cetralization and consolidation of facilities within the districts. Centralization ought to be encouraged so long as the corollary extension of services outward from the centers to the smaller communities is a required condition of centralized development.

(Recommendation 9)

Needs are derived from professional judgment, public acceptance, effective demand, available technology, and delivery patterns. There is a danger of moving from the present overly simplified indicators to indicators which are overly complex, too expensive, and too difficult for practical use. The greatest danger, however, lies in the substitution of rigid indicators for informed and flexible good judgment. Indicators can support decisions, but they should not supplant subjective decisions on need which should always be made at the district and local levels.

(Recommendation 10)

Separate service occupancy goal factors must be developed for obstetrical, surgical, pediatric, medical psychiatric, intensive, and coronary service care units; for urban, suburban, and rural facilities; and for large, medium, and small facilities. A procedure for the conduct of ongoing patient origin studies must be developed and implemented. The Oregon Regional Medical Program 1967 Patient Origin Study can be used as a model.

(Recommendation 12)

Some health professionals are not yet aware of the need for and desirability of health care development within each district. Some of the larger hospitals have not as yet given serious consideration to the possibility of extending services outward to smaller hospitals, other categories of health facilities, and other communities.

(Recommendation 14)

The security of health insurance reserves must be guaranteed to al least the current level. Health insurers will probably not willingly accept a loss in interest income unless it is clearly offset by health service cost reductions.

(Recommendation 15)

There will be competition from other states for federal Hill-Burton funding assistance.

(Recommendation 17)

Requires developing additional income from some source of additional taxation; the constant, gradual reduction of health service benefits provided to public beneficiaries; or a reduction in the number of public beneficiaries.

(Recommendation 18)

Some companies may not choose to continue selling health insurance in Oregon after the new standards are enforced. Some mechanism must be devised to assure the transfer of their subscribers (without penalty) to other companies accepting the standards. Some consumers may not be able to or may not choose to purchase a more expensive coverage.

(Recommendation 19)

The difficulties inherent in predicting changes in public responsibilities occasioned by newly proposed or passed social legislation

at both the state and federal levels. Fixed annual and biennial budgets applied to a provider environment of progressive inflation. Legislative reluctance to match promised services with allocated resources. Health service provision costs not subject to legislative control. Reluctance of public agencies to engage in open dialogue with provider representatives coupled with provider representatives' skepticism as to the good intentions of public officials.

(Recommendations 20 and 21)

A higher level of risk will have to be accepted as a consequence of more rapid change. Incentive design requires a detailed knowledge of cause and effect relationships, together with scientific knowledge of human motivation. Financial incentives may be possible for certain innovations only if new sources and levels of funding can be identified.

(Recommendation 22)

Extablishing a "reasonable" upper limit may be difficult. Defining an "experimental" situation and devising adequate safeguards and guidelines may be difficult. Difficulty in finding qualified people (due to public embarrassment) to serve on such a committee.

(Recommendation 25)

Proposal would require an initial increase in costs of health care services for group purchasers. A mechanism to pool and distribute funds must be devised. Procedures for evaluating the productivity of research and development funds must be devised. Personnel capable of designing, managing, and reporting the results of research and development projects are not at present widely available in Oregon. Incentives encouraging the rapid implementation of innovations proven in research and development projects have not yet been formulated.

EVALUATION CRITERIA

(Recommendations 1, 2, and 3)

Uniform definitions should be completed, distributed, review by the organizations concerned, revised, and finalized (first edition) by December 30, 1973. The facility operators' associations should agree that the definitions are realistic, simple, accurate, and usable.

The statewide accounting and statistical reporting system based on the definitions should be implemented by December 30, 1974. The district planning organizations should be satisfied with the information produced; and the facility operators' associations should be satisfied with the effort and cost required to provide the required information.

The service standards should be in the first edition by December 30, 1975. Public purchasers and health insurance carriers should substantially agree that the standards represent the minimum level of services they are willing to underwrite, while the facility operators' associations substantially agree that the standards are practical, realistic, and humane.

The cost of staff, meetings, office space, consultants, and printing should not exceed one tenth of one percent of the total gross expenditures of all of the health facilities in Oregon per year (1971-75).

(Recommendation 4)

Enabling amendments should be prepared in 1971, reviewed, and widely discussed in 1972, and passed in 1973. New standards should be developed in 1975 and implemented in 1976. The facility operators and planning organizations should agree that the new standards are realistic, practical, and in the public interest.

(Recommendation 6)

The completion of a coordination status report by October 31, 1971.
The completion of a reorganization proposal by March 15, 1972.
The distribution of the reorganization proposal to all concerned citizens and organizations in the state and the conduct of public hearings in each administrative district completed by October 31, 1972.
Implementing order and/or revised laws in 1973. Complete organization change by December 31, 1974. Assume coordinated operation January 1, 1975.

(Recommendation 7)

Enabling legislation enacted by 1973.

(Recommendation 8)

The existence in every district by December 31, 1972 of recognized planning agencies capable of performing the functions delineated in Methodology.

(Recommendation 9)

In the field evaluation of the new indicators establishing their advantages over the Hill-Burton Bed Need Determination formula of 1970 in determining the "true and actual" needs for health facility development in the state.

(Recommendation 10)

Revised formula utilized to prepare the 1972 State Plan.

(Recommendation 12)

Formulation of guidelines for regional health centers during 1971. Designation of a center in each district by 1973. Development of plans for all centers by 1975.

(Recommendations 13 and 14)

The availability of a new source of "start-up" capital by 1973.

(Recommendation 15)

Implementation of Title VI of the Medical Facilities Construction and Modernization Amendments of 1970 (P.L. 92-296).

(Recommendation 17)

Implementation of a new revenue source. Evidence of payment of full costs for services actually provided at or above the specified standard.

(Recommendation 18)

Acceptable standards in force by 1973.

(Recommendation 19)

Administrative mandate in 1971. New method of forecasting in operation by 1972. Dialogues initiated by October, 1971. Promise of adequate reimbursement mechanism by January, 1973.

(Recommendations 20 and 21)

Passage of the required amendments by 1974. Installation of a body of pilot-tested incentives by January 1, 1975.

(Recommendation 22)

Passage of the described legislation in 1973.

(Recommendation 25)

Progress as outlined in the methodology culminating in a uniform research and development tax applied as of January 1, 1974.

PRIORITY

To be determined.

(The Objectives within the Facilities Section have been ranked according to general levels of importance and urgency below, however, action should

be initiated as soon as practicable toward the accomplishment of all the listed objectives. Many of the objectives and activities undertaken toward their satisfaction are interrelated and interdependent.)

Priority	Objective #	Description
1	4	Revise health facility licensing laws
2	7	Capital for existing and anticipated needs
3	6	New indicators of need
4	8	Remove constraints and develop incentives to innovations
5	9	Expand research and development in health care delivery systems
6	5	Coordination of planning, licensing, and financing
7	1	Uniform definitions
8	2	Uniform accounting and reporting system
9	3	Uniform service standards

EXHIBIT 1

EXPLANATION OF MAP AND CHART

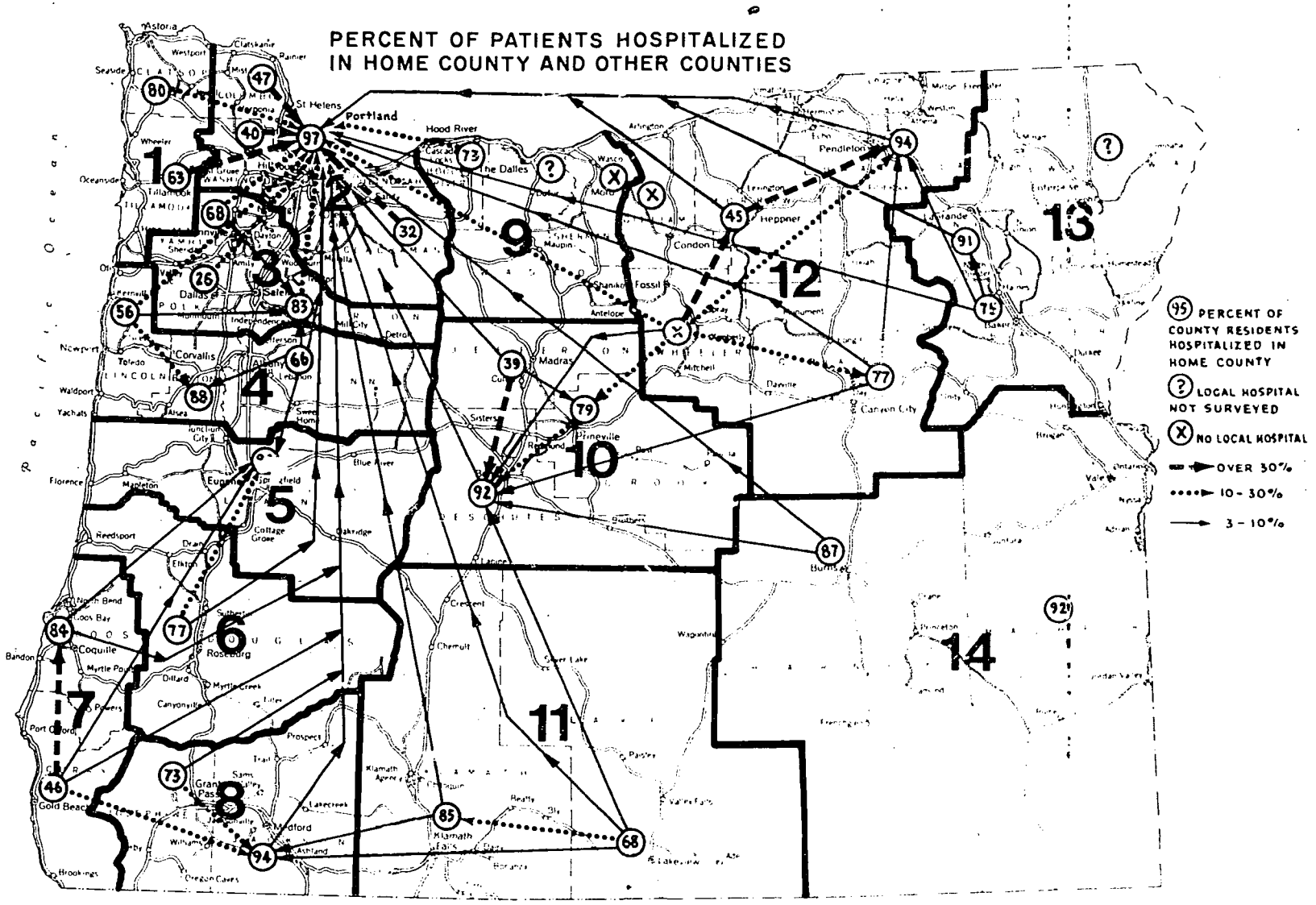
SHOWING HOSPITAL USE

Map - Percent of Patients Hospitalized in Home County and Other Counties

The number appearing in each county indicates the percent of county residents who needed hospital services and who were hospitalized within the home county. The arrows leading from that number indicate the percent of people leaving the county for hospitalization. The X indicates no local hospital. For example, in Harney County, 87% of the residents needing hospital services are hospitalized in Harney County. From 3 to 10% of the residents in need of hospital services go to Deschutes County. From 3 to 10% of the county residents in need of hospital services go to Multnomah County.

Chart - Where People Receive Services

This chart shows essentially the same information as the Map, with more detailed information. For instance, in the left hand column looking at District 14, Harney County: looking across the page on the line with Harney County we find that 5.6% of the patients from Harney County receive hospital services in District 2. Less than 1% receive hospital services in District 3. 5.8% of Harney County patients receive hospital services in District 10. Less than 1% of Harney County patients receive hospital services in Districts 11 and 12. 87.9% of Harney County patients receive hospital services in District 14, their home district.



State of Oregon DISTRICTS

Office of the Governor - Planning Section

district boundary

5 district number

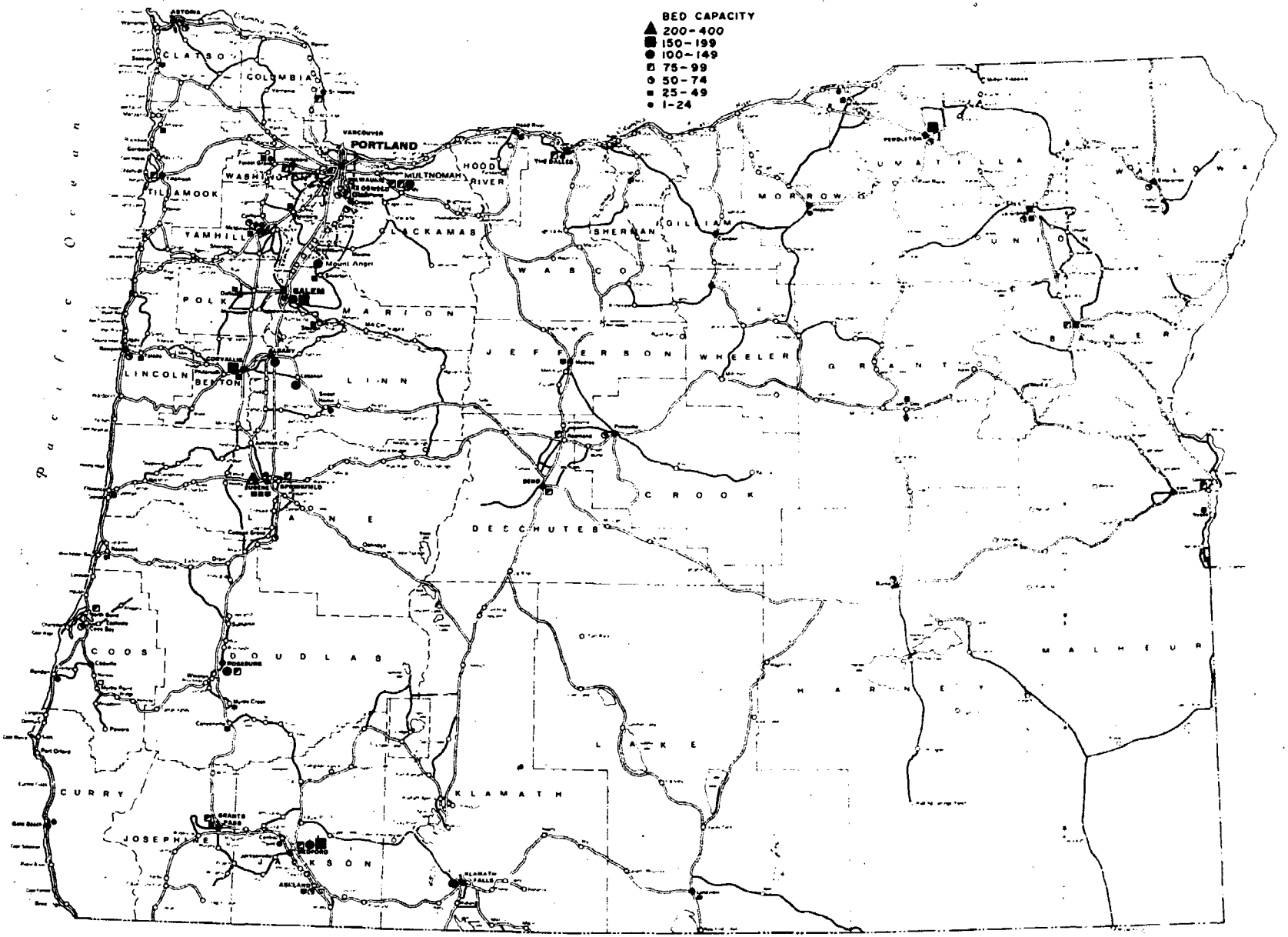
Data from Oregon Regional Medical Program.

* Percentage less than 1.0%
• Data Incomplete

WHERE PEOPLE RECEIVE HOSPITAL SERVICES - SHOWING THE % OF PATIENTS FROM EACH COUNTY OR AREA IN THE DISTRICT OF HOSPITALIZATION

District	County of Residence	District of Hospitalization													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	Clatsop	80.4	19.0	0	*	*	0	*	0	0	0	*	0	*	*
	Tillamook	63.9	33.9	1.5	*	0	0	0	0	0	0	*	0	0	0
2	Clackamas	0	94.4	4.8	*	*	0	0	*	*	*	*	0	*	*
	Columbia	1.9	96.2	*	0	*	*	0	*	*	0	0	*	0	0
	Multnomah	*	99.1	*	*	*	*	*	*	*	*	*	*	*	*
	Washington	*	97.1	2.0	*	*	0	*	*	0	*	0	*	*	0
3	Marion	*	13.6	84.0	1.4	*	*	*	*	0	*	*	*	*	*
	Polk	0	10.6	86.2	1.9	*	0	0	0	*	*	0	*	0	0
	Yamhill	*	24.3	74.4	*	*	0	0	0	0	*	0	*	*	0
4	Benton	0	4.5	2.2	89.9	2.2	*	0	*	0	*	*	0	*	*
	Lincoln	0	20.2	6.8	69.6	2.7	0	*	*	0	*	0	0	*	*
	Linn	*	9.0	8.6	74.9	6.8	*	*	*	0	*	0	*	*	0
5	Lane	*	4.3	*	*	93.7	*	*	*	0	*	*	*	*	*
6	Douglas	0	5.6	*	*	12.8	76.8	1.4	2.4	0	*	*	0	0	*
7	Coos	*	6.8	*	*	6.3	1.6	83.6	*	0	*	*	0	*	*
	Curry	0	4.4	*	0	4.5	1.2	76.6	12.6	0	0	0	*	0	0
8	Jackson	*	3.2	*	*	*	*	*	95.8	0	*	*	*	*	0
	Josephine	0	4.3	*	*	*	*	*	93.5	0	*	0	0	0	*
9	Hood River	0	24.5	*	*	*	0	0	*	73.2	0	0	*	0	*
	Sherman•														
	Wasco•														
10	Crook	0	5.5	*	0	0	0	0	0	0	94.2	0	0	0	0
	Deschutes	0	5.1	*	*	*	*	0	0	0	92.8	*	0	*	*
	Jefferson	0	10.1	*	*	*	0	0	0	0	88.2	*	*	0	0
11	Klamath	0	5.5	*	0	1.8	*	0	5.9	0	1.2	85.2	*	0	0
	Lake	0	9.4	2.9	0	*	0	0	5.1	0	3.9	78.3	0	0	0
12	Gilliam•														
	Grant	0	9.0	*	0	*	0	0	0	0	3.5	0	82.4	1.7	2.8
	Morrow	0	8.8	0	0	0	0	0	0	0	0	0	91.2	0	0
	Umatilla	*	4.8	*	*	*	0	0	*	0	0	0	94.0	*	*
	Wheeler	0	16.3	3.0	0	0	0	0	0	0	15.9	0	64.8	0	0
13	Baker	*	8.8	*	0	*	0	*	*	0	0	0	4.6	82.8	2.2
	Union	0	5.1	*	*	*	0	0	0	*	0	0	2.3	91.9	*
	Wallowa•														
14	Harney	0	5.6	*	0	0	0	0	0	0	5.8	*	*	0	87.9
	Malheur	0	2.8	*	0	0	0	0	*	*	0	0	*	1.9	94.3
	All Oregon	2.2	49.0	9.1	5.3	9.0	2.8	3.1	6.8	0.6	3.1	2.1	3.8	2.0	1.3
	Washington	2.3	87.9	1.4	*	1.1	*	*	*	1.7	*	0	1.5	*	*
	California	*	8.4	*	1.0	*	*	*	64.0	0	*	23.3	*	0	*
	Idaho	*	15.2	*	*	1.2	*	*	0	*	1.0	*	1.8	1.1	77.7
	Other States	2.3	48.8	5.6	3.8	9.1	1.5	3.0	12.6	1.4	2.8	3.4	2.0	1.2	1.5
	GRAND TOTAL	2.2	49.3	8.8	5.0	8.7	2.7	3.0	7.1	0.6	3.0	2.2	3.7	1.9	1.7

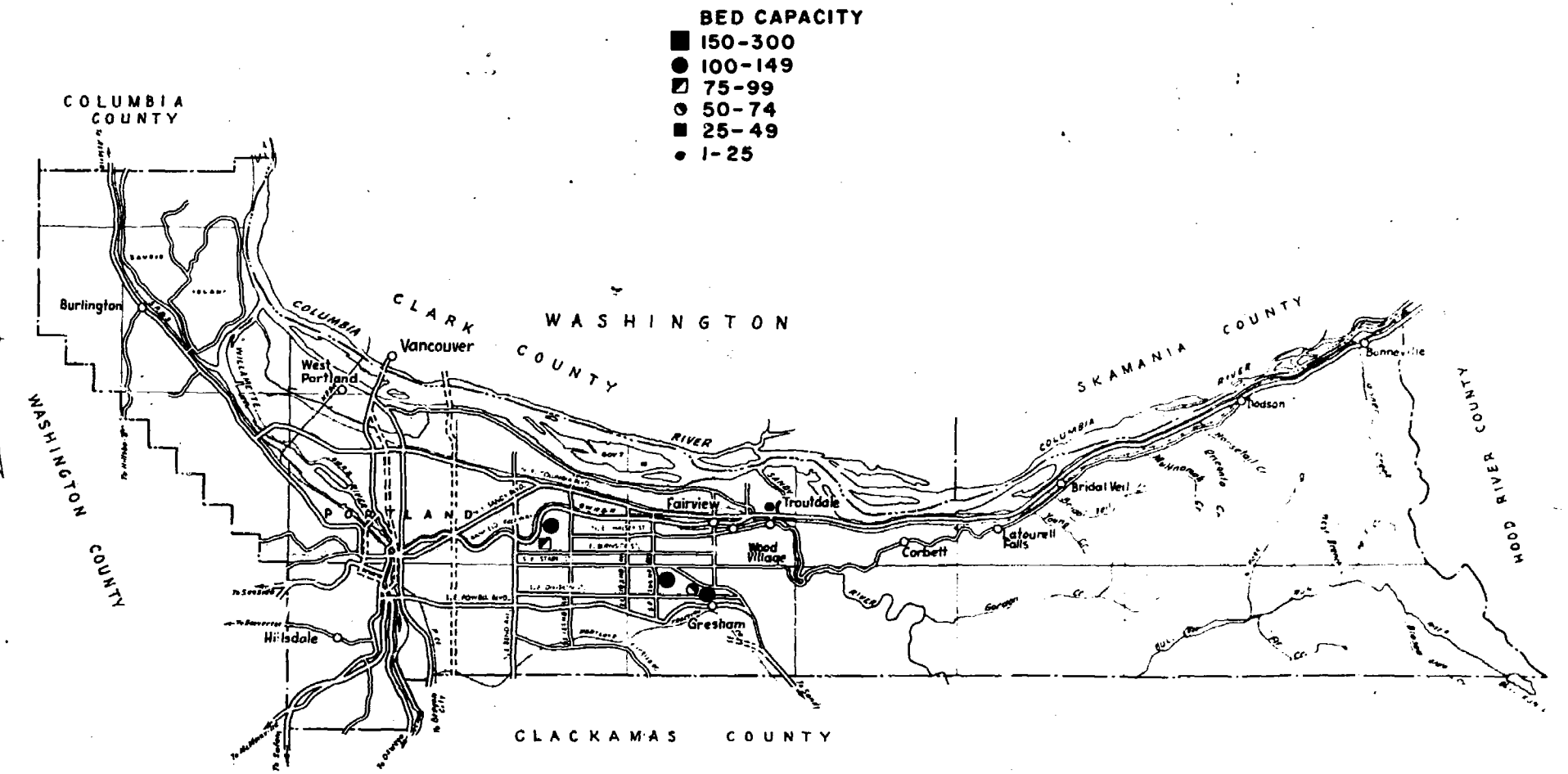
HOSPITALS IN OREGON*



*MAP DOES NOT INCLUDE STATE HOSPITALS OR MULTNOMAH COUNTY

EXHIBIT 2

HOSPITALS IN MULTNOMAH COUNTY



*MAP DOES NOT INCLUDE HOSPITALS IN CITY OF PORTLAND

EXHIBIT 2

HOSPITALS IN PORTLAND

BED CAPACITY
- 300-500
- 200-299
- 100-199
- 50-99
- 25-49
- 1-24

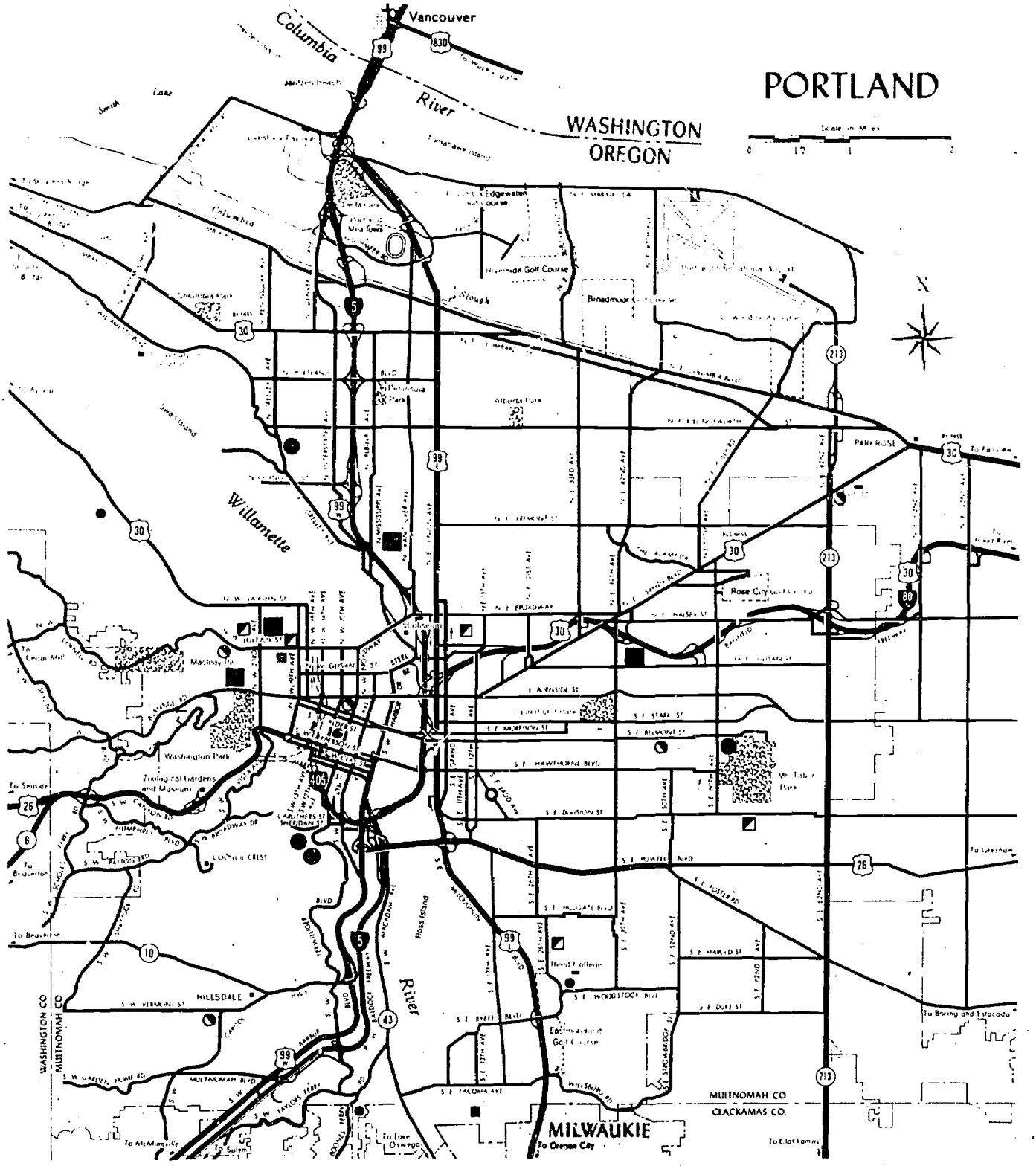


EXHIBIT 2

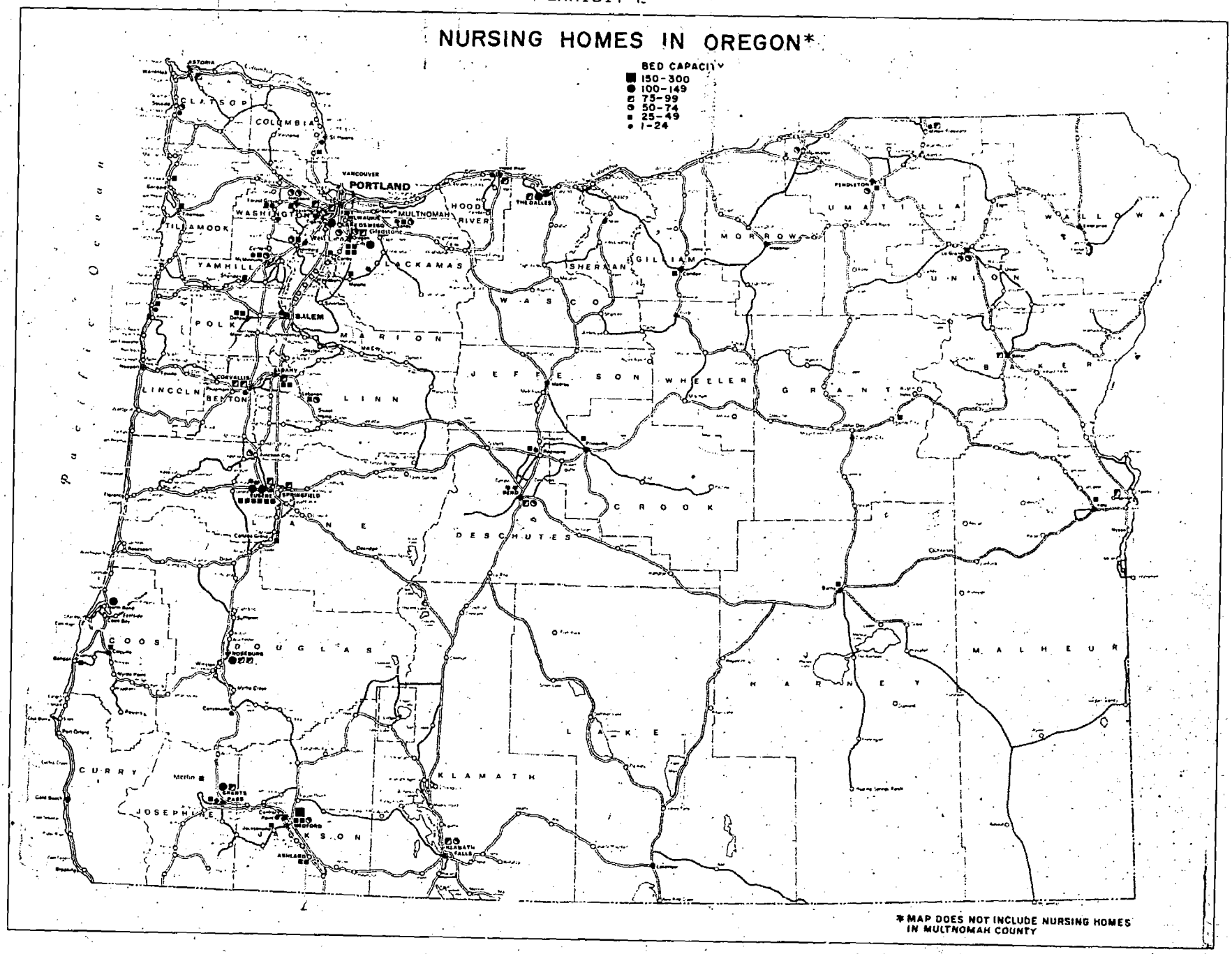
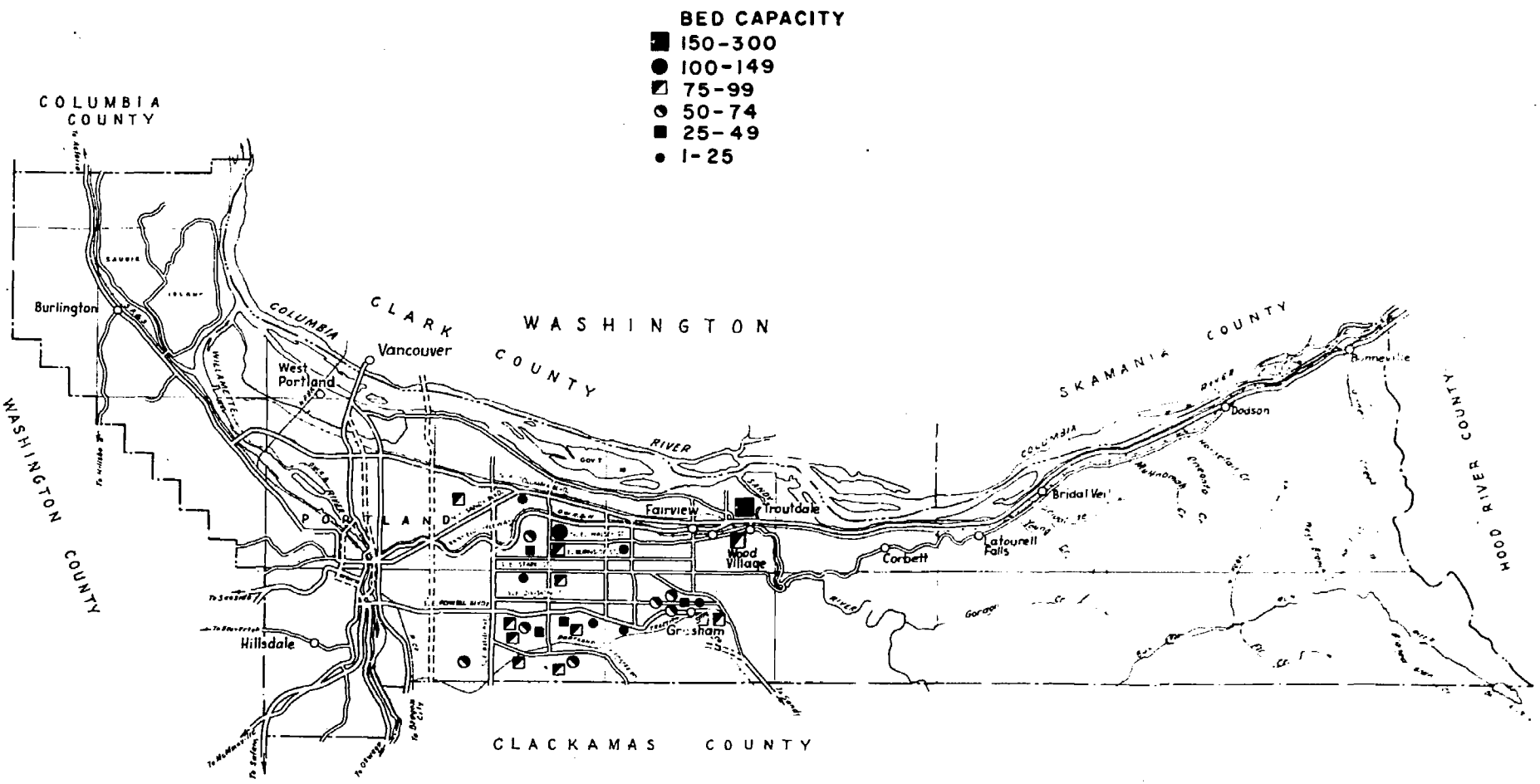

NURSING HOMES IN OREGON*
BED CAPACITY
150-300
100-149
75-99
50-74
25-49
1-24
Pacific Ocean
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
PORTLAND
VANCOUVER
HOOD RIVER
THE DALLES
PENDLETON
UMATILLA
WALLOWA
MORROW
GILLIAM
SHERMAN
WASCO
UNION
YAMHILL
CLACKAMAS
POLK
SALEM
MARION
JEFFERSON
WHEELER
GRANT
BAKER
LINCOLN
BENTON
LINN
CORVALLIS
ALBANY
LANE
EUGENE
SPRINGFIELD
CROOK
DESCHUTES
COOS
DOUGLAS
ROSEBURG
MALHEUR
HARNEY
LAKE
CURRY
KLAMATH
JOSEPHINE
JACKSON
GRANTS PASS
MEDFORD
ASHLAND
KLAMATH FALLS
*MAP DOES NOT INCLUDE NURSING HOMES IN MULTNOMAH COUNTY

EXHIBIT 2

NURSING HOMES IN MULTNOMAH COUNTY*



*MAP DOES NOT INCLUDE NURSING HOMES IN CITY OF PORTLAND

EXHIBIT 2

NURSING HOMES IN PORTLAND

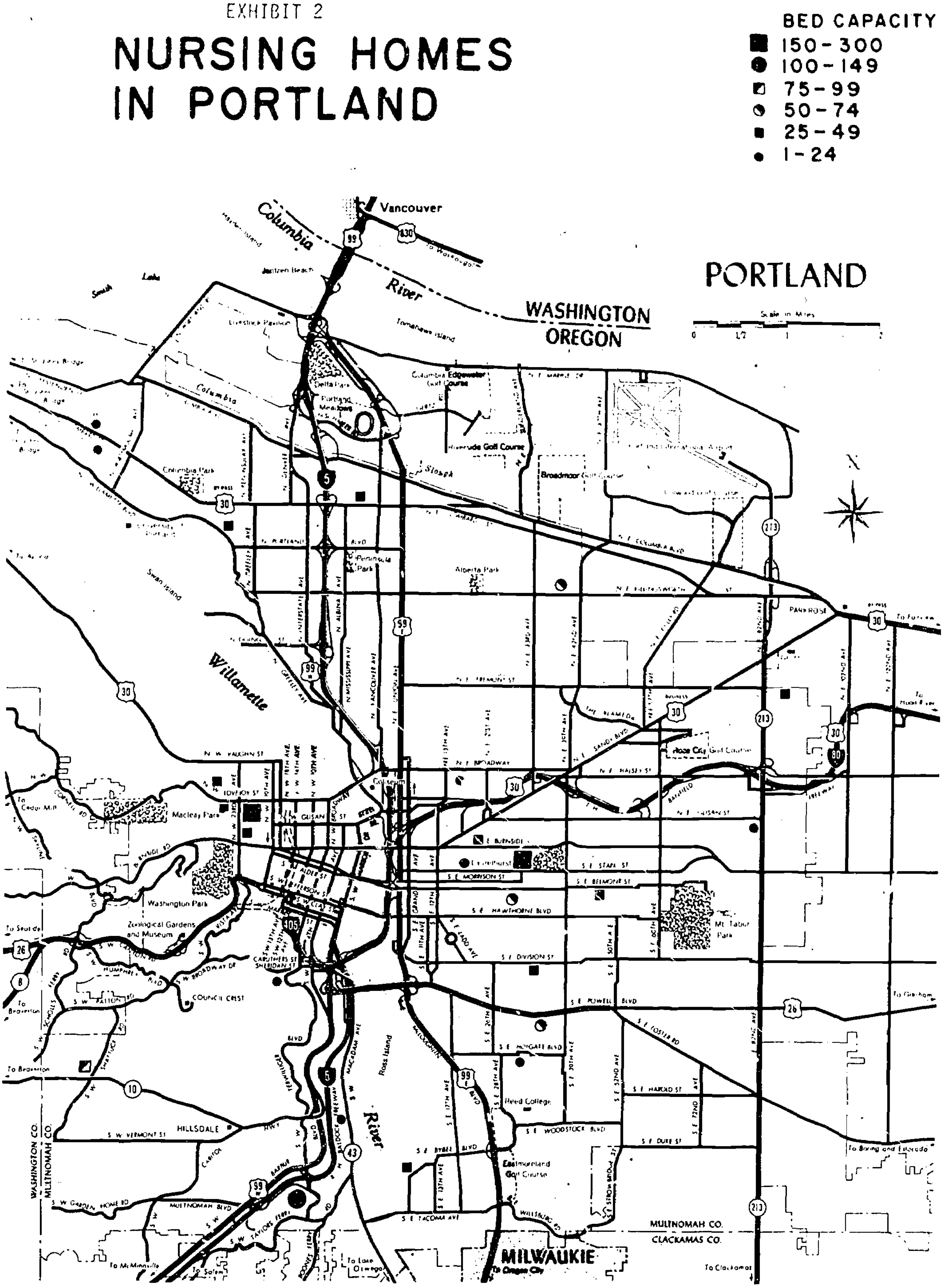


EXHIBIT 3

SPECIFIC CONDITIONS AS IDENTIFIED BY CONTRIBUTING RESOURCE AGENCIES

Paragraph Number	Page Number	Source of Edited Suggestions/Comments
1	97	Oregon Association of Hospitals
2	97	Oregon Association of Hospitals; Salem and Astoria Hospitals
3	97	Oregon Association of Hospitals
4	98	Emanuel Hospital, Portland
5	98	Robinette/Gustafson
6	98	Emanuel Hospital, Portland
7	99	Oregon Association of Hospitals
8	99	Oregon Association of Hospitals
9	99	Oregon Association of Hospitals
10	99	Robinette/Gustafson
11	99	Emanuel Hospital, Portland
12	100	Physicians' Medical Laboratories, Portland; OSBH Public Health Lab Section; and Robinette/Gustafson
13	101	Oregon Association of Hospitals; Physicians' Medical Labs, Portland; Gustafson
14	102	Oregon Association of Hospitals; Emanuel Hospital; OSB Nursing; Robinette/Gustafson
15	102	Emanuel Hospital, Portland
16	102	Oregon Association of Hospitals
17	102	Gustafson
18	103	Oregon Association of Hospitals
19	103	

EXHIBIT 3 (Cont.)

Paragraph Number	Page Number	Source of Edited Suggestions/Comments
20	105	Oregon Association of Hospitals; Emanuel Hospital; McMinnville Hospital
21	107	Oregon Association of Hospitals; Oregon Health Care Association; Medical Association Section, Public Welfare Division; Health Facilities Section, OSBH
22	108	Associated Home Health Service, Portland; and Public Health Nursing Section, OSBH

1. THE ROLE OF HEALTH FACILITIES IN PROVIDING HEALTH SERVICES IS CURRENTLY UNDERGOING SERIOUS QUESTIONING.

There is much current discussion about the appropriateness of the traditional role of hospitals, nursing homes, homes for the aged, and home health agencies in the total spectrum of health services delivery. The Kaiser Foundation in Portland and the Physicians' Association of Clackamas County has developed a much more than traditional health service system, and other Portland hospitals are beginning to move in a more comprehensive direction. Rogue Valley Memorial Hospital in Medford has also expanded its traditional inpatient role with the addition of many ambulatory community health programs such as dental health, multiphasic screening services, and diabetic schools, etc. Most facilities in the state, however, provide either acute inpatient coupled with emergency outpatient services (hospitals) and some extended care services; long-term inpatient care (nursing homes); long-term custodial or residential care (homes for the aged); or outpatient home health care services (home health agencies). New forms of organization have not been encouraged by permissive legislation, permissive regulations, or financial incentives even though health maintenance organizations (such as the Kaiser System) have shown approximately 20% lower operating costs than the traditional fee-for-service system. How fee-for-service compares to capitation basis in quality of care or other standards of performance is unknown. The health maintenance organization system and the public utility or certification of need questions are those being most prominently discussed by health professionals today.

2. EXISTING STATE BOARD OF HEALTH RULES AND REGULATIONS GOVERNING FACILITY LICENSURE DISCOURAGE ORGANIZATIONAL INNOVATION.

Present State Board of Health Rules and Regulations discourage organizatonal mergers of two or more existing facilities by requiring separate licensure and standards of service for each building operated by the unified organization (for example: to qualify for a hospital license, you must maintain in each facility certain services, such as x-ray, laboratory, emergency room, etc.). Present federal Medicare certification and reimbursement requirements make it impossible to effect complete mergers. Separate numbers are required for billing and cost reimbursement for each building, which forces duplication of records and personnel, and substantially reduces the potential cost savings inherent in shared management.

3. HIGH JUDGMENT AWARDS IN MALPRACTICE LIABILITY SUITS INVOLVING HEALTH FACILITIES, RESULTING IN UNFORESEEABLE ESCALATION OF INSURANCE PREMIUMS, HAVE RAISED FACILITY OPERATING COSTS, INHIBITED INNOVATION, AND STIMULATED OVER-UTILIZATION OF CERTAIN SERVICES.

Unlimited financial awards in malpractice cases throughout the nation have caused major increases in insurance rates (1964 - $27.71/bed, 1970 - $49.21/bed for hospitals) which are then added (as an additional cost of business) to health facility rates and charged to persons who have been institutionalized. The recent increase in the number of suits, as well as their size, has created an important negative incentive for those who might wish to experiment with new methods of providing health services (since new methods are not "standard in the community" by definition and thus invite legal action where results are not what the patients had desired). They have also stimulated the ordering of questionably necessary procedures and tests (especially lab tests and x-rays in emergency cases) for the primary purpose of protection against liability.

4. SOME OREGON RESIDENTS HAVE DIFFICULTY GAINING ACCESS TO NEEDED SERVICES.

Many of the less affluent, as well as others in our society have difficulty in finding entry into the health care system. They interpret health care to be for a specific injury or illness incident rather than to supply a continuum of services. When these incidents do occur, it is difficult for them to find assistance because they do not have an on-going relationship with providers. This may be because of health costs; because they live at a distance from where the service is provided; because they lack transportation; or because of difficulties in arranging time during the limited hours a clinic may be open.

5. ORGANIZED HOSPITAL, AMBULATORY, AND OUTPATIENT CLINIC SERVICES ARE NOT WIDELY AVAILABLE IN OREGON.

Hospital outpatient services are not widely available to patients in Oregon. Most such services have been provided by private (one- and two-doctor offices) and by group practice clinics (e.g., Kaiser Foundation, The Dalles Clinic, Eugene Clinic, Lake Oswego Clinic, etc.). Hospital outpatient services which do exist are usually found at state and county institutions and in experimental situations (such as those being conducted under Health Services Research Center grants at Bess Kaiser Hospital in Portland). Group practice is generally believed to be expanding in Oregon, particularly in larger communities. There are no adequate measures of need for clinics because of a lack of agreed upon definitions and criteria for measurement. Also, there are no measures of adequacy which have been specifically applied to Oregon.

6. MANY HOSPITAL EMERGENCY ROOMS ARE INADEQUATE.

Emergency rooms in most areas of the state are not able to handle a rapidly increasing volume of service. Many emergency rooms are ill equipped and overcrowded; most are not staffed on a 24-hour basis with adequately trained personnel; and most are underfinanced due to unrealistic fee schedules.

7. THE LACK OF STATEWIDE STANDARDS HAS CAUSED A WIDE VARIATION IN THE CAPABILITIES OF EQUIPMENT AND PERSONNEL PROVIDING AMBULANCE SERVICE IN OREGON.

This causes serious problems for the organized emergency rooms operated by hospitals.

8. THERE IS NO MECHANISM TO SPREAD THE COST OF AMBULANCE SERVICES OVER THE COMMUNITY SERVED.

Many health facilities have been required to subsidize ambulance service with funds derived from institutionalized patients.

9. MANY DECEPTIVELY INADEQUATE HEALTH AND ACCIDENT INSURANCE POLICIES ARE STILL BEING SOLD IN OREGON.

This problem is felt most acutely by persons with inadequate or fixed incomes, many of whom are members of the older age groups and/or are members of minority groups. Nearly 800 companies are licensed to sell insurance in Oregon. Nearly 350 companies are able to sell "Life and Health" benefits of infinitely varying adequacy.

10. REHABILITATION SERVICES ARE POORLY UTILIZED AND PROVIDED BY ALL TYPES OF HEALTH FACILITIES WITHOUT ADEQUATE QUALITY CONTROLS OR WIDELY ACCEPTED STANDARDS.

The most intensive, wide-scope physical and/or emotional rehabilitation services are provided by the Rehabilitation Institute of Oregon, Lovejoy Rehabilitation Institute, the University of Oregon Medical School Hospital, and the Veterans' Administration hospitals. Extensive emotional and physical rehabilitation services are available through the state psychiatric hospitals and the larger non-governmental hospitals in Metropolitan Portland, such as Emanuel Hospital. In addition, most hospitals offer at least physical therapy treatment; and since the advent of Medicare, most nursing homes, homes for the aged, and home health agencies provide some form of rehabilitative services. The quality, scope, and extent of utilization of these services is as varied as are the institutions providing the service. No widely accepted standards are applicable to the rehabilitative services field, and in the absence of readily available funds for the support of these kinds of services, the services are not believed to be as widely utilized as their obvious value would suggest.

11. MOST REHABILITATION SERVICES ARE NOT INTEGRATED WITH OTHER FACILITY SERVICES.

There are only a few free-standing rehabilitation facilities in Oregon. While they provide excellent services to the population, they are required by licensure to provide some services which are seldom

used such as operating rooms, x-ray facilities, and laboratories. Where these facilities are close to major hospitals, these operating rooms, x-ray facilities, laboratories, and other services could be shared in order to improve the scope and quality of services available to all the facilities at a reduced cost per unit of service.

12. THE TECHNOLOGY OF CLINICAL LABORATORY SCIENCE IS IN A STATE OF RAPID CHANGE.

Every hospital incorporates a clinical laboratory and provides laboratory services for hospitalized inpatients and outpatients. Prior to July 1, 1970, 59 additional laboratories were also licensed in Oregon to conduct venereal disease examinations. (Historically, this standard was used to license laboratories.) The Oregon Clinical Laboratory Act of 1969 (438.010 - 438.990) which went into effect on July 1, 1970 requires a much more comprehensive standard of laboratory operations for licensure and requires all laboratories serving five or more practitioners to be licensed. As of September 8, 1970, 196 laboratories had been mailed license applications, and 148 applications had been returned and were being processed. About 85 of the total can be expected to be hospital laboratories, and the remaining 111 invitees are non-hospital related laboratories serving practitioner offices and clinics. Since the licensing laws do not apply to laboratories serving less than five practitioners, the number, quality, and scope of service of these smaller laboratories is unknown. We do know, however, that most physicians do perform some determinations in their own offices.

1970 licensing standards will probably reduce the present number of laboratories in small offices and clinics. Automation and computerization are making a large number of determinations feasible at a fraction of their previous cost. Automated installations require major capital investment and a higher volume of service than can be generated by two or three physicians or a small hospital.

The role of the "physician-oriented" laboratory as contrasted with the "commercial" laboratory presents a continuing economic and ideological struggle.

Current experimentation in the area of multiphasic screening provides promise of material advances in the availability of early identification and preventive services. State licensure laws will need to incorporate standards for multiphasic screening centers which are autonomous from other facilities.

Actions will have to be taken to alleviate shortages of trained laboratory personnel.

13. EXISTING LAWS GOVERNING LICENSURE OF HEALTH PROFESSIONAL AND TECHNICAL WORKERS APPEAR TO DISCOURAGE NEW METHODS OF MANPOWER UTILIZATION; COMPOUND AN ALREADY SERIOUS HEALTH MANPOWER SHORTAGE; INCREASE THE COST OF HEALTH CARE SERVICES; AND PROTECT AND ENCOURAGE THE CONTINUED PRACTICE OF NONSCIENTIFIC PRACTITIONERS.

Licensing laws inhibit the development of new ways to use scarce technically trained health manpower more effectively and prevent the development of "career ladders" which could materially reduce high turnover rates.

A 27-member federal task force on Medicaid and related programs appointed in 1969 to advise the Secretary of Health, Education, and Welfare on the Medicaid program recommended the removal of chiropractic from Medicaid. The task force pointed out that an earlier (1968) study by Health, Education, and Welfare recommended that chiropractic services continue to be excluded from Medicare. Major recommendation of the 1968 Health, Education, and Welfare report entitled "Independent Practitioners Under Medicare," was as follows:

> "Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment. Therefore, it is recommended that chiropractic service not be covered in the Medicare program."

Concerning chiropractic, the Report of the National Advisory Commission on Health Manpower (Vol. 2, November 1967) contained the following statements:

> "Although chiropractic is not the only existing cult, it is the only one which still constitutes a significant hazard to the public.
>
> "...The only legal issue regarding chiropractic is how best to protect the public from its dangers.
>
> "...It should be recognized that no matter how high they are set, no matter how strictly they are enforced, licensure standards cannot redeem the invalidity of chiropractic."

In its conclusions, the Report of the National Advisory Commission on Health Manpower asserted,

> "Attempts to control unscientific schools of practice or cultism by licensure cannot give unscientific practices a scientific basis but can endanger the public by giving unscientific schools, such

as chiropractic, protection through the sanction of the law."

14. THE SUPPLY OF TRAINED HEALTH MANPOWER IS INADEQUATE.

Discussion and recommendations regarding chronic shortages, maldistribution, and questionable utilization of skilled health manpower may be found in the "Health Manpower" Section of the Comprehensive Health Plan.

15. SOME HOSPITALS BELIEVE THAT FACILITIES FOR THE CARE OF ABORTION CASES ARE INADEQUATE.

The 1969 Legislature liberalized the abortion law of the state but made no provision for the construction of facilities to perform the procedures. Some hospitals are able to accept the responsibility for this public decision without undue difficulty, while other hospitals are not. In hospitals where separate facilities are not available, mixing these patients in with normal obstetrical patients is creating complex emotional and psychological problems for some of the physicians, patients, visitors, and others.

16. THE ESTABLISHMENT OF NEW HEALTH FACILITIES IS NOT CONTROLLED ON THE BASIS OF COMMUNITY NEED OR OPERATOR CAPABILITY.

Duplicative and unnecessary health facilities have been and can still be established in Oregon. While there are controls on the use of public funds to subsidize the construction of new facilities, there is no means of preventing the development of an unneeded new facility which can provide its own construction capital. For these prospective facility operators there is no existing mechanism: 1) to require a demonstration of adequate working capital; 2) to require evidence of available trained personnel to staff the facility; or 3) to require evidence of managerial or professional ability to operate the facility successfully after it has been built.

17. MOST EXISTING HEALTH FACILITIES DO NOT HAVE A FORMAL LONG-RANGE PLANNING PROGRAM TO GUIDE THEIR FUTURE GROWTH AND DEVELOPMENT.

Most health facilities do not now have long-range development plans and do not have the resources to develop them without assistance. Planning agencies which might provide the needed assistance exist only in Portland and Eugene. These agencies are not funded sufficiently to assist every facility operator in their own area and are not able, therefore, to provide material assistance outside their own area. Section 314 (a) (2) of the Public Health Service Act was amended by Public Law 90-174 (December 5, 1967) to include the following new paragraph:

"(I) effective July 1, 1968, (i) provide for assisting each health care facility in the state to develop a program for capital expenditures for replacment, modernization, and expansion which is consistent

with an overall State plan developed in accordance with criteria established by the Secretary after consultation with the State which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and (ii) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (i)) of each health care facility in the State and recommend appropriate modification thereof;."

This Federal law which might provide the assistance required by health facility operators, has not as yet been implemented in the state of Oregon.

18. MOST HEALTH FACILITIES DO NOT DISPOSE OF WASTES IN ACCORDANCE WITH THE POLLUTION-CONTROL GOALS OF THE STATE.

19. PRESENT METHODS (MEANS OF MEASUREMENT) OF ASCERTAINING TRUE COMMUNITY NEEDS FOR HEALTH FACILITIES ARE GROSSLY INADEQUATE.

Our primary means of measuring health facility needs is the Hill-Burton formula. The Hill-Burton Bed-Need-Determination formula was originally devised in 1945 and although reviewed annually, has not been significantly revised in the intervening 25 years. It was originally intended to be used as a "rough-rule of thumb" guide for the equitable distribution of Federal funds intended to stimulate the construction of small, rural hospitals. Over the years, the repetitive use of the word "need" has led to popular misunderstanding of its purpose. Many people have presumed the formula revealed ACTUAL facility needs, rather than simply providing an objective mechanism for the fair distribution of a Federal capital subsidy. The formula was not expected to determine true needs even in 1945. By 1970, twenty-five years of technological and social change have converted a once practical formula into an anachronism which causes serious problems to the health facilities of Oregon. Problems are caused because of its continued use for the distribution of Hill-Burton funds, but more importantly because of its recent acceptance as a "true need indicator" by other Federal and state agencies and by loaning agencies. As a "true need indicator," the formula has, at least, the following serious shortcomings:

a. The formula combines all of the various hospital service categories into one category and averages their various occupancy rates into one, over-all, occupancy factor. This occupancy factor is used in a mathematical process to develop an over-all bed need. The occupancy factor always relates to a utilization percentage derived from combined medical, surgical, obstetrical, and pediatric services. Yet there might be one or more hospitals in a geographic area experiencing an extremely low occupancy in pediatrics or obstetrics while experiencing

an extremely high occupancy in the medical and surgical service units. When a "bed need" is calculated on the basis of the combined services occupancy rate in relation to a goal factor of 80% over-all occupancy, no "bed need" may be revealed under conditions of actual critical need. The hospital might, in fact, have a desperate need for additional medical-surgical beds but no need in the obstetrical or pediatric area. Many of the Hill-Burton authorities comment that the hospital should be flexible enough to convert its obstetrical or pediatric beds into medical-surgical use, even though they readily admit that in many specific instances building limitations make such a conversion impossible.

The conversion argument is not applicable, however, to intensive medical and surgical care units (coronary care unit, for example) which must be available for immediate use for special purpose, while a "regular" bed is kept in reserve for the moment when the patient no longer requires the special services of the intensive care bed. In other words, application of the formula could result in a determination of "no need" for a coronary care unit, as a result of low obstetrical census.

The 80% over-all hospital occupancy goal factor was originally intended as a "rule-of-thumb." As a "rule-of-thumb" it remains a useful tool for hospitals of 300 or more beds with a well balanced patient census. Eighty percent occupancy rate has always been known, however, to be an unrealistic goal for any particular service (obstetrics should probably not exceed 60%, pediatrics 50%, and intensive care 50%, while surgery service may safely exceed 85%, and the medical service may sometimes safely exceed 90%); and it is well known to be unrealistic for large hospitals with unbalanced patient census, as well as for nearly all small hospitals, regardless of their service balance. The 80% goal factor is simply too rigid, therefore, for rational use in the determination of needs, especially when applied without discrimination throughout the entire state.

b. Population estimates used with the bed-need determination formula are provided to the Oregon State Board of Health Vital Statistics Section by the Federal Department of Health, Education, and Welfare. The Vital Statistics Section allocates the totals to the hospital service areas and provides a table of estimated populations to the Health Facilities Licensing and Construction Section of the Oregon State Board of Health for their use in calculating bed needs. The population estimates are extremely conservative for any given locality when compared with estimates compiled by the Oregon State Census Department. If toward the end of a ten-year census cycle the Oregon State Census Department is the most accurate, then the Health, Education, and Welfare figures tend to artifically depress the estimate of needed beds.

c. Hospital service areas (which are not formulated from patient origin studies) are arbitrarily selected and do not always correspond to the actual geographic areas served by health facilities. The Portland area (2), for example, combines the larger downtown metropolitan facilities with those facilities located in St. Helens, Hillsboro, Forest Grove, and Oregon City. The Pendleton area (12-B) combines the larger, stable community of Pendleton, with the smaller, but much more rapidly growing communities of Umatilla and Hermiston. We question whether the area boundaries actually represent the true service areas of the health facilities involved.

   Grouping dissimilar communities, populations, and facilities together produces distorted need judgments not based on facts. Needs in small, rural institutions should not be determined by the same criteria used to determine needs in large, metropolitan institutions.

   Suburban health service provision characteristics are different from urban and small community characteristics. When an area combining all three characteristics is arbitrarily judged to be one service area to which an inflexible formula can be applied, the true needs of all of the institutions are certain to be hidden rather than revealed.

d. Bed capacities utilized in the bed-need determination formula (and reported in the State plan) are those capacities that institutions could establish according to Hill-Burton standards, not the capacities actually being used or the average capacity over a twelve-month period. Institutions often cannot achieve the capacity the Hill-Burton standards indicate they could have, and important actual needs are thus hidden rather than revealed.

Public Law 91-296, which extends and expands the Hill-Burton program through fiscal 1973 requires the Secretary of Health, Education, and Welfare to submit a study of the allocation formula to Congress on May 15, 1972. At least until that date, no improvement can be foreseen for the Hill-Burton agency in its ability to measure and report the "true actual needs" for health facility developments in the state of Oregon. In the meantime, an archaic formula heavily supplemented by subjective judgment is the only "need" measure available for use.

20. MECHANISMS TO PROVIDE CAPITAL FUNDS FOR FACILITY IMPROVEMENT ARE INADEQUATE.

Non-profit hospitals, which constitute the majority of hospitals in Oregon, have difficulty in securing adequate financing from insurance companies and other lenders because there is no method whereby the lender can secure a portion of equity as a condition to the loan. In this absence of an "equity kicker" the interest rates can be high

enough to serve as a negative incentive to needed construction. This problem is especially acute for organizations that have traditionally depended on grants, donations, and contributions for new construction and alteration. It has also been a problem for facilities that, as a matter of pricing policy, have not established rate levels high enough to permit the funding of depreciation costs.

Frequently, aged people with chronic health conditions desire the comfort and accessability to physician and hospital services which go with residence in a facility which is close to or connected with a general hospital. There are some funds available to assist in the construction of these facilities; however, more adequate funding is needed.

The Hill-Burton program, while helpful, has been inadequate in assisting facility development. On recommendation of their Advisory Council, the State Board of Health has limited Federal assistance to one-third of the new construction cost, not to exceed $12,000 per bed for hospitals and $5,500 per bed for nursing home and other medical facilities. (The one-third assistance was determined to be the most equitable method to permit the availability of Federal funds to more areas.)

New hospital construction costs are now nearing $40,000 per bed and rising at about 7 to 10% each year. Nursing home construction costs are believed to average more than $20,000 per bed and are increasing at a comparable rate. As of September, 1970, Hill-Burton assistance in the amount of $32,469,270 has been provided for 144 projects which (when all have been completed) will have cost an estimated total of $125,242,257. Hill-Burton assistance represented, therefore, 25.9% of the estimated total cost of construction on these projects. An unknown number of projects were completed during this period without Hill-Burton assistance.

Oregon does not provide any state funds to match the Federal and local contributions. Other states approve much higher levels of Federal participation and then match the Federal contribution with an equivalent state contribution. Alaska, for example, is reported to permit 40% Federal and provide a matching state 40% (with no upper limits) for a total of 80% of the total construction cost of the new health facility or facility expansion.

Investor-owned (for-profit) health facilities are not eligible for Hill-Burton construction subsidies. They are eligible for Federal Housing and Administration mortgage assistance, but only upon certification of the need for the facility development by the Hill-Burton agency. Housing and Urban Development mortgage insurance may soon be newly available to this group of facilities if the companion bills S.4267 and HR16643 are passed into law. Eighteen Oregon hospitals (and numerous other health provider organizations) fall into this category. Several of these (McMinnville, Forest Grove, Dallas, etc.) provide 100% of the available hospital services in their communities. These facilities

must add 7-10% capital acquisition costs to the basic service costs charged their patients if they are to modernize or expand their facilities in response to community needs.

The Medicare and Medicaid reimbursement formulae provide insufficient capital allowances. In fact, the formulae are so restrictive that they do not even meet the operational costs of providing care to Medicare and Medicaid beneficiaries. As a result, private paying patients are required to subsidize services provided to Federal social security patients, as well as to non-paying patients. Federal beneficiaries now represent from 25-40% of the average hospital's census. Some mechanism must be devised to provide for the capital and operational financing requirements traditionally provided by donations, contributions, bequests, and excesses of charges over costs earned from paying patients.

21. NURSING HOME AND HOME FOR THE AGED DEVELOPMENTS ARE UNDER THE PRIMARY CONTROL OF THE PUBLIC FINANCING AGENCIES.

According to the 1971 Oregon State Hill-Burton plan, there is an unmet need for new nursing home beds; and of those that already do exist, nearly 50% do not meet minimum Federal standards. Yet the 134 licensed nursing homes in the state average only about 80% occupancy (nursing homes unlike hospitals can effectively be operated at more than 95%), and the occupancy rate seems to be going down (even though the percentage of our population 65 years of age and older is steadily increasing). New construction of both nursing homes and homes for the aged (sometimes called retirement apartments) has stopped. The nursing home market may be saturated; but homes for the aged average 100% occupancy, and nearly everyone agrees there is a critical need for additional homes for the aged, foster homes, and day-care homes. In the face of rising Federal standards of care (implemented by means of Medicare and Medicaid certification formulae) coupled with drastically tightened cost-reimbursement formulae and constantly increasing pressures to push patients to ever lower skill levels of service, the risks involved in the expansion of the state's nursing home and home for the aged resources outweigh any benefits that might accrue to the owners from the operation of these new resources.

The Oregon Health Care Association estimates that nearly 80% of the state's total nursing home patient census will be recipients of one or another form of public assistance during the next six years. If this is even partially true, then Public Welfare controls the development of long-term health facilities in Oregon. The public financing organizations involved have not engaged in facility planning, however, and have not attempted to work with facility operators to help them plan the orderly and economical transition of existing facilities to meet shifting program requirements. As a result, skilled nursing home beds stand empty as do a lesser number of semi-skilled beds, while the under-utilization costs of these empty beds inflate

the cost of nursing home care. Homes for the aged are overflowing, but no plans for expanding their capacity are evident. Also, no plans are on the horizon for foster homes; day-care homes; social, recreational, and home-assistance services which might be developed as supplements to, or substitutes for, homes for the aged.

In the meantime, the Hill-Burton program will support the construction of additional nursing homes, but are precluded by Federal law to assist with the more critically needed development of homes for the aged (and extended aged-support services).

22. HOME CARE SERVICES ARE AVAILABLE TO MOST OF THE POPULATION, BUT ARE POORLY UTILIZED.

Discussion and recommendations on Home Health Care Services may be found in the "Home Health Services" Section of the Comprehensive Health Plan.

EXHIBIT 4

SUPPLEMENTARY MATERIAL

The Facilities Study prepared under contract by Arthur Young and Company from which this Section was prepared, as well as additional material used in compiling the data as indicated in the index on "Source Material" attached, is available for review in the State Comprehensive Health Planning office.

This material has been consolidated in a first attempt to provide a state and district compendium of health facility facts and figures relevant to health facility planning and development. Unfortunately, this data in its present form is not sufficiently comprehensive for use at the district level by areawide agencies, nor is there any such directory or summary of health facility planning data in existence in Oregon at this time. A comprehensive directory could be compiled from the indexed source material, with the addition of information from the listed references. Because of the significant effect such a directory could have in implementing need discussions at the district level, it is strongly recommended that the State Comprehensive Health Planning Agency be authorized and funded to prepare such a document.

EXHIBIT 4

INDEX OF SOURCE MATERIAL

DISTRICT FACTS

DEFINITIONS OF TERMS

AHA REGISTERED HOSPITAL APPROVALS AND AFFILIATIONS, 1969

REVENUE FOR COMMUNITY HOSPITALS, 1969

STATEWIDE SUMMARY OF HOSPITAL UTILIZATION AND CAPITALIZATION STATISTICS

STATEWIDE SUMMARY OF HEALTH FACILITIES BY ADMINISTRATIVE DISTRICT

PROPORTIONAL DISTRIBUTION OF RESOURCES BY ADMINISTRATIVE DISTRICT STATEWIDE SUMMARY

SUMMARY AND LIST OF LICENSED HEALTH FACILITIES IN EACH ADMINISTRATIVE DISTRICT

STATEMENT ON THE FINANCIAL REQUIREMENTS OF HEALTH CARE INSTITUTIONS AND SERVICES, JANUARY 14, 1969 REVISION

EXHIBIT 4

REFERENCES

1. The Oregon Association of Hospitals for details on actual operating hospital capacities, short-term vis-a-vis long-term care breakdowns, and hospital ownership.

2. The Oregon Health Care Association for similar detail on nursing homes.

3. The Oregon Association of Licensed Homes for the Aged for similar detail on homes for the aged.

4. The Oregon Medical Association for lists of physicians' offices, partnerships and clinics.

5. The Oregon State Board of Health:

    a. Public Health Laboratories Licensing Section for greater detail on medical laboratories.

    b. Health Facilities Licensing and Certification Section for greater detail on hospitals, extended care facilities, nursing homes, homes for the aged, and home health agencies.

    c. Health Facilities Planning and Construction Section for greater detail on hospitals, public health centers, long-term care facilities, and diagnostic and treatment centers.

    d. Division of Local Health Services for greater detail of home health agencies.

6. The Oregon State Department of Public Welfare for greater detail on homes for the aged, home health agencies, foster homes for the aged, and the welfare medical aspects of hospitals and nursing homes.

7. The Mental Health Division for greater detail on mental health facilities.

8. The 1971 Oregon State Plan for the construction and modernization of hospitals, public health centers, and medical facilities (the State Hill-Burton Plan).

9. Planning for Health, a community planning guide with a directory to state and community health resources (Comprehensive Health Planning, Program Planning Division, Executive Department, Salem).

10. Health Facts (Comprehensive Health Planning, Program Planning Division, Executive Department, Salem).

11. District Facts (Program Planning Division, Executive Department, Salem).

12. Physician's Handbook (Oregon State Board of Health, Portland).

13. Hospitals, J.A.H.A., August 1, 1970, Vol. 44, Part 2, Administrator's Guide Issue.

HEALTH INFORMATION SYSTEM

GOAL ESTABLISH AN EFFECTIVE, STATEWIDE HEALTH INFORMATION SYSTEM.

CONDITION

One of the greatest problems in the application of the Comprehensive Health Planning Act has been the lack of adequate information relating to the health of the people of Oregon. Health data have notoriously been either "too little" or "too late" to have a great impact on the health planning process. Compounding the problem are the fragmented health programs characteristic of our present health care delivery system. In attempting to provide adequate baseline information, hundreds of agencies, multiple sources of funding, confusing and inadequate statistics, duplication of efforts and waste of manpower, money and materiel have resulted. A health information system designed to bring together and correlate these multiple sources of data, as well as to document problem areas and program deficiencies must be implemented. One approach to gather and visually depict health and health-related information is the Comprehensive Health Information Planning System (CHIPS).

The CHIPS program is designed to collect, correlate and coordinate reported data from health-related agencies of the state and local government through the use of socio-economic stratified maps. To prepare the base map for an area, the local community is stratified into three socio-economic levels according to the block survey procedures developed by the Communicable Disease Center, Atlanta, Georgia. The entire community is surveyed on a block by block basis for such environmental conditions as poor drainage or weed control, rodent harborages, dilapidated and deteriorating houses. These factors are then combined with Census data to determine the geographic boundaries of the community's socio-economic levels.

The local health departments, home health agencies, comprehensive health planning committees and all other agencies having a health activity (e..g, Welfare, Vocational Rehabilitation, mental health clinics, police departments, etc.) are encouraged to participate.

The kinds of information included in the system are limitless. Such data as vital statistics, epidemiological reports, sanitarian complaints, nursing visits, welfare case loads, drunk driving arrests, medical facilities are transcribed onto the map transparencies as dots indicating their location in the community. Confidentiality of information is maintained since no names or addresses are used and the maps are scaled so as to make it impossible to define individual streets or small areas.

Each type of health information is transcribed onto a separate transparency. The transparencies of related conditions can be overlaid to show clustering

effects and help to identify problem areas. For example, the transparency indicating reported cases of hepatitis can be overlaid on the transparency of sanitarian complaints to determine if environmental factors may be responsible for outbreaks of hepatitis.

These transparencies prepared in the local community are forwarded to the central state office and considered with reports from other communities to identify health problems throughout the state.

The system can eventually be expanded to include information from private physicians, hospitals, and voluntary agencies to provide a comprehensive view of health problems in Oregon.

CURRENT PROGRAMS AND ACTIVITIES

The Public Health planning section of the Oregon State Board of Health consisting of a planning coordinator, a research analyst, and a federal assignee is responsible for the organization, training, supervision and implementation of the CHIPS program in Oregon. Under the supervision of the Oregon State Board of Health, a demonstration of the CHIPS system has been completed in Douglas County and efforts are now under way to initiate the program in all counties in the state.

In addition to assisting the counties, the planning section acts as a repository for the data collected and lends assistance in the analysis of problem situations identifed through CHIPS.

In county implementation of the CHIPS program, the local health department is the initial agency responsible for organizing the system. Because of the comprehensiveness of the system, however, other community agencies must be encouraged to cooperate in the data collection. To date, ten Oregon counties have adopted the CHIPS program: Benton, Crook, Deschutes, Douglas, Harney, Jefferson, Josephine, Klamath, Umatilla, and Washington. Instruction and training is now under way in Clackamas, Linn, Polk, and Yamhill counties.

AUTHORITIES

To be researched.

OBJECTIVE

By 1973, establish a statewide reporting and retrieval system for health information using standardized procedures to provide a comprehensive data base necessary for health planning.

RECOMMENDATIONS AND METHODS

1. *STATE COMPREHENSIVE HEALTH PLANNING ASSUME RESPONSIBILITY FOR COORDINATION OF COMPREHENSIVE HEALTH INFORMATION PLANNING SYSTEM (CHIPS) IN ALL FOURTEEN ADMINISTRATIVE DISTRICTS.*

   Methods

   a. *Governor's Health Planning Committee and areawide health planning committees encourage state and local agencies, private physicians, and hospitals to adopt the CHIPS health information system.*

   b. *Comprehensive Health Planning add two staff members to implement CHIPS and provide assistance to local areas for: 1) eliciting cooperation from all necessary agencies and individuals for a successful program, 2) training of local health personnel in the CHIPS techniques, and 3) provision of the maps and transparencies needed for transcription of data.*

   c. *Oregon State Board of Health and the Mental Health Division allocate adequate 314(d) monies to fund one person in each health region to administer CHIPS under the regional health officer.*

   d. *Comprehensive Health Planning conduct periodic conferences for participating agencies to discuss and resolve problems encountered in the CHIPS program and to expand the system to include new data items as needed.*

2. *DEVELOP A SYSTEM FOR THE ANALYSIS, SYNTHESIS, AND DISTRIBUTION OF HEALTH INFORMATION TO ALL AGENCIES INVOLVED IN HEALTH PLANNING.*

   Methods

   a. *Comprehensive Health Planning establish a data center for local health information collected through CHIPS.*

   b. *State Comprehensive Health Planning Agency, in conjunction with the University of Oregon Medical School, the Oregon State Board of Health, and Human Resource agencies, establish a procedure for the referral of health problems identified through CHIPS to the appropriate professional expertise for analysis. Health specialists in private practice and from voluntary and community agencies, as well as those affiliated with state agencies should be included in the system.*

   c. *Comprehensive Health Planning make the data available to other agencies and the general public through the publication of annual summary reports.*

d. *Comprehensive Health Planning study the feasibility of coordinating the health information system with existing data systems in human resources.*

e. *Comprehensive Health Planning study the feasibility of computerizing the health information system.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Evaluation of the CHIPS program will be conducted by the Comprehensive Health Planning Agency. A successful system will insure a coordination of all health-related agencies, a sharing of data applicable to all agencies, and documentation of existing problem areas and the activities relating to them.

PRIORITY

To be determined.

HEALTH MANPOWER

GOAL ASSURE AN ADEQUATE SUPPLY OF QUALIFIED HEALTH MANPOWER TO SATISFY THE NEEDS AND DEMANDS FOR QUALITY HEALTH CARE OF THE PEOPLE OF THE STATE OF OREGON.

CONDITION

The material presented herein represents an earnest attempt to provide an overview and give perspective to the very complex health manpower situation. The time limitation for preparation of this Section has disallowed compilation of comprehensive data on the many facets of the supply of health manpower; however, every attempt has been made to at least identify the most salient health manpower programs and problems in Oregon. The many shortcomings of this report (such as the lack of comprehensive data on many of the allied health occupations and health-related programs) are self evident and will be corrected in subsequent revisions of this section. It is anticipated that prior to implementation of any of the recommendations, provision will be made for an in-depth study of the area concerned.

General Considerations

Need for medical care is a biologic determination which implies that a patient is ill or injured and requires treatment. Need is quantitatively affected by population expansion, as well as by environmental, economic, genetic, educational, and a variety of other factors which influence the incidence of illness or injury.

Demand for health care is an economic concept and implies that someone wishes to buy health services. Demand is limited to those who seek care and they may or may not need services. It should be noted that many who wish to buy health services may exhibit no demand for health services whatsoever for the simple reason that they have no way in which to finance fulfillment of that wish. In other words, demand is quantitatively affected by the economic state of the individual or society. Demand includes services desired as a result of education or self-concern, as well as need.

Medical care refers to the use of the services of a professional or allied health worker for the treatment of an illness or injury.

Health care includes medical care and refers to the services of all health-related occupations for prevention (including public health endeavors, periodic examination to detect or exclude symptomless disease, immunizations and education), treatment, and restoration, as well as activities designed to insure a healthful living environment.

The health "industry" like any other industry, is a "system of labor or habitual employment." However, the product involved is delivery of skilled personal services requiring specialized education and training. Health workers have not been adequately defined in terms of range of duties, degrees of responsibility, or limits of training.

There have been some health worker definitions set forth by statute and statutory boards, as well as by voluntary certifying bodies. Many of these, as well as other existing and emerging health occupations are poorly defined in terms of requisite training, duties, and relationships to other health workers. Neither have adequate career ladders been established.

Within the "health industry," the supply sector is represented by the educational facilities which train the health worker; the patient is the recipient of the services performed; and management is represented by the employer of the health workers (usually the hospital, physician, nursing home, etc.). Management responds via employment to the "demands" for health care. Ideally, the supply sector should be able to respond to management's demands for health workers. The central problem in the assessment of health manpower need involves the supply-demand system. The health care system is a sector in which normal supply-demand market mechanisms may not be expected to function as efficiently as in the usual economic sector, and the evident health manpower shortages that in fact now exist certainly bear this out. Health manpower training and supply have evolved without any overall design as a result of various pressures applied, resulting in the creation of health occupations and training programs as the need arose. Unfortunately, to date, no one agency has been comprehensively concerned with this problem on a statewide basis, nor has there been any mechanism devised to make the whole recruitment and training system respond to the changing needs of the people. A list of the current health occupations categorized by areas of special interest (some 137 occupations covering about 20 health-related fields) is attached as Exhibit 1.

The demands for quality health care have increased to a greater extent and more rapidly than would be expected from population expansion alone. Factors which have affected the demand for health care include:

1. the relative affluence of our economy;

2. the increased education and sophistication of the public regarding health care (qualitatively and quantitatively);

3. the increased health insurance coverage by the private, labor and governmental sectors;

4. the advances in medical knowledge, offering more definitive treatment in many areas;

5. the loss of a fearful attitude toward the physicians and hospitals;

6. the sociological evolvement of the philosophy that good health (good medical) care is a "right" and not a "privilege."

Health Manpower Resources

There are three basic resources for health manpower:

1. Untrained individuals who have the aptitude and desire to enter the field of health services;

2. Health workers already trained;

3. Trained health workers needing continuing education or refresher training (e.g., medical corpsmen returning from military services, inactive nurses, physicians, etc.)

Educational and Training Facilities

Our educational system is an unusual combination of government and free enterprise, both of which respond to community, state and national pressures, and which receive funds from Federal, State, and/or community resources. A dearth of coordinated planning and communication between the educational and medical care delivery systems, pressure to increase the supply of health workers, and other factors have generated unnecessary duplication of educational programs. This has been particularly so when Federal funds have been involved, and has resulted in an uncoordinated crisis-oriented system of supply. Too often the stimulus for training programs for health workers has been the availability of funds or the aggrandizement of an institution. The supply sector has tended to operate without regard for management or patient needs. Furthermore, there has not been any agency, governmental or other, to evaluate and determine the capability of private or vocational schools to carry out these health manpower training programs. As a result, the supply of health workers is neither flexible nor standardized, quantitatively or qualitatively.

The charts attached as Exhibit 2 reflect health career training programs in Oregon as of June 1, 1970.

Recognizing that educational facility staffing and funding is a continuing problem in Oregon, as elsewhere, one major problem in the nurses training area deserves special attention. There are two hospital-based, diploma-level nurses training programs in Oregon conducted at Good Samaritan and Emanuel Hospitals in Portland. In the absence of other financial support mechanisms, each of these hospitals subsidize their nurses training in an amount ranging between $750,000

and $900,000 each year. In other words, the patients are absorbing the costs of these hospital training programs, and the costs of these programs are becoming an overwhelming burden for the two hospitals which could result in closure of these schools.

Health Occupations Standards

In Oregon, less than 15% of the 137 health-related occupations are presently required to be licensed/certified by Oregon Statute (Note asterisked items in Exhibit 1). These consist mainly of the classic professions (e.g., physicians, dentists, nurses, pharmacists, etc.) licensed by their individual boards and registered annually.

Accurate data is available from these licensing boards on their licensees. Other groups such as laboratory technologists, radiological technicians, etc., meet standards of their national accrediting organizations and function under a registry by these organizations, but are neither registered nor licensed by the state. Still other health occupations are neither licensed nor registered and have no genuine local, state, or national standards.

Thus, state policy is inconsistent in the exercise of regulatory functions pertaining to the qualifications and competence of health workers entrusted with some facet of patient care. Furthermore, the state does not have the capability to determine the quantity, quality, distribution or utilization of its health workers.

Since the well-being of the patient is at issue, and accepting the premise that most health workers function in extension of the physician's care, the expanding complexity of health problems and health care demand some regulation of standards of education and training for health occupations. The degree of regulation of educational and training standards should be proportional to the degree of responsibility of the health occupation.

Physician Manpower

There are not enough physicians to meet the health care demands of the people of the state, despite the increasing number of physicians being licensed to practice. If the physician to population ratio is used as a measure of the supply of physicians over the past ten years, Oregon has made great strides as can be seen in Table 1.

Table 1

Physician To Population Ratios

Type and Status	1960	1970
Number of Active Physicians 1/	2,206	2,932 2/
Oregon Population 3/	1,768,687	2,056,171
Ratio of Physician to Population	1:802	1:701 4/

1/ Data from Board of Medical Examiners (includes D.O.'s).
2/ As of July 1, 1970.
3/ Data from Bureau of Census, Portland, Oregon.
4/ If only M.D. ratio is calculated, ratio becomes 1:739.

The physician to population index, however, can be misleading because not all active licensed physicians are engaged in direct patient care and physician distribution is not uniform. In 1968, the ratio of practicing physicians5/to population was 1:805; whereas ratio of all professionally active physicians to population was 1:749. The difference in numbers represents physicians working in administration, research, teaching, public health, etc. While those areas are important and ultimately provide a benefit to the people, the fact remains that these physicians are not available for direct patient care.

Table 2 shows the steady increase in numbers of licensed physicians from 1960 to 1970; as well as an increase in the number of physicians who became inactive. (NOTE: for every two physicians newly licensed, one physician became inactive.)

5/ As shown in Oregon Physician Manpower Report, 1968, Oregon Medical Association (does not include 150 D.O.'s licensed in state.)

Table 2

Numbers of Licensed Physicians in Oregon 1/

Type and Status	1960	1965	1969	1970 2/
		ACTIVE		
M.D.'s	2,062	2,344	2,608	2,781
D.O.'s	144	146	148	151
Total	2,206	2,490	2,756	2,932
		INACTIVE		
M.D.'s	806	961	1,098	1,187
D.O.'s	90	110	121	127
Total	896	1,071	1,219	1,314

1/ Data from Board of Medical Examiners' Report, 1960-70.
2/ As of July 1, 1970.

Table 3 shows the methods by which licensure is granted and indicates that the State of Oregon continues to attract physicians from other areas. The sudden marked increase in the 1970's cannot necessarily be construed as a definite or continuing trend.

Table 3

Number of Physicians' Licenses Issued 1/

Method	1960	1965	1969	1970 2/
Examination 3/	37	47	6	1
Endorsement	29	47	87	118
Reciprocity:				
M.D.	63	79	73	94
D.O.	8	12	4	9
TOTAL	137	185	170	222

1/ Data from Board of Medical Examiners.
2/ As of July 1, 1970
3/ No D.O. School in the State of Oregon.

Despite these increases (recognizing that there are some few who would disagree) it is generally held that there are still inadequate numbers of physicians to provide direct patient care to the increasing numbers of people needing medical care, much less for the projected demands for health care.

The problem is further complicated by the fact that physicians are free to decide their type of practice and to locate where they wish, regardless of shortages and public need (i.e., the distribution of physicians is self-determined for the most part--and in a country that prides itself on the guarantee of freedom, this is to be expected). Thus, we find that physicians tend to settle in areas that provide attractions such as modern well-equipped hospitals; colleagues complementing their specialties; sufficient population to utilize and compensate them for their skills; and physical, educational and cultural attributes desired by the physician and his family. This results in geographic maldistribution of physicians and indeed, for most of the principle health occupations.

In addition to the increasing rate of loss of physicians into inactive status and maldistribution of physicians, other factors contribute to the physician shortage including:

1. an increased trend toward specialization in the past 20 years, reducing the numbers of primary physicians available for direct patient care;

2. a diversion of large numbers of physicians into teaching, research, administration, public health, etc., (note however that only 6% of University of Oregon Medical School graduates have entered fields not directly concerned with patient care.);

3. a diversion of physicians "time" for patient care by administrative and other "paper" work and by tasks that could be well performed by other trained persons;

4. an inadequate number of training programs for allied health personnel (to whom the physician would be able to delegate some functions) and failure to coordinate existing training programs with one another or with current management needs; and

5. procrastination in structuring and implementing the "team concept" and active teaching of "team techniques."

Dental Manpower

An in-depth study on dental health in Oregon is included in a separate section of the State Comprehensive Health Plan entitled "Dental Health." Concern is given here to shortages in dental manpower resulting from an increased demand for dental care.

Recognizing that such figures may be misleading, it is interesting to note in Table 4 below that the number of licensed dentists in the state actually decreased between 1960 and 1970.

Table 4

Dentist Population Ratio [1]

	1960	1970 [2]
No. of Licensed Dentists	2,401 [3]	2,308 [3] 1,400 [4]
Oregon Population	1,768,687	2,056,171
Ratio of Dentists to Population		1:1,469 [4]

1/ Data from Board of Dental Examiners.
2/ As of July 1, 1970.
3/ Includes active and inactive dentists.
4/ Refers to active dentists only.

Table 5 shows that while the total number of licensed dentists in the state actually decreased between 1960 and 1970, the number of active dentists increased slightly between 1965 and 1970. This slight increase, however, was insufficient to keep pace with the population expansion in Oregon.

Table 5

Number of Licensed Dentists in Oregon [1]

	1960	1965	1969	1970
Active	2/	1385	1388	1400
Inactive	2/	946	953	908
Total	2401	2331	2341	2308

1/ Data from Board of Dental Examiners.
2/ Not available.

Table 6 shows that there has been a moderate increase in the number of graduates from the University of Oregon Dental School from 1960 to 1970.

Table 6

Number of Graduates, U. of O. Dental School 1/

1960	1965	1969	1970 2/	1974 3/
63	73	70	78	80-81

1/ Data from the Board of Dental Examiners and U. of O. Dental School.
2/ As of July 1, 1970.
3/ Estimate based on number of admissions to first class in 1970 minus average loss per class.

Table 7 shows that the number of newly licensed dentists annually remained fairly constant from 1960-69. The figure for 1970 is based on newly licensed dentists as of July 1, 1970 and together with current projections for the remainder of 1970, indicates a significant increase in the annual rate of newly licensed dentists in Oregon. The figures are broken out to reflect in-state and out-of-state graduates.

Table 7

Number of Newly Licensed Dentists Annually in Oregon 1/

	1960	1965	1969	1970 2/
U. of O. DS Graduates	63	69	60	67
Other	21	16	27	12
Total	84	85	87	79

1/ Board of Dental Examiners.
2/ As of July 1, 1970.

There is increasing geographic mobility in the dental profession, as in most others, especially among new graduates and returning veterans. It is hoped that the advantages of Oregon living will have a positive effect in attraction and retention of dentists to Oregon to provide adequate

dental manpower to meet the needs of state residents.

At this point, it should be noted that there is significant controversy surrounding the question of actual dentist shortage in Oregon. Lacking substantive data and evaluation mechanisms to settle this controversy, we must limit ourselves at this time to a brief discussion of the principle factors affecting determination of actual need.

1. There is no question but that there is a large unmet need for dental care in Oregon.[1/] The primary cause is the lack of ability on the part of those requiring such care to pay - or in some cases, a low priority for dental care in relation to available funds. If financial means are developed to pay for needed dental services (i.e., if public funds are made available for dental care), a dental manpower shortage will be evident in direct proportion to the amount of funds provided for such care.

2. There is little question but that funds used for preventive programs would produce a much greater benefit per dollar spent, then could be realized by programs limited to the delivery of dental care. Preventive dental care programs are at a minimum in Oregon at the present time. Prevention, specifically fluoridation of public water supplies and effective training and motivation of school age children to more adequately care for their dental health at home, would reduce dental caries by more than 50% and have a tremendous influence in holding down dental manpower needs of the future.

   In the absence of fluoridation of public water supplies (see Dental Health Section), there will be increased demands for dental manpower to provide individual topical fluoride treatment. Preventive dental care for children, which includes fluoride treatment, education in home dental care, and early treatment of existing caries, is as important to dental health as immunization against communicable disease etc., is to general health. Should such programs be instituted and/or financial means developed to allow treatment of other existing dental problems in Oregon, the shortage of dental manpower may well become critical.

3. The use of modern methods in dental treatment and the expanded use of dental auxiliaries make it possible to more than double the capabilities of treatment to the public by the individual dentist, as well as to reduce the per unit cost of dentistry without jeopardizing the quality of treatment. Although the use of dental auxiliaries has increased appreciably in the last 10-15 years, the utilization potential of these para-dental personnel to extend the dentists' skills points up the importance of expanding their use. In this regard, the Oregon Dental Association, the Board of Dental Examiners, and representatives of the University of Oregon Dental School have recently undertaken a program to expand

1/ It has been estimated that over 70% of Oregon's population is in need of dental care (see Condition statement, "Dental Health" section of the Comprehensive Health Plan).

the scope and usage of dental hygienists and assistants. Dental assistant programs have burgeoned throughout Oregon, especially in the community colleges.

In summary, it may be said that while actual "need" would indicate a critical shortage of dentists, "demand" as evidenced by the lack of public outcry about the shortage of dentists and apparent manageable patient work loads by Oregon's practicing dentists contraindicates this shortage. It should be added, however, that this lack of demand appears to be due to one or a combination of the following factors:

1. Dental care is at the absolute minimal level of need.

2. The ability to pay for service is the prime governing force.

3. There is inadequate public awareness of the necessity for continuing dental care.

4. The population at risk gives dental care a low priority until onset of pain or disability occurs.

Nurses 1/

It is recognized by the health field and widely publicized that there is a growing shortage and need for nurses in this country. Figures for the projected shortage vary, but all estimates indicate a need for more nurses. Considerations in this area, possibly the most complex health manpower area of all, include:

1. Continuous "oversupply" is essential since, at any given time, approximately 30% of the trained nurses are not active professionally (responsibilities of marriage and family, ill health, adverse employment situations, lack of economic motivation, etc.).2/ Availability is affected significantly by current economic trends. Maldistribution of nurses will not be corrected by training programs per se, in that their husband's place of employment and opportunity affect the geographic availability of nurses.

2. There is a continual influx of nurses re-entering the labor market after absence from nursing for varying periods of time (e.g., during periods of economic stress or lessened family responsibilities) mandating refresher courses on a continuing basis to update these nurses' skills.

3. The Licensed Practical Nurse programs, designed to provide a group of nurses prepared to give nursing care in situations relatively free of complexity and to assist the registered nurse in more complex situations, have not been markedly successful and have produced a

1/ See "Nurses Training Programs" under Education in Current Programs and Activities.
2/ This figure is higher in many other states as well as nationally.

large number of nursing care personnel either inadequately trained or improperly utilized for their designed function. These programs may have relieved the shortage of bedside nurses to a larger degree if their education had continued to be geared to the "practical" aspects of hospital nursing rather than developing into more academic and wide ranging programs.

4. In recent years, great emphasis has been put on academic training without a concomitant coordinated program to provide vertical mobility, except in the direction of teaching and administration.

5. Although hospital-based nurses training is expensive in comparison with community college nursing programs, it does produce a nurse with sufficient clinical experience in bedside and personal techniques to become operational with minimum orientation in the employing institution (hospital).

6. Preceptor training or specialized training of nurses has produced excellent results in certain areas of competence (e.g., Coronary Care Unit, Intensive Care Unit, Pediatric Assistant) proving that nurses can function as, and are a prime source for physician associates. These nurses may or may not have had maximum academic training, but have proven their aptitude by quality performance. To date, nothing has been done in Oregon to make these special areas of competence more attractive in terms of status or remuneration, or to incorporate these areas of clinical specialty into a career ladder.

Allied Health Team

The concept of the allied health team has been espoused, but team composition, responsibilities, and techniques for functioning within the framework of that concept have not been delineated.

Allied Health Manpower

Health occupations have arisen in response to demand. For the most part, educational facilities have structured training courses in response to local demand without widespread effort to achieve any degree of standardization. There are some national organizations which have set up minimum standards of training and education, but unfortunately, these have not always been applied by the training faculty nor the employing agencies. Where standards have been set by one state, such training is often not acceptable to or recognized by another state making it difficult to attract needed or desired health occupation workers from other states (e.g., physical therapists).

Recruitment of Health Workers

In the absence of some form of control or coordination, recruitment into training for health occupations does not reflect the real employment

market. While the lack of financial support mechanisms is a most significant factor affecting the lack of needed training programs, consideration must be given also to the many personal factors which influence entry of potential health workers into the health service field. In the absence of any coordination or control, applicants are seeking positions in occupations in which there is an oversupply of skilled personnel whereas enrollments may go unfilled in training programs for occupations in which shortages exist.

For instance, in the social work field, both in undergraduate and graduate levels, there are currently more applicants than training facilities can absorb. Further, the employment prospects of all persons trained in social work are dim with few, if any, budgeted positions open in this field throughout the state at present. On the other hand, a reverse situation exists in the medical secretary career field, according to research by the Health Manpower Intelligence Facility. In this field, training institutions report a chronic lack of students seeking training, whereas there are heavy demands by employers to fill budgeted positions.

In professional categories, the relevancy of recruitment to supply can be shown by the following data:

Table 8

University of Oregon Medical School

	1960	1965	1969	1970	1974
Applications	386	599	734	736	
Admissions	76	83	90	96	
Ratio-application/adm.	5:1	7:1	8:1	8:1	
Graduates	72	76	85	80	92(±2)

Such ratios for medical schools have been known to run as high as 10-12 to 1 during the 1940's and 50's. However, the great demand for scientists made by the industrial technological explosion and the increases in remuneration offered to graduates with a BS or MS diverted many potential medical students, unwilling to devote another four years to graduate work

plus 1-3 years of additional training. Not to be misled by these figures showing a pool of applicants eight times the number admitted, it should be noted that each applicant to medical school in this country makes an average of five to six applications. National statistics for the fall of 1969 show that nearly 45% of applicants to medical school gained admission.

Table 9

University of Oregon Dental School

	1960	1965	1969	1970	1974 1/
Applications	298	166	390	340	
Admissions	80	80	85	85	85
Ratio-application/adm.	4:1	2:1	5:1	4:1	
Graduates	63	73	70	78	80-81

1/ Estimate from University of Oregon Dental School.

Although there is nothing to prevent a student from applying to medical or dental school, many colleges discourage students from applying unless acceptance is a real possibility, and it would appear that a large percentage of the applicants are in fact qualified for admission. Notwithstanding the multiple applications of the medical school applicant, most likely equally true for dental school applicants, it must be concluded that "raw supply" or recruitment is not a problem area for physicians and dentists. (In view of the increasingly more critical demand and need for physician manpower, the medical school is in the middle of a planned enrollment expansion which will result in a 15% increase in the number of medical students graduated in 1974, and when completed, will result in a 35% increase of graduates and an increase in the size of the student body by at least 116 students from current enrollment figures.)

Four nurses training institutions in Portland were surveyed.2/ Three of these facilities reported an application/admissions ratio of at least 2:1; the University of Oregon Nursing School stated that it admitted about 66% of its applicants. All facilities concurred that there was room for more students in 1970, and all facilities except the University of Oregon reported that some of their applicants were unable to enroll because of finances. Thus, it would appear that there is a high degree of

2/ Emanuel Hospital, Good Samaritan Hospital, University of Oregon Nursing School, University of Portland School of Nursing.

attraction to this field. Impediments to entering the program should be delineated. Information as to demands and recruitment problems for the health-related occupations training conducted in the community colleges and elsewhere will be developed in continuing studies conducted by the Health Manpower Intelligence Facility.

CURRENT PROGRAMS AND ACTIVITIES

The Health Manpower Council was created by gubernatorial directive to be the advisory and policy-making body for the Health Manpower Intelligence Facility. In early 1969, the Council became advisory to the Governor's Health Planning Committee and was appointed as the Comprehensive Health Planning ad hoc study Committee on Health Manpower, later becoming the standing Committee on Health Manpower. Heretofore, there has been no effective state program or policy for evaluating and coordinating training in the health occupations, i.e., no quality or quantity control. The Council has been attempting to fill this void; however, progress has been slow. Difficulties in developing and implementing a coordinated program of health manpower training have been encountered because the facilities involved are accustomed to operating independently and because the problems in this field are so numerous and far-reaching.

Due to the broad-based representation, developmental experience, and established relationships, the Council occupies an unusual position for assisting in the coordination of Oregon's health manpower programs, including the establishment of mechanisms for receiving as well as relaying information to the supply sector on the changing demands for health workers in the state.

Health Manpower Intelligence Facility

The Health Manpower Division of the Department of Health, Education, and Welfare is a federal agency which concerns itself with national manpower problems. In 1967, Oregon (one of four states in the nation) was awarded a funded contract to study the health manpower problems in the state. The Health Manpower Intelligence Facility has been operating since on annual federal contracts, with the Oregon State Board of Health initially, and later the Oregon Medical Association Education Foundation serving as its fiscal agent. The Health Manpower Intelligence Facility has completed a hospital survey of employment, a training capabilities survey, and an analysis of health manpower problems. At present, the Health Manpower Intelligence Facility staff is involved in collecting data for employment projections, studying availability of health workers, and preparing protocols for proposed projects concerned with health worker utilization.

The Cooperative Area Manpower Planning System (CAMPS)

The Cooperative Area Manpower Planning System has been designated by the Governor as the agency with overall manpower planning responsibility for the state of Oregon, and as such has concern with both national and state level manpower problems in the health occupations as well as all others.

Oregon State Board of Health

The primary function of the Oregon State Board of Health is in the area of public health services and thus it becomes an employer of health workers charged with delivering these services. There are some training programs, restricted to skilled health workers, within the department. The Oregon State Board of Health serves as the examining and licensing authority for those health occupations not having an independent licensing board (e.g., physical therapists, podiatrists, etc.).

Education 1/

Authority for program planning is fragmented between the State System of Higher Education, the State Board of Education, the Division of Continuing Education, various school districts, hospital training schools, and licensed proprietary institutions. Individual schools set their own priority for establishment, curtailment, or abolition of health manpower training programs.

1. State Board of Education

   Private and vocational schools are licensed by the State Board of Education, the basis for which is fiscal responsibility and not the educational capability of the facility. The Board has, however, frequently initiated investigation into the suitability of a given training program in any field. (Unfortunately, proprietary schools duplicate these programs and generally operate independently of this agency's planning.) The Board has begun to build into its curriculum a new program for vocational awareness and counseling for all careers, including health, and will be attempting to de-emphasize orientation to college and universities. There is a limited program for select high schools within the state to provide vocational training.

2. Board of Higher Education

   The University of Oregon Medical School and Dental School both come under the Board of Higher Education; however, each is responsible for its own program planning. Coordination with the other universities in the System is ongoing with reference to pre-requisite education.

1/ See Exhibit 2 for listing of Health Careers Training Programs in Oregon.

The University of Oregon Medical School is the only institution in the state currently responsible for the education and training of physicians; however, there are other allied programs in that institution such as nursing, medical technology, radiology technology, speech therapy, etc.

The University of Oregon Dental School is the only institution in the state currently responsible for the education and training of dentists. There is no program for dental laboratory technicians ongoing there, although there is a dental assistant and a dental hygienist program. (There is also dental hygienist and dental assistant programs at Oregon Technical Institute in Klamath Falls, and both types of programs throughout Oregon's community college system. A dental laboratory technology program is operating at Portland Community College.)

The Division of Continuing Education has in the past offered limited programs for refresher training and specialized techniques for nurses. There are other classes offered in the para-medical careers based on demand.

3. Nurses Training Programs

At the present time in the state of Oregon, there are two baccalaureate degree nursing programs, two hospital-based diploma nursing programs, five associate of arts degree programs, and thirteen licensed practical nurse programs. College- (baccalaureate level) level training is available at the University of Oregon and the University of Portland; diploma-level nurses training is available at Good Samaritan and Emanuel Hospitals in Portland (these programs are less than three years in length and lead to a diploma in nursing and licensure as a registered nurse as do the baccalaureate programs); associate degree nursing programs are offered at Portland Community College, Chemeketa Community College (Salem), Lane Community College (Eugene), and Southern Oregon College (Ashland). A new program will accept its first students just after the first of the year at Linn-Benton Community College in Albany (these programs also lead to registered nurse status). In addition, there are thirteen programs providing vocational-level training for licensed practical nurses (one in a hospital setting, eleven in community colleges, and one under Adult Education in a school district). The University of Oregon Nursing School also conducts a graduate program in which approximately 40 graduate students are currently enrolled.

The Oregon State Board of Nursing reports that there were 451 students enrolled in college level, 519 students enrolled in diploma level, and 348 students enrolled in associate degree level courses during fiscal year 1968-1969. The 196[illegible] and 1970 annual statistical reports of the Oregon State Board of Nursing lists the following numbers of graduates from these programs:

	1969	1970
College level (B.A.)	120	111
University of Oregon	(110)	(95)
University of Portland	(10)	(16)
Diploma level	185	161
Associate degree level	53	124

No studies have been undertaken to analyze the location or production of the schools in relation to the needs of health facilities for well-trained nurses.

Employment Division

Thi department is primarily a job placement agency for all occupations including health workers with less than professional skills and has recently been made responsible for the MEDIHC program aimed at recruitment, training, and utilization of experienced military medics returning to civilian occupations. This is primarily a program for educational counseling and/or job placement for those desirous of staying in the health field.

Professional Licensing Boards

Professional licensing boards (e.g., Board of Nursing, Board of Pharmacy, Board of Medical Examiners, Board of Dental Examiners, Board of Optometry, etc.) are independent agents of state government with the prime responsibility for protecting the public through licensure of professional medical people who wish to practice in the state. The boards evaluate credentials, administer examinations, issue licenses, take disciplinary action against unsafe and unethical practitioners, and initiate court action for illegal practice. It would follow that these boards exert great influence on school curriculum content.

Professional Organizations

Professional organizations such as the Oregon Medical Association, the Oregon Association of Hospitals, the Oregon Nurses Association, the Oregon Dental Association, and many others serve primarily to maintain the standards of professional capability and practice of their members as well as to promote public and community health.

Other Training Facilities and Resource Agencies

1. Community colleges throughout Oregon offer training programs for dental hygienists, dental assistants, dental laboratory technicians,

medical secretaries, medical records technicians, associate degree and licensed practical nurses, and a multitude of other health-related occupations.

2. Proprietary schools offer numerous training programs ranging from medical secretary to dental prosthetist. There is no effective statewide program at the present time for coordination of planning. The Educational Coordinating Council has been working in this area recently, however, it does not have the requisite statutory authority and is dependent on voluntary cooperation.

3. The Office of Economic Opportunity, Manpower Development Training Act, and Jobs Corp have been involved largely in financial support for minority or depressed groups to enable them to enter training programs requiring minimal education. The acquired skills and employment opportunity probabilities have never been evaluated.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1972, establish mechanisms to assess current supply, utilization and projected demands for health workers.

2. By 1972, establish an effective statewide system for coordinating health occupation training programs of both the public and private sectors.

3. By 1973, develop programs designed to standardize education and training of the various health occupations where this does not now exist, and develop mechanisms to insure continuing high standards of vocational and professional competence.

4. Establish procedures to make the supply of health workers both more flexible and more responsive to demand.

RECOMMENDATIONS AND METHODS

(Objective #1)

1. *THE GOVERNOR'S HEALTH PLANNING COMMITTEE CHARGE ITS STANDING COMMITTEE ON HEALTH MANPOWER[1]/ WITH THE TASK OF ESTABLISHING GUIDE-*

1/ *The Governor's Health Planning Committee's standing Committee on Health Manpower and the Health Manpower Council are presently one and the same organization and will be hereafter referred to in this Section as the CHP (Comprehensive Health Planning) Health Manpower Committee.*

LINES AND POLICY FOR DEVELOPING STANDARDIZED NOMENCLATURE AND CLASSIFICATION CRITERIA FOR HEALTH OCCUPATIONS IN OREGON.

Methods

a. *The CHP Health Manpower Committee establish a study group including representation from Governor's Manpower Coordinating Council, Educational Coordinating Council, Employment Division, health professional licensing boards, and other interested agencies to study health occupation nomenclature and classification categories, and to oversee the preparation of a health occupation classification guide.*

b. *The Health Manpower Intelligence Facility, with advisory assistance from the CHP Health Manpower Committee referenced in Method (a) above, prepare and publish by 1972, a health occupation classification guide, reflecting standardized nomenclature and classification categories for all health occupations in Oregon.*

2. *HEALTH MANPOWER INTELLIGENCE FACILITY DEVELOP EFFECTIVE DATA COLLECTION TECHNIQUES AND ESTABLISH A STATEWIDE "INFORMATION BASE" REFLECTING CURRENT HEALTH MANPOWER SUPPLY, UTILIZATION, AND DEMANDS IN OREGON.*

Methods

a. *Health Manpower Intelligence Facility, with advisory assistance from the CHP Health Manpower Committee and in cooperation with the health professional licensing boards, devise standardized application and registration forms with computer adaptability for use by the individual licensing and certifying boards by 1972.*

b. *Health Manpower Intelligence Facility develop an ongoing study of supply and utilization of health workers, as well as collect and maintain data on projected health manpower demands and opportunities in Oregon to include:*

    1) *Collection of current data on budgeted vacancies and other employment information including but not limited to: a) current utilization practices of management; b) qualification requirements; and c) management policies regarding interchangeability of health workers.*

    2) *Continuing study of medical care facility planning, as well as employment and market trends for health facilities and other community-based health services.*

    3) *Collection of information and maintenance of a centralized file on scholarships and loan funds available in Oregon for health occupations.*

c. *Health Manpower Intelligence Facility make employment probability forecasts on the basis of current data and projected trends, providing such information regularly to the CHP Health Manpower Committee who will be responsible to make periodic reports on current and projected supply-demand trends available to the Educational Coordinating Council, Governor's Manpower Coordinating Council, Employment Division, recruitment centers, and other interested agencies.*

(Objective #2)

3. *DEVELOP MECHANISMS TO COORDINATE THE ACTIVITIES OF RECOGNIZED PLANNING AGENCIES, PROFESSIONAL LICENSING BOARDS, AND TRAINING INSTITUTIONS INVOLVED IN HEALTH MANPOWER TRAINING PROGRAMS OF BOTH THE PUBLIC AND PRIVATE SECTORS IN OREGON.*

Methods

a. *The Governor's Health Planning Committee support legislative proposals prepared by the Educational Coordinating Council expanding the scope and authority of the Educational Coordinating Council to evaluate needs and coordinate both public and private sector educational programs, including health occupation training programs in Oregon.*

b. *The Governor's Health Planning Committee charge its CHP Health Manpower Committee with responsibility to work with existing recognized planning agencies (Educational Coordinating Council, Governor's Manpower Coordinating Council, and others), as well as the health professional licensing boards to develop effective coordination and evaluation of all health manpower training activities, licensing, certification, registration, and other programs relating to health manpower.*

1) *The CHP Health Manpower Committee effect liaison with and provide information and advisory assistance to the Educational Coordinating Council, Governor's Manpower Coordinating Council, health professional licensing boards, Employment Division, and other public and private agencies affecting health manpower supply and demand, and in cooperation with these agencies, establish procedures designed to insure coordinated, statewide health manpower training programs.*

2) *The CHP Health Manpower Committee, together with the health professional licensing boards and the Educational Coordinating Council, establish procedures for the systematic evaluation of current health occupation training program content. Criteria should include, but not be limited to:*

a) *qualifications and availability of suitable faculty;*

b) *adequacy of academic facilities;*

c) *adequacy of clinical facilities;*

d) *length of training with reference to skills acquired and anticipated remuneration;*

e) *suitability of enrollment requirements for the program;*

f) *adaptability of program to a career ladder;*

g) *current or anticipated need for skills being taught;*

h) *comparison with standards of other states or national organizations.*

3) *The CHP Health Manpower Committee review all proposed health occupation training programs (forwarded from the Educational Coordinating Council through the Governor's Health Planning Committee to the CHP Health Manpower Committee) and make recommendations to the Educational Coordinating Council, the Governor's Health Planning Committee, and other agencies, on the appropriateness and financial support of these proposals.*

4) *The CHP Health Manpower Committee review existing health occupation training programs against need, and provide the Governor's Health Planning Committee and the Educational Coordinating Council with recommendations for initiation, modification, or curtailment of health occupation training programs.*

(Objective #3)

4. *DEVELOP DEFINITIVE AND EFFECTIVE POLICIES REGARDING CERTIFICATION[1/] AND LICENSURE[2/] FOR THE HEALTH OCCUPATIONS.*

Methods

a. *Comprehensive Health Planning encourage a moratorium on any legislation establishing new classification, certification, or licensure standards or categories.*

1/ Certification - verification of satisfactory completion of a training program issued by a duly accredited training facility.

2/ Licensure - permission granted through the state's authority for a person to function within the limits of his competency.

b. *CHP Health Manpower Committee establish a task force to review activities of both national and state organizations involved in certification and licensure; study necessary revisions to existing categories and standards for all professional, as well as allied health occupations; and make recommendations to the Governor's Health Planning Committee designed to optimize utilization of health manpower in the delivery of health care.*

5. *MAINTAIN THE STATUTORY AUTONOMY OF THE HEALTH PROFESSIONAL LICENSING BOARDS; HOWEVER, ALIGN THESE BOARDS WITHIN A COMMON ORGANIZATIONAL STRUCTURE FOR COORDINATION OF ACTIVITIES.*

Method

Encourage legislative support for the proposed reorganization of Human Resources, establishing a Professional Licensing Board section in the Division of Health Affairs to coordinate the activities of these boards.

6. *REQUIRE THAT LICENSING OF HEALTH-RELATED EDUCATIONAL TRAINING FACILITIES BE BASED ON EDUCATIONAL COMPETENCE, AS WELL AS FISCAL RESPONSIBILITY.*

Method

The Educational Coordinating Council, in cooperation with the CHP Health Manpower Committee develop and sponsor legislation (assigning responsibility and providing requisite authority and funding) designed to insure that health-related educational facility accreditation and licensing standards relate directly to competence of the facility in the applicable educational field, as well as to its fiscal responsibility.

(Objective #4)

7. *IMPLEMENT PROCEDURES TO IMPROVE COMMUNICATION BETWEEN SUPPLY AND DEMAND SECTORS IN HEALTH MANPOWER.*

Methods

a. *The CHP Health Manpower Committee establish working relationships with the Educational Coordinating Council; the Governor's Manpower Coordinating Council; and health-related professions, providers, voluntary agencies, and other interested agencies to study and make recommendations on: 1) establishment of health occupation classification criteria (see Recommendation 4); 2) changing needs for programs; 3) methods to make supply of health workers more responsive to demand; 4) recruitment and training programs; and 5) anticipated changes in the health manpower field.*

b. *Health Manpower Intelligence Facility make employment probability forecasts which will be made available through the CHP Health Manpower Committee to the health manpower supply and demand sector. (see Recommendation 2, Method c.)*

8. *INCREASE THE SUPPLY AND EFFECT BETTER UTILIZATION OF HEALTH WORKERS TO OVERCOME CURRENT HEALTH MANPOWER PROBLEMS.*

Methods

a. *Based on actual or anticipated need, explore the feasibility of increasing the number of physicians, dentists, and nurses available to meet Oregon's health manpower demands.*

1) *Physicians*

a) *University of Oregon Medical School continue to explore all possibilities of increasing the number of graduates as quickly as possible without sacrificing standards of medical education by:*

(1) *admitting a new class of medical students every nine months and operating the school on a 12-month basis, so that a 4-year course can be accomplished in three calendar years (or less in special cases);*[1/]

(2) *increasing the number of students admitted to each class at a greater rate than has been done in the past;*

(3) *rotating students through qualified community hospitals with local hospital staff functioning as faculty, thus freeing medical school faculty to educate another class.*

b) *University of Oregon Medical School expand refresher course programs now being conducted on a limited basis for physicians wishing to review certain areas of practice, as well as for physicians previously inactive or in limited practice, administration, or research who may wish to become involved in direct patient care by:*

1/ *This is a method used in World War II and was proven effective. The faculty costs are higher of course, but savings are realized by not having to build additional structures to accommodate larger classes (i.e., better utilization of existing resources), and it has the significant advantages of providing a guaranteed increase in physician production within 3 years and can be retracted without loss.*

(1) offering a course in basic science review;[1]

(2) structuring a 1-3 month preceptorship, combining didactic work with rotation through the Medical School Clinics and County Hospital;

(3) combination of both (1) and (2) above.

2) Dentists

a) University of Oregon Dental School continue to explore all possibilities of increasing the number of graduates as quickly as possible without sacrificing standards of dental education by:

(1) admitting a new class of dental students every nine months, operating the school on a 12-month basis, so that a 4-year course can be accomplished in three calendar years (or less in special cases).

(2) increasing the number of students admitted to each class at a greater rate than has been done in the past.

3) Nurses

a) The CHP Health Manpower Committee, together with the Educational Coordinating Council and the State Board of Nursing:

(1) Encourage nurses training programs to train in excess of the number of nurses required by a minimum of 30%.

(2) Encourage community colleges in Oregon to implement refresher courses (with emphasis on basic nursing procedures) for nurses who have been inactive to attract them back into active duty.[2]

(3) Encourage nursing schools to more actively recruit men to enter the nursing profession.

1/ For a number of years the University of Pennsylvania School of Medicine has conducted a course of one semester duration designed to provide a background in the basic sciences. After extensive revision, the School of Medicine announced a new program lasting 15 weeks and including three hours per day of formal teaching by senior faculty members and four hours per day of clinical teaching by discipline (Medicine, Surgery, Physical Medicine, Pediatrics, Cardiology, Gastroenterology, Dermatology). The content is under continuous review by the faculty so that the courses will meet the needs of the student in a flexible, but well structured semester.

2/ A curriculum for those courses has already been developed for the community colleges and will be distributed in February, 1971.

b) The CHP Health Manpower Committee:

(1) Explore the feasibility and potential for health care institutions to provide nursery care for the children of nurses who wish to be active professionally but are deterred by family responsibilities.

(2) Explore possibility of expanding the utilization of nurses on a part-time basis (consistent with demands of family responsibilities).

c) The Educational Coordinating Council and CHP Health Manpower Committee initiate studies on the need and feasibility of continuing education programs focusing on clinical nursing in depth, to include pharmacology, biochemistry, observation of symptoms, etc.

b. Augment utilization of health workers' skills.

1) Physician Assistants

The Oregon Medical Association, University of Oregon Medical School, and representatives of involved specialty organizations encourage development of and define criteria for a Physician Assistant program to be conducted at the Medical School. This program should be acceptable to the physicians who are the potential employers of such assistants; the medico-legal ramifications should be explored prior to program implementation.

(a) The Governor's Health Planning Committee and its CHP Health Manpower Committee encourage utilization of nurses with special skills as the resource core for physician associates and/or assistants. (The role of the professional nurse can be and in some instances is being expanded, e.g., Pediatric Nurse Practitioner in Colorado, Nurse Midwives in the Eastern States, etc.)

(b) The Governor's Health Planning Committee and its CHP Health Manpower Committee encourage development of the MEDIHCS program of the Employment Division and/or the MEDEX program, and encourage referral of those military corpsmen who have high potential as physician assistants.

2) *Dentist Assistants*

The Oregon State Board of Dental Examiners, the University of Oregon Dental School, the Oregon Dental Association, together with the Educational Coordinating Council and the community colleges, explore possibilities for restructuring and expanding the scope of existing dental assistant and dental hygienist programs. Emphasis should be placed on early development of a program designed to supply a large number of dentist assistants qualified to do special procedures (especially in the area of topical fluoride treatments) and incorporation of a training course qualifying these assistants to teach home care methods and to remove dental plaque. These assistants could teach in school and community programs, as well as work in dentists' offices. (The Oregon Dental Association and others are already working in these areas. The present core of dental assistants and dental hygienists provide an excellent resource for developing assistants capable of expanded functions.)

3) *The University of Oregon Medical School and Dental School implement special classes in techniques of team practice (Allied Health Team Program) which should involve medical and dental students and all the current identifiable members of the health team (nurse, specialty consultants, social worker, physical therapist, occupational therapist, speech therapist, etc.)*

4) *The CHP Health Manpower Committee, together with the Educational Coordinating Council, implement actions to introduce the concept of a multi-skilled health worker to community colleges and other training facilities to provide for more flexible allied health workers.1/ Recommendations for curriculum change might include:*

   a) *Medical records technicians could be taught to function as medical secretaries, or vice versa.*

   b) *Inhalation therapists could learn the techniques of electrocardiograph technicians, surgical technicians, cardiopulmonary technicians, etc., or vice versa.*

1/ *Definitive legislation concerning certification and licensure should be deferred until there has been more experience with multi-skilled health workers.*

5) *The Board of Pharmacy, in cooperation with the Oregon State University School of Pharmacy, and the Oregon Pharmacy Association, explore the potential, structure, and curriculum of a short, intensive special program designed for personnel from the other health disciplines. This training program could qualify personnel functioning in other capacities to perform select drug procedures such as simple dispensing from stock bottles, and could alleviate problems and improve pharmaceutical services to smaller nursing homes and homes for the aged. This program could be offered to nurses already employed by such facilities, to MEDIHC personnel, and others capable of performing such responsibilities.*[1/]

6) *The CHP Health Manpower Committee, together with the Educational Coordinating Council, health professional licensing boards, and other interested agencies, embark upon a study to develop realistic career ladders for the health occupations. This will require review of all curricula with the appropriate organizations to explore possibilities of career ladders allowing horizontal and vertical mobility without educational penalty.*[2/]

The promotional opportunities for nurses should be enlarged beyond administration and teaching. All possible mechanisms for entry into career ladders must be considered objectively. Criteria must be established for competency, and challenge examinations and equivalency testing must be provided. Provision must be made for appropriate remuneration.

7) *Consideration should be given to revising laboratory and nursing personnel licensing standards, rules, and regulations to permit personnel to perform functions for which they are qualified regardless of their level of formal academic achievement.*

c. *Expand recruitment of health workers into the state.*

1) *The CHP Health Manpower Committee, together with health professional licensing boards and other interested agencies, institute a review of Oregon's existing licensure and certification laws and those of other states to identify unnecessary*

1/ Such assistants could be allowed to dispense medications from the facilities' pharmacies, under the general supervision of a consultant pharmacist.

2/ For nurses, this would include coordination of the Nursing Board, Oregon Nurses Association, Oregon League for Nursing, hospitals involved in training nurses, University of Oregon Medical School, Oregon Medical Association, Medical Examination Board, etc.

barriers, inequities, and inconsistencies in requirements and qualifications to make relocation to Oregon more attractive without sacrificing necessary standards. (For instance, in the physician area the question may be raised as to the necessity for the Basic Science examination in view of the rather general acceptance of the National Board Examination.)

2) *The Oregon Medical Association, Oregon Association of Hospitals, Oregon Dental Association, and others should work together to establish programs publicizing the advantages of living and practicing in Oregon in order to attract needed professionals.*

d. *Develop programs designed to correct existing maldistribution of health workers.*

1) *The CHP Health Manpower Committee, together with the University of Oregon Medical School, Dental School, Nursing School, and others, develop new programs which offer newly graduated physicians (preferably after rotating internship), new licensees, physicians wishing to relocate, and other allied health workers, incentives to serve for specific periods of time in rural and/or deprived areas where critical shortages exist. Incentives could be in terms of direct money subsidies, income tax rebate, or credit for military service (latter would have to be coordinated with Selective Service).*

e. *Increase the numbers of health care personnel capable of providing direct patient care.*

1) *Increase supply of key health workers (reference: Methods a, b, and c above.)*

2) *The State Board of Nursing and the Educational Coordinating Council encourage universities, hospitals, and community colleges with nurses training programs to increase the emphasis on direct patient care. Efforts should be made to increase utilization of hospitals for clinical and bedside-care training.*

3) *Health facilities and health-related services should be encouraged to use qualified inactive or semi-retired professionals, as opposed to the potentially active practicing professional, where feasible, for administrative and/or less physically demanding assignments.*

4) *Encourage the judicious use of qualified paramedical personnel to perform those duties of physicians, dentists, and nurses which can be delegated to lesser-trained personnel.*

f. *The Governor's Health Planning Committee, the CHP Health Manpower Committee, the Governor's Manpower Coordinating Council, the Educational Coordinating Council, the Oregon Association of Hospitals, and other interested agencies should explore alternate possibilities of obtaining financial support for essential health manpower training programs. Immediate attention should be given to alleviating the financial burdens now being absorbed by the patients of the two hospital-based diploma nursing programs.*

g. *The CHP Health Manpower Committee should develop recommendations for the reallocation of 1971-73 State budget funds currently devoted to less essential purposes, to the establishment of a health manpower educational assistance fund. These funds should be provided in the form of institutional grants and/or scholarships to educational institutions able to utilize the funds to effect an increase in the number of trained health personnel currently in short supply.*

9. *COMPREHENSIVE HEALTH PLANNING REQUEST FUNDING AND POSITION AUTHORIZATIONS TO HIRE TWO FULL-TIME STAFF MEMBERS, KNOWLEDGEABLE IN THE HEALTH MANPOWER FIELD, TO PERFORM STATE LEVEL HEALTH MANPOWER PLANNING DUTIES AND RESPONSIBILITIES, AS WELL AS PROVIDE NECESSARY STAFF ASSISTANCE TO ENABLE THE CHP HEALTH MANPOWER COMMITTEE TO PERFORM THE FUNCTIONS RECOMMENDED IN THIS REPORT.*

NOTE: 1) *Specific health manpower recommendations relating to rehabilitation programs and problems in Oregon are located in the "Rehabilitation (Physical Disabilities)" Section of the Comprehensive Health Plan.*

2) *Although this Section currently is restricted to the more pressing health manpower problems involving physicians, dentists, nurses, select assistant programs, and some allied health manpower training programs, it is anticipated that further revisions of this Section will allow incorporation of information and recommendations on the entire spectrum of health occupations.*

OPERATIONAL PROBLEMS

In addition to the usual operational problems inherent in most new or expanded programs (i.e., normal resistance to change; shortage of money, manpower and materiel), some specific operational problems are:

1. The heretofore absence of a single responsible coordinating health manpower planning staff. A minimum of two full-time staff members knowledgeable in the health manpower field are essential to initiate recommended programs of the Comprehensive Health Planning Health Manpower Committee.

2. Difficulties in coordinating the many divergent activities affecting health worker supply and demand, including problems of representation and vested interests, demanding effective liaison between public and private sectors of both the education and health care delivery system.

3. The lack of substantive data on actual health manpower needs, complicated by changing patterns in health care delivery and changing professional and allied health personnel roles in the delivery system.

EVALUATION CRITERIA

Evaluation mechanisms for assessing recommendations to be established by the Comprehensive Health Planning Health Manpower Committee. The ultimate criteria will involve measurement of how close supply (qualitatively, as well as quantitatively) matches demand. Unfortunately, there is a long lag-time for the completion of the product (one year for technical skills to 4-7 years for physician's skills) which dictates long-range evaluation programs.

PRIORITY

To be determined.

EXHIBIT 1

HEALTH-RELATED OCCUPATIONS

ADMINISTRATION

- Hospital Administrator
- Medical Administrator
- *Nursing Home Administrator

BASIC SCIENCES AND RESEARCH

- Biochemist
- Biologist
- Biomathematician (Biostatistician)
- Biophysicist
- Cryogenicist
- Cytologist
- Endocrinologist
- Entomologist
- Epidemiologist
- Immunohematologist
- Geneticist
- Health Physicist
- Hydrostatistician
- Microbiologist
  - Bacteriologist
  - Mycologist
  - Parasitologist
  - Virologist
- Pharmacologist
- Physiologist
- Serologist

ELECTROLOGY

- *Electrologist

ENVIRONMENTAL HEALTH

- Industrial Hygiene Engineer
- *Registered Sanitarian
- *Sanitarian
- Sanitary Engineer

FOOD AND DRUG PROTECTION

- Food and Drug Analyst
- Food Technician
- Laboratory Analyst

DIETETICS AND NUTRITION

- Dietitian
- Dietitian Intern
- Food Service Supervisor
- Food Service Technician
- Nutritionist (dietitian background)

NOTE: This list should be used only as a guide; new occupations are being added.

* Occupations licensed and/or certified in Oregon, as asterisked.

HEALTH-RELATED OCCUPATIONS

DIETETICS AND NUTRITION (Cont.)

Nutritionist (Ph.D., Biochemistry)

EDUCATION

Health Education Teacher

Physical Education Teacher

Public Health Educator

PHYSICIAN AND RELATED OCCUPATIONS

*Doctor of Medicine

Anesthesiologist

Cardiologist

Dermatologist

Family Practitioner 1/

Geriatrician

Hematologist

Internist

Neurologic Surgeon

Neurologist

Obstetrician & Gynecologist

Occupational Medicine

Ophthalmologist

Orthopedic Surgeon

Otolaryngologist

Pathologist

Pediatrician

Physical Medicine & Rehabilitation

Plastic Surgeon

Preventive Medicine & Public Health

Proctologist

Psychiatrist

Radiologist

Surgeon (general)

Urologist

Physician Assistant 1/

*Doctor of Chiropractic

*Doctor of Naturopathy

*Doctor of Osteopathy

*Doctor of Podiatry

*Doctor of Veterinary Medicine

DENTISTRY AND ALLIED ARTS

Dental Assistant

*Dental Hygienist

Dental Laboratory

Dental Laboratory Technician

1/ Programs to be established June, 1971.

* Occupations licensed and/or certified in Oregon, as asterisked.

HEALTH-RELATED OCCUPATIONS

DENTISTRY AND ALLIED ARTS (Cont.)

*Dentist

- Endodontist
- Oral Pathologist
- Oral Surgeon
- Orthodontist
- Pedodontist
- Peridontist
- Prosthodontist
- Public Health Dentist

HOSPITAL AND RELATED OCCUPATIONS

- Obstetrics Technician
- Nurse Aide
- Orderly
- Psychiatric Aide
- Ward Secretary

MEDICAL TECHNOLOGY AND RELATED OCCUPATIONS

- Bloodbank Technologist
- Cardio-pulmonary Technician
- Certified Laboratory Technician
- Chemistry Technologist
- Cytotechnologist
- Electrocardiograph Technician
- Electroencephalograph Technician
- Histologic Technician
- Laboratory Technician
- Medical Technologist
- Nuclear Medical Technologist (Isotope Tech.)
- Operating Room Technologist

MORTUARY SCIENCE

- *Embalmer
- *Funeral Director

NURSING AND RELATED OCCUPATIONS

- *Professional Nurse
  - Associate Degree Nurse
  - Diploma Nurse
  - Bachelor of Science
  - Master of Science
- *Licensed Practical Nurse
- *Home Health Aide
- Medical Emergency Technician

ORTHOPEDIC/PROSTHETIC APPLIANCE MAKING

- Orthotist
- Prosthetist

* Occupations licensed and/or certified in Oregon, as asterisked.

HEALTH-RELATED OCCUPATIONS

PHARMACY

*Pharmacist

Pharmacist Intern

RADIOLOGY - ENGINEERING - ELECTRONICS

Bio-Medical Engineer

Bio-Medical Engineering Technician

Medical Nuclear Technologist

Radiation Engineer

Radiobiologist

Radio Therapy Technician

Radiochemist

Radiologic Physicist

Radiologic Technologist

Radiological Health Specialist

Safety Engineer

SECRETARIAL AND OFFICE

Medical Secretary

Medical Assistant

SOCIAL WORK AND COUNSELING

*Clinical Psychologist

Medical Social Worker

Psychiatric Social Worker

*Psychologist

Psychometrist

Social Worker

*Social Psychologist

Vocational Rehabilitation Counselor

SPEECH PATHOLOGY/AUDIOLOGY

Audiologist

*Hearing Aid Fitter

Speech Pathologist

THERAPY

Corrective Therapist

Educational Therapist

Inhalation Therapist

Manual Arts Therapist

Music Therapist

Occupational Therapist

Occupational Therapy Assistant

*Physical Therapist

*Physical Therapy Assistant

Recreational Therapist

* Occupations licensed and/or certified in Oregon, as asterisked.

HEALTH-RELATED OCCUPATIONS

VISUAL/EYE CARE OCCUPATIONS

Dispensing Optician

Ophthalmic Technician

Optical Technician

Optician

*Optometrist

Orthoptist

LIBRARY SERVICES

Medical Illustrator

Medical Librarian

Medical Records Librarian

Medical Records Technician

* Occupations licensed and/or certified in Oregon, as asterisked.

SOURCE: Licensed Occupations in Oregon
Employment Division
Oregon State Employment Service
Salem, 1970.

HEALTH CAREERS TRAINING IN OREGON[1/]

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Biomedical Engineering	Clackamas Community College	High School	Projected for 1976	
Clinical Psychologist	U. of O.	B.S.	5 years	Ph.D. degree
	U.O.M.S.	Ph.D. candidate w/M.S. or equiv.	1 year intern.	Certificate
Community Health Aide	U. of O.	High School or equiv.	2 acad. yrs.	Toward degree (ESPA)
Cytotechnologist	Marylhurst College	High School	2 years + 1 year intern.	Certificate (ASCP)
	U.O.M.S.	2 yrs. college	1 year intern.	Certificate (ASCP)
	Michel Institute of Technology	High School or equiv.	1 year + 1 year intern.	Certificate (ASCP)
Dental Assistant	Oregon Technical Institute	High School or equiv.	2 years	Associate degree
	Chemeketa Community College	Age 16 or over, H.S. grad G.E.D.	3 terms or 1 acad. year	Certificate
	Columbia Christian College	High School or equiv.	1 year minimum	Certificate
	Linn-Benton Community College	High School or equiv.	1 year	Certificate
	Lane Community College	High School or equiv.	1 year	Certificate
	Portland Community College	High School or equiv.	9 months	Certificate
	Blue Mountain Community College	High School or equiv.	9 months	Certificate
	Southern Oregon College	High School or equiv.	Pre-professional transfer	General studies, then transfer

1/ This information was extracted from a detailed listing of all health career training programs in Oregon as of June 1, 1970, as compiled cooperatively by the Women's Auxiliary of the Oregon Medical Association and the Health Manpower Intelligence Facility.

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Dental Hygienist	Professional: U.O.D.S.	1 year college	2 acad. years	Certificate
	Lane Community College	High School or equiv.	2 acad. years	Associate Degree
	Mt. Hood Community College	High School or equiv.	2 acad. years	Associate Degree
	Portland Community College	High School or equiv.	2 acad. years	Associate Degree
	Oregon Technical Institute	45 quarter hrs. of college	2 acad. years	Associate Degree + Certificate
Dental Lab Technician	Columbia Christian College	High School	1 yr. minimum, supervised	Certificate
	Portland Community College	High School	2 years	Certificate or Associate Degree
Dentist	U.O.D.S.	3-4 years of college pre-dental	4 years	Doctor of Dentistry D.M.D.
Dietitian	Oregon State University	High School	4 years	B.S. Degree
	U.O.M.S.	4 years college	12 months intern.	Certificate
Electrocardiographic Technician	St. Vincents Hospital	High School	on-the-job training	no certificate or degree
Electroencephalographic Technician	U.O.M.S.	High School	6 months	
Embalmer (Funeral Service Education)	Mt. Hood Community College	1 year college	1-2 years	2 years for A.S. Degree
Environmental Health Technologist	Southern Oregon College	High School, G.E.D.	4 years	B.S. in Health and P.E.
	Oregon State University	High School, G.E.D.	2-5 years	B.S. and M.S. Degree
	Clackamas Community College	High School, G.E.D.	2 years	Associate Degree

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Health Educator	Southern Oregon College	High School or equiv.	4 years	B.S. in Health and P.E.
	Portland State University	High School or equiv.	4 years	B.A., B.S. Degree
	University of Oregon	High School or equiv.	4 years	B.A., B.S. Degree
	Marylhurst College	High School or equiv.	4 years	B.A., B.S. Degree
	Oregon State University	High School or equiv.	4 years	B.A., B.S. Degree
Histologic Technician	Emanuel Hospital	High School	1 year	Certificate
Home Health Aide	Bess Kaiser Hospital	None	1-2 months	A.S. Degree
Hospital Administrator	University of Oregon	B.S. Degree	1 year acad., 1 year intern	M.A. Public Administrator
Inhalation Therapist	Treasure Valley Community College	High School	22 months	
	Lane Community College	High School (incl. Chem. & Alg.)	2 years	
	Mt. Hood Community College	None	2 years	
	Emanuel Hospital	High School	6 months-1 year	
Medical Assistant	Chemeketa Community College	High School	3 terms or 1 acad. year	Certificate of Grad.
	Clackamas Community College	High School or equiv.	3 terms	1 year Certificate
	Southern Oregon College	High School or equiv.	3 years	B.S. in General Studies
	Lane Community College	High School or equiv.	1 year	Certificate
Medical Illustrator	Marylhurst College	High School	2-4 years	B.A., Art major, Biology minor
Medical Receptionist	Bess Kaiser Hospital	High School	2 years	Associate Degree

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Medical Record Clerk	Portland Secretarial School	High School	6 weeks program	Certificate
Medical Record Technician	Central Oregon College	High School	Projected for Fall, 1970, 2-years	Associate Degree
	Portland Secretarial School	High School		Diploma
	Portland Community College	High School	12 months	Certificate
Medical Secretary	Portland Secretarial School	High School	10 months	Diploma
	Umpqua Community College	High School	2 year option	Associate Degree
	Portland Community College	High School	2 years	Associate Degree
	Clackamas Community College	High School or equiv.	1 year, beginning 1970	Certificate
	Southern Oregon College	High School or equiv.	2 years	Associate Degree
	Merritt-Davis Sch. of Commerce	High School or equiv.	15 months	Certificate
	Western Business University	High School	1 year	Diploma
	Eugene Business College	High School	1 year	Diploma
Medical Social Worker	U.S. Veterans Hospital	B.S. Degree	1 year	M.S.W.
	University of Oregon	B.S. Degree	2 years	B.A. or B.S. in S.C.P.A.
Medical Lab Technician	Portland Community College	High School	Projected for Fall 1970 - 2 years	Associate Degree
	Oregon Technical Institute	High School	2 years	Associate Degree

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Medical Technologist	Pre-professional: George Fox College	High School	3-4 years	For certification: 12 mos. in approved hospital
	Marylhurst College	High School	3-4 years	12 mos. in approved hospital
	Southern Oregon College	High School	3-4 years	12 mos. in approved hospital
	Umpqua Community College	High School	1 year only	12 mos. in approved hospital
	Oregon State University	High School	3-4 years	12 mos. in approved hospital
	University of Oregon	High School	3-4 years	12 mos. in approved hospital
	Oregon Technical Institute	High School	3-4 years	12 mos. in approved hospital
	Professional: Portland Adventist Hospital	3 yrs. college	4th year only	1 year at U.O.M.S. for Certificate MT (ASCP) or at any Approved Hospital B.S. and M.T. (ASCP) or National certification exames given for MT (ASCP
	St. Vincents Hospital	3 yrs. or 90 sem. hrs.	4th year only	
	Sacred Heart General Hospital	3 yrs. college	4th year only	
	Emanuel Hospital	3 yrs. college	4th year only	
	U.O.M.S.	3 yrs. college	4th year only or 2 years	
	Good Samaritan Hospital	3 yrs. college	4th year only	
Medical Transcriptionist	Portland Secretarial School	High School	10 months	Diploma
	Umpqua Community College	High School	1 year	Diploma
	Southern Oregon College	1 year as sec.	2 years	Associate Science Degree
	Merritt-Davis Secretarial School	High School	3 months	Certificate

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Nurse, L.P.N.	Treasure Valley Community College	High School or equiv.	12 months	Certificate LPN
	Chemeketa Community College	High School or equiv.	3 terms or 1 acad. year	Certificate LPN
	Portland Adventist Hospital	High School grad. or 18 years	12 months	Certificate
	Portland Community College	High School grad. Math, English	1 acad. year (4 terms)	Diploma
	Umpqua Community College	High School or equiv.	1 year	Certificate
	Lane Community College	High School or equiv.	44 weeks	Certificate
	Central Oregon Community College	High School or equiv.	1 year	Certificate
	Mt. Hood Community College	None	1 year	Certificate
	Blue Mt. Community College	High School	11 months	Certificate
	Clackamas Community College	High School	4 terms	Certificate
	Southwestern Oregon Community College	Ages 18-50	4 quarters	Certificate
	Southern Oregon School, Practical Nursing	High School	7 terms	Certificate
Nurse's Aide, Assistant or Orderly Home Health Aide	Chemeketa Community College	18 years of age	12 weeks	Certificate
	Linn-Benton Community College	18 years of age	12 weeks	Certificate
	Lane Community College	18 years of age	11 weeks	Certificate
	Clatsop Community College	18 years of age	48 credit hrs.	Certificate
	Clackamas Community College	18 years of age	11 weeks	Certificate
	Bess Kaiser Hospital	18 years of age	1-2 months	Certificate
	Emanuel Hospital	18 years of age	8 weeks	Certificate

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Nurse's Aide, Assistant or Orderly (Cont.)	Good Samaritan Hospital	High School	6 weeks	Certificate
	St. Vincents Hospital			
Nurse, R.N., B.S., Associate Degree or Diploma	Pre-nursing: University of Oregon	High School or equiv.	1-2 years	Pre-professional Certificate
	Marylhurst College	High School or equiv.	1-2 years	Associate Degree
	Oregon State University	High School or equiv.	7 terms	Pre-professional Certificate
	Professional: Portland Adventist Hospital	High School or equiv.	2 years	Diploma Certification
	Chemeketa Community College	High School or equiv.	2 years	Associate Degree
	Lane Community College	High School or equiv.	2 years	Associate Degree
	Portland Community College	High School or equiv.	2 years	Associate Degree
	Southern Oregon College	High School or equiv.	2 years	Associate Degree
	University of Oregon School of Nursing	1 year or R.N. cert.	3 years	B.S. Degree
	Good Samaritan Hospital	High School	3 years	Diploma eligible for R.N.
	Emanuel Hospital	High School or equiv.	3 years	Diploma Certification
	University of Portland	High School or equiv.	4 years	B.S.
Nutritionist	Oregon State University	B.S. Degree	Graduate Program- 2 years	M.S. and Ph.D. Degree
Occupational Therapy Assistant	Mt. Hood Community College	None	1 year	Certificate Occupational Therapy Assoc.

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Occupational Therapist	Marylhurst College	High School	2 years	
Optician	Marylhurst College	High School or equiv.	2 years	2 years for B.A.
Optometrist	Southern Oregon College	High School or equiv.	2 years	Transfer to Pacific University
	Pacific University	High School	6 years	O.D. (Doctor of Optometry)
Orthoptic Technician	Southern Oregon College	High School or equiv.	2 years	Transfer to Pacific University
	U.O.M.S.	High School or equiv.	18 months	Certificate
Pharmacist	Oregon State University	High School	5-6 years	B.S. or M.S. licensed pharmacist
Physician and Surgeon	U.O.M.S.	3-4 years of college in prescribed pre-medical course 1st year may be taken at a community college	4 years medical	M.D. Degree
Physical Therapist	Pre-professional: Southern Oregon College	High School	3 years	Transfer to out-of-state school
	University of Oregon	High School	4-5 years	Transfer to out-of-state school
	Oregon State University	High School	4-5 years	Transfer to out-of-state school
	Marylhurst College	High School	2 years	Transfer to out-of-state school
Physical Therapy Assistant	Mt. Hood Community College	High School	2 years incl. 1 yr. clinical	Associate Degree

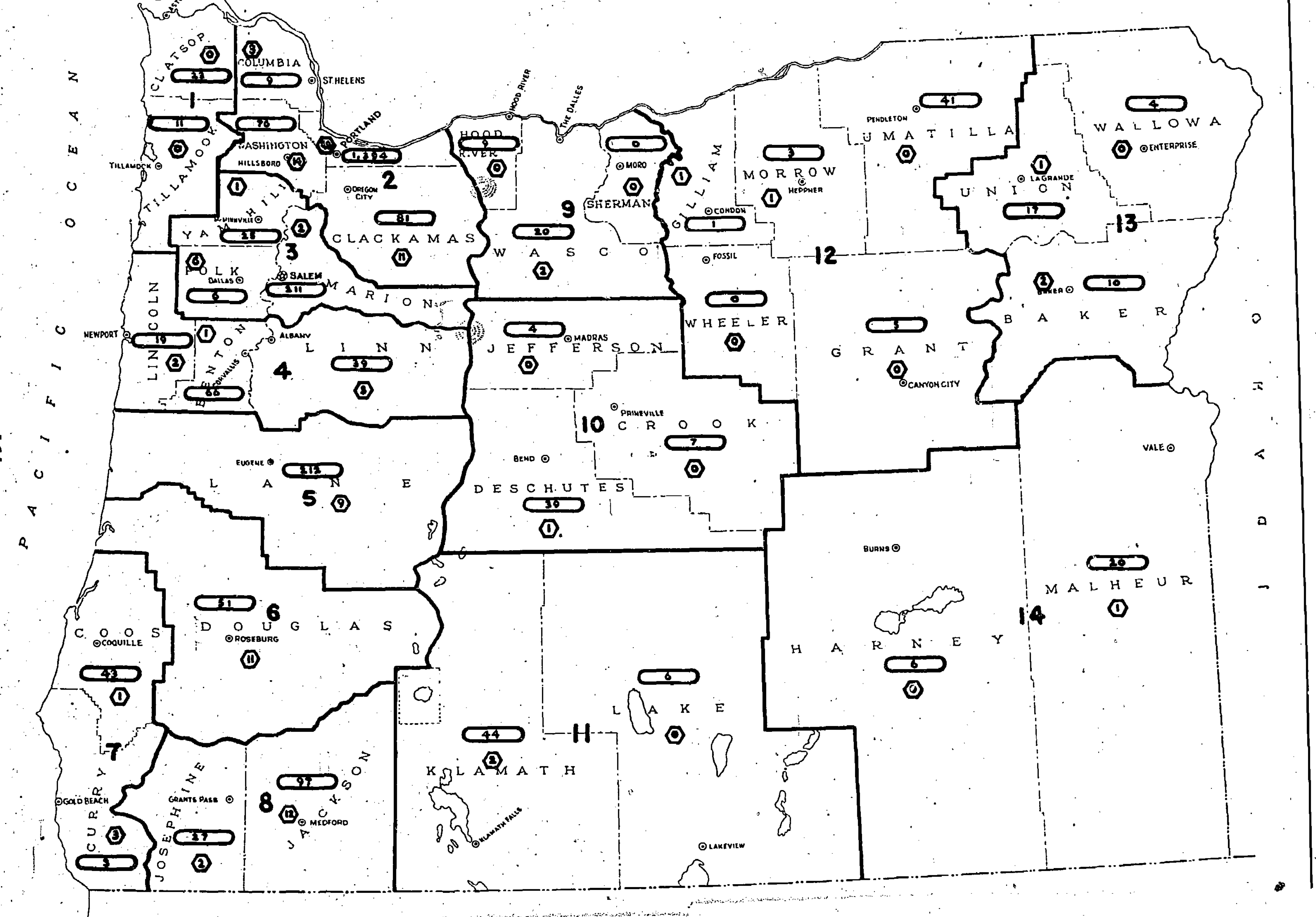
CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Psychiatric Aide	U. S. Veterans Hospital	High School or equiv.		
	University of Oregon	High School or equiv.		
Radiologic Technologist	U.O.M.S.	High School	24 months	Certified ARRT
	Portland Community College in coordination with: St. Vincents Hospital	High School	30 months Coordinated with acad. work	Associate Degree Certified ARRT
	Good Samaritan Hospital		Coordinated with acad. work	
	Physicians & Surgeons Hospital		Coordinated with acad. work	
	Emanuel Hospital		Coordinated with acad. work	
	Portland Adventist Hospital		Coordinated with acad. work	
	Albany General Hospital	High School	2 years	Certificate
	Sacred Heart Hospital	High School	2 years	Certificate
	Oregon Technical Institute	High School	2 years	Associate Degree
Recreation Assistant	Mt. Hood Community College	High School or equiv.		
	Clackamas Community College	High School or equiv.		
Recreational Therapist	University of Oregon	High School, Recreation Major	2 acad. yrs. +	B.A. or B.S. in C.S.P.A.
Sanitarian	Oregon State University	High School	4 years	B.S. Degree
	Portland State University	High School	4 years	B.S. Degree
Sanitation Engineer	Oregon State University	Projected - 1973	Graduate Program	M.S. or Ph.D. Degree

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Social Mental Health Technician	Clackamas Community College	High School	2 years	
Speech and Hearing Therapist	Oregon College of Education	High School or equiv.		
	Oregon State University	High School or equiv.	Variety of academic levels	
	University of Oregon	High School or equiv.		
Speech Pathologist and Audiologist	U.O.M.S.	M.S. Degree	2-4 years	
Surgical Technician	Emanuel Hospital	High School or equiv.	4-6 months	Certificate
	Multnomah County Hospital	High School or equiv.	4-6 months	Certificate
Veterinarian Accredited pre-professional	George Fox College	High School or equiv.	2 years minimum	
	Southern Oregon College	High School or equiv.	2 years minimum	
	Oregon State University	High School or equiv.	2 years minimum	B.S. Degree
	Linfield College	High School or equiv.	2 years minimum	Transfer to Veterinary School
	University of Oregon	High School or equiv.	2 years minimum	
	Portland State University	High School or equiv.	2 years minimum	
	Lewis and Clark University	High School or equiv.	2 years minimum	
	University of Portland	High School or equiv.	2 years minimum	
Veterinarian Aide	Mt. Hood Community College	High School or equiv.	Projected	

CAREER	SCHOOL	PREREQUISITE	LENGTH OF COURSE	DEGREE
Ward Secretary	Bess Kaiser Hospital	High School or equiv.	1-2 months	Certificate
	Emanuel Hospital	High School or equiv.	1-2 months	Certificate
Ward Clerk	Good Samaritan Hospital and Medical Center	High School or equiv.	2 months	Certificate

EXHIBIT 3

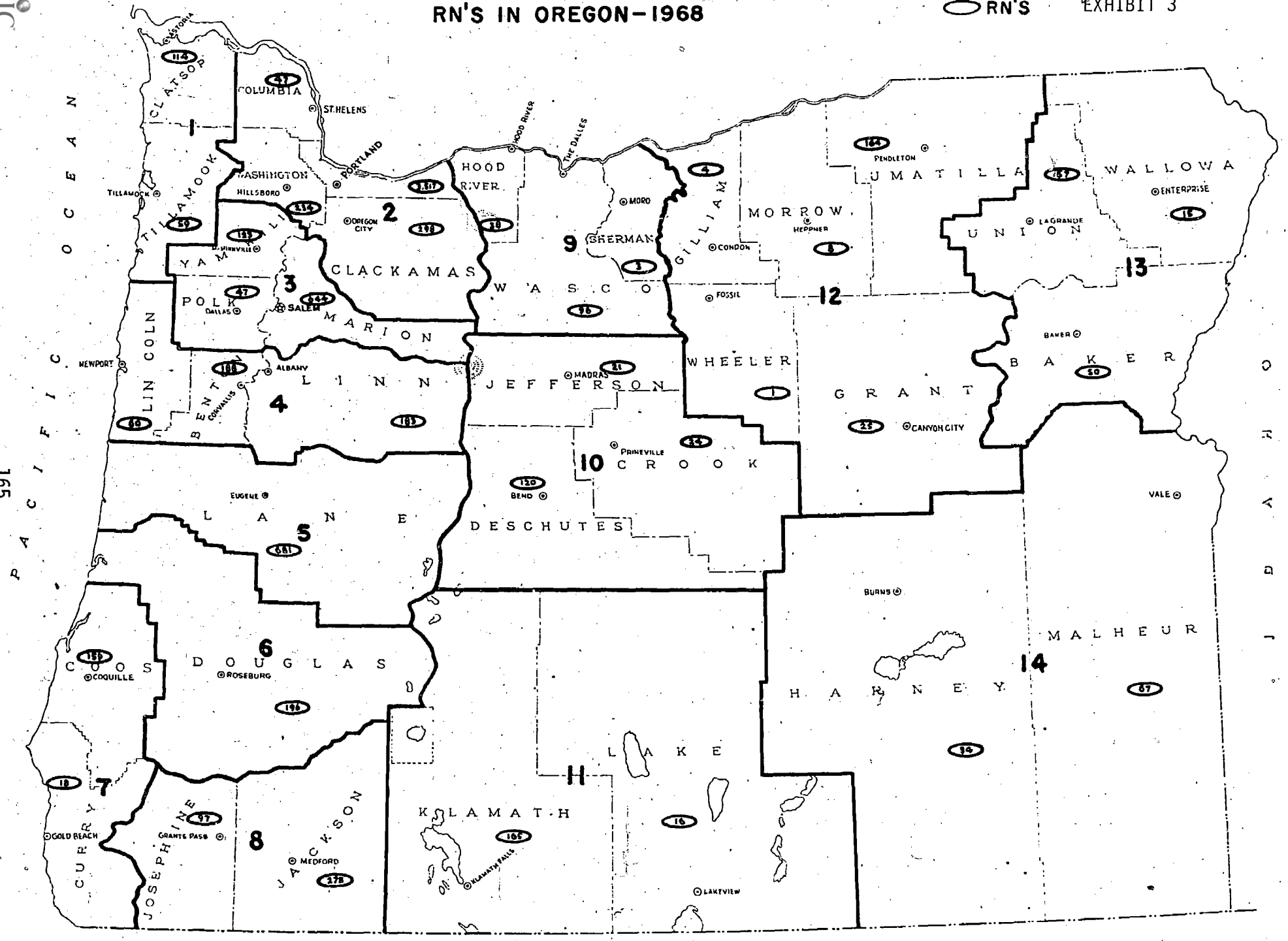
MD'S AND DO'S IN OREGON-1968



RN'S IN OREGON–1968

RN'S

EXHIBIT 3



HOME HEALTH SERVICES

GOAL ESTABLISH HOME HEALTH SERVICES AS AN INTEGRAL PART OF A COMMUNITY SYSTEM OF MEDICAL SERVICES AND FACILITIES PROVIDING AN OPTIMAL BALANCE OF ECONOMY AND EFFECTIVENESS.

CONDITION

Home health services, for the purpose of this Plan, consist of individualized care provided to persons in their home, on a visiting basis, by professional personnel under the direction of a physician. The nature of home health services varies in comprehensiveness among communities. The standards developed for home health agencies since the enactment of Medicare have influenced most types of home health services.

Under Medicare, home care treatments may be given by a registered nurse, physical therapist, occupational therapist, speech therapist, medical social worker or home health aide. Some agencies in Oregon provide additional ancillary services such as dietary guidance, clinical laboratory, vocational guidance, inhalation therapy, psychological counseling, medical equipment, and supplies.

Home health care should be viewed as an essential and dynamic component of comprehensive health care. In order to understand the scope of comprehensive health services, we must identify and define three distinct categories of personal health care according to their function. The three classes or levels of care include medical self care, health maintenance, and acute care.

Medical Self Care - the amount of care that can be properly given by an individual to himself or by the supporting or family unit. Medical self care is dependent upon such items as physical ability, degree of health knowledge, intellect, available equipment, and supplies.

Continuing Medical Care - that level of medical care which is required to maintain a certain level of health, to reduce the amount of unfavorable change or to increase the degree of favorable change (as in the rehabilitation process). This process usually requires more extensive supportive services including personalized self-help training and requires an extensive evaluation to determine the patient's actual status.

Crisis or Acute Care - this level is a service in which a patient recovers or regresses quickly. In this level there are many types of care such as medical, surgical or emergency services. In the emergency service, for example, the treatment is to reduce certain emergency conditions, such as spurting blood, fractured bones, etc. Most patients will progress from this level of care in a short period of time such as

one to three weeks. In addition, most cases will require limited follow-up with medical self care being used quite extensively.

Home health care relates or can be an overlay to each of these classes of care. The following examples explain the relationship of home health services to other providers of services.

General Hospital - home care is a continuation of treatment started in the hospital and provides an effective feedback mechanism about patients' response to continual treatment.

Rehabilitation Hospital - home care is the optimal completion of the rehabilitation process. When feasible, it should be utilized by most discharged patients. The home care program should be called upon as soon as health facility discharge is anticipated to assist in the therapeutic plan for the patient.

Extended Care Facility and Nursing Home - home care utilization would effectively reduce the length of stay for selected patients, allowing them to complete their recovery at home and to permit sufficient counsel for the family to determine their ability or inability to adequately care for the patient.

Physician - home care is the extension of the physician's therapeutic arm, acting as his assistant by providing those services he prescribes. In addition, home health services provide personalized health education for patients. This permits physicians to devote more time to their in-office and in-hospital patient load.

Medical Self Care - home care is used to teach or train the family to properly care for the patient and to teach the patient to properly care for himself and thus become an independent self care unit.

Modern home care has its roots in the care of the sick by the country doctor followed by religious orders using trained nurses to visit the homes of the sick in 1877. Yet, in terms of an organized service which is integrated with other parts of the health care system, home health services are just now maturing and increasing in numbers.

In 1966, prior to Medicare, only four agencies in Oregon were providing home care to approximately 450,000 of the total 1,768,687 population. With the implementation of Medicare, 30 home health agencies were certified in Oregon. However, four (official) agencies voluntarily withdrew during 1969-70 (Columbia, Wallowa, Tillamook, and Umatilla Counties). Budget, utilization and volume of administrative and clerical detail necessitated by the Medicare regulations were their stated reasons for withdrawal. The official Portland agency and Multnomah County combined during 1969. A hospital-based home health agency for Columbia County has been approved and an application is now pending for a similar program in Umatilla County.

The problem of providing adequate home health care services essentially resolves itself into (1) under-utilization of existing services, (2) under-financing.

Under-Utilization

In Oregon, the State Board of Health reported that 6,276 patients had received home health agency services in a one year period ending June 30, 1970. The need is estimated by the service agencies to be in excess of 35,000. This means that only 17.9% of the current need is being met by existing services. Of the 6,276 receiving services, Medicare paid for 5,117 (81.5%). A description of the types of services provided by home health agencies is shown in Exhibit 1.

The location of existing certified home health agencies leaves thirteen (13) counties without service. Districts 9 and 12 have no service and District 13 has only one agency. In October 1967, Oregon had total coverage in 69% of the counties, partial coverage in 6% and no coverage in 25%.

Of the 25 agencies providing services in September 1970, 20 were public agencies (local health departments), one was a visiting nurse organization, one was hospital based, and 3 were operated by other non-profit agencies.

Medicare certification regulations require nursing care and at least one other service (physical, speech, or occupational therapy, medical social work, or home health aide). While Social Security encourages the provision of as many services as possible, it will not continue certification for any service that is not utilized. In addition, Medicare states that these services must be provided on a fee-for-service basis and that the same fee must be charged for all patients. The cost is determined annually by a financial audit. In most areas, home care services are available to non-Medicare patients who can personally afford them.

The extent to which agencies are certified to provide services in addition to nursing is:

United States		Oregon
69.4%	Physical Therapy	84%
15.1%	Occupational Therapy	32%
22.7%	Speech Therapy	32%
22.6%	Medical Social Service	36%
38.6%	Home Health Aide	68%

There is, however, a wide range in the extent to which agencies are providing the comprehensive range of services envisioned by the Congress:

Number of Agencies U. S.	Number of Services in addition to Nursing Provided	Number of Agencies Oregon
1,166-58%	1	9-36%
444-22%	2	5-20%
195-10%	3	4-16%
116- 6%	4	4-16%
78- 4%	5 or more	3-12%

In September 1970, three Oregon agencies (one in Salem and two in Portland) were certified to provide a comprehensive service; however, only one agency in Portland had staff in all services. The remaining two agencies contracted from independent private practitioners for at least two of the five services. The five non-governmental agencies, in 1968, provided an estimated 70 percent of the total visits.

A listing of the 1968 and 1970 visit statistics gathered by the Oregon State Board of Health indicate that availability and utilization in home care are different. For example, in 1968 32 percent of the certified agencies had speech therapy services available but only 0.5 percent of the total home care visits were for speech therapy. The following table summarizes the visits:

Utilization of Services by Visit	Percent for Fiscal Year 1968	1970
Skilled Nursing and Home Health Aide	89.9%	88.5%
Physical Therapy	8.7%	9.4%
Speech Therapy	0.5%	0.9%
Occupational Therapy	0.5%	0.8%
Medical Social Service	0.4%	0.4%

The rural and sparsely populated areas have a great but unmet home care service need. This is due mainly to the high percentage of elderly people living in these areas and the limited physicians' services available. Home care services are most needed for long-term patients requiring assistance in making the home adjustment or in learning to live with their disability.

The home care setting and its influence on rehabilitation has been expressed by Howard Dewey, Ph.D.:

> "Experience with long-term illnesses where people have been separated from their families have revealed how debilitating such separation is. The stream of life continues for those who are in the home and their interests grow and change and their activities and involvement continue to modify with time, and it is almost impossible to keep a relative who is physically separated abreast of such changes. The patient feels left out

and neglected and often becomes depressed and increasingly withdrawn. While there may be factors existing in the home which are not always conducive to health, close work with a patient being treated in the home environment can identify such problems and often be corrected.

"The problems presented by a patient being separated for long periods of time from his family are insurmountable, even though they are usually well identified. Another aspect of home treatment is the security afforded the patient of familiar surroundings, and for the most part, association with those who sincerely love him and are concerned about his recovery or rehabilitation. Again, this may present problems as too much pressure can be exerted; but again, problems can be fairly readily identified and treated on an on-going basis within the home while the pattern for those who are long-term hospital cases is for them to be neglected and forgotten, or when visited they are called upon out of a sense of duty or guilt rather than because of interest and true desire."

Since home care involves treatment of each patient by the individual professional, it provides proportionately more skilled treatment time to the patient than is provided in a hospital. For example, hospital "bedside registered nurse man-hours per bed day" is about 32 to 35 percent as compared to about 60 to 70 percent of the "direct nursing care time" in a home care program.

Proper utilization of home health services is a major problem. Apathy, political attitudes, inability or unwillingness to pay and lack of understanding of potential benefits appears to jeopardize the establishment of home health services in certain areas, or the financial viability of existing services.

Funding

Traditionally, home care has been financed with the voluntary dollar, and until the advent of Medicare, third-party payment was focused on hospital services. The Medicare dollar has made it possible to provide limited home care services to patients over 65 and is the first nationwide plan which encourages the use of home care by subsidizing home health services. However, to be 'covered' by Medicare, home care services must include either skilled nursing, physical therapy, or speech therapy which are classified as 'primary services' and must be provided by persons qualified in their field. Occupational therapy, medical social service, and home health aide services are classified as secondary or supportive and can only be 'covered' when a primary service is required. In addition, the Social Security Administration has restricted the use of Medicare funds by eliminating payment for the 'custodial services' of the home health aide. This often leads to serious consequences for the home-bound patient.

Some home care agencies utilize nurse coordinators who are stationed in a hospital to assist the physician and hospital staff to arrange for home care upon discharge from the hospital. Robert F. Ehinger, M.D., Deputy Commissioner, Erie County Health Department, New York, advised against using this approach since their experience demonstrated that when the coordinator was absent from the hospital there were no referrals to home care and that the expense was difficult to justify. This, he felt, was a somewhat temporary solution which supported the need for a total health care system. In Multnomah County an estimated $63,000 was spent on coordinator services in 1969.

Home health services has proven to be a financial savings:

> The Good Samaritan Stroke Program in Portland saved over $500,000 in Oregon.
>
> Blue Cross of New York reduced their average claim costs $259 each on 2,000 cases after paying for home care services because home care was more effective and therefore less expensive.

In addition, home care is less expensive as compared to other levels of care. In a study conducted by Kaiser Research Institute, Portland, the reported costs during 1968 for the following levels of care were:

Home Health Care	$ 5.26	Per patient day
Extended Care Facility	$39.08	Per patient day
Acute Hospital	$72.62	Per patient day

Associated Home Health Service reported a 1969 per patient day Medicare cost of $5.40 compared to an average hospital charge of $55 per patient day, and an average extended care facility charge of $16 to $28 per patient day. Included in the home health care per patient day cost was the services of a physical therapist, occupational therapist, and speech therapist, all of which are additional charges in the hospital and extended care facility. The major financial resources available to home care providers include tax-supported, welfare, and voluntary health dollars as well as insurance carriers.

Tax-supported-Federal

Medicare which was primarily responsible for the development of home care by including home care benefits has made recent changes in regulations which eliminate payment for "personal care services", such as assisting a patient with bathing or other personal care needs. In the Portland area, agencies reported a reduction in their home health aide staff from 32 to 4 in the last eight months.

Tax-supported-State

The local health services division of the State Board of Health distributes the state funds to local health departments. This division is the

designated state agency responsible for Medicare certification. No state funds have been available from the state for payment of home care services.

Tax-supported-Local

Since Medicare provided a source of revenue for home care programs, most local health departments have become certified home health agencies. This has provided some relief of local tax burdens.

Welfare and Community Voluntary Health Funds

The community fund resources are presently providing limited funds to qualified voluntary agencies. Thus, funding through community resources is both restrictive and limiting. The welfare department has paid for home care services in only two of Oregon's 36 counties. Also, Oregon has not funded home care as a categorical benefit in its state Medicaid plan. The Regional Medical Program has demonstrated through the Good Samaritan Hospital Stroke Program that a tremendous savings could be generated through the use of home health services, yet there still is limited financing available to purchase follow-up home care.

Insurance financing of home care is very limited. A survey of insurance carriers revealed that home care benefits were being paid by only a few under comprehensive plans such as:

The Physician Association of Clackamas County is implementing a comprehensive coverage which is partially underwritten by the participating providers and includes a paid-in-full home care benefit subject to a per-visit deductible.

New York Life has a "Medicare" type policy which includes home care benefits.

Kaiser Foundation has completed an exhaustive feasibility study of home care in a prepaid group and has continued to provide home care benefits in its plan.

In addition, the survey of major hospital insurance companies indicates that home care benefits could not be provided unless the following criteria were met:

1. Provide a comprehensive service.
2. Have a standardized review system.
3. Maintain uniform record keeping.
4. Develop uniform quality of care standards established by professional peers.

Budget problems are common to all home health agencies. Although Medicare reimburses the agencies for services provided in the home

according to their individual established fee, and for specified operating costs on a ratio basis, considerable gap occurs in actual cost recovery. Reimbursement for patients under Medicare's Plan A provides the greatest amount of recovery, but patients under Plan B are personally responsible for the $50 deductible and 20 percent of the fee cost. Many of these patients have very limited incomes and can pay only part of the 20 percent and $50 deductible. Regulations require agencies to provide care for both A and B patients. Consequently, the agencies are forced to absorb some costs, particularly on initial visits, for patients under Medicare. For non-Medicare patients, the agency risk of cost recovery is even greater. Some of these patients are able to pay the full fee, but the majority referred have very limited incomes or are on Public Welfare.

Home health agencies are experiencing considerable financial difficulty due to their continued and increasing number of unpaid claims for Public Welfare patients and others for whom there are no available financial resources. Consequently, many agencies can no longer continue to admit non-Medicare patients without prior promise of payment. This has necessitated either the return or initial admission of some patients to nursing homes or hospitals. Although Public Welfare refers many patients or may give prior approval for assuming the cost, they are usually unable to pay. Public Welfare in Oregon reportedly has been unsuccessful in obtaining a budget line item for the purchase of home care service. Title XIX, Medicaid, which includes Federal matching coverage for home care, has not been implemented.

CURRENT PROGRAMS AND ACTIVITIES

At present there are 25 home health agencies in the State of Oregon which have been certified as providers of Medicare benefits under Title XVIII, PL. 89-97, Social Security Act. The certified home health agencies in Oregon are:

Associated Home Health Service, Inc., Portland
Benton County Health Department, Corvallis
Clackamas County Health Department, Oregon City
Clatsop County Health Department, Astoria
Coos County Health Department, Coquille
Curry County Health Office, Gold Beach
Douglas County Health Department, Roseburg
Harney County Health Office, Burns
Health Services, Inc., Eugene
Home Health Service Agency for Lane County, Eugene
Jackson County Public Health Center, Medford
Josephine County Health Department, Grants Pass
Kaiser Foundation Hospitals, Portland
Klamath County Health Department, Klamath Falls
Lincoln County Health Department, Newport
Linn County Health Department, Albany
Malheur County Health Office, Vale

Marion County Department of Health, Salem
Multnomah County Division of Public Health, Portland
Polk County Health Office, Dallas
Tri-County Home Health Agency, Bend
Union County Health Office, La Grande
Visiting Nurse Association of Portland, Portland
Washington County Health Department, Hillsboro
Yamhill County Health Department, McMinnville

A more detailed description of the services offered by these agencies and the geographic area covered is shown in Exhibit 2.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1972, establish a mechanism for the systematic identification, classification, and inventory of all home health services in Oregon.

2. By 1972, establish a mechanism to identify patterns of use for home health services so as to incorporate home health services into the community peer review system.

3. By 1973, develop a coordinated system of home health services in Oregon to insure comprehensive care and eliminate gaps in service.

4. Develop a broad financial base for all aspects of home health services.

5. Improve utilization of home health services through increased public and professional education and information programs.

RECOMMENDATIONS AND METHODS

(Objective #1)

1. *ESTABLISH A STATEWIDE COMMITTEE ON HOME HEALTH SERVICES RESPONSIBLE FOR THE IDENTIFICATION, CLASSIFICATION, INVENTORY, AND ESTABLISHMENT OF MECHANISMS FOR THE COORDINATION OF ALL HOME HEALTH SERVICES IN THE STATE.*

Method

The Governor's Health Planning Committee appoint a Home Health Services Committee. The committee membership should consist of representatives from: 1) non-institutional state professional organizations (e.g., Oregon Medical Association, Oregon Association of Home Health Agencies), 2) regional organizations (e.g.,

Region X Comprehensive Health Planning, Region X Director of National Association of Home Health Agencies), and 3) individuals and representatives from organizations selected for their ability to take new problems, analyze them, and develop workable solutions. The composition of the committee will be half professional and half community representatives. The committee will also meet the new requirements under the "Health Improvement Act of 1970" which requires home health agencies to be included in the health planning process.

2. *ESTABLISH CLEARLY DEFINED CRITERIA AND STANDARDS TO CLASSIFY AND EVALUATE ALL HOME HEALTH SERVICES IN OREGON.*

   Methods

   a. *The State Home Health Services Committee prepare standards for the classification of home health agencies according to the level of care provided. (see Exhibit 3 for a description of recommended standards.)*

   b. *State Home Health Services Committee develop procedures for the continual evaluation of home health services in Oregon.*

3. *INVENTORY ALL EXISTING HOME HEALTH AGENCIES IN OREGON TO DETERMINE THEIR ACCESSIBILITY, STAFFING, COMPREHENSIVENESS, AND DELIVERY OF SERVICE, AS WELL AS TO IDENTIFY GAPS AND DUPLICATION OF SERVICES.*

   Methods

   a. *State Home Health Services Committee encourage and assist all areawide comprehensive health planning committees to activate special committees on home health services whose membership would be similar to the state committee. Area committees would be responsible for the identification, coordination, evaluation, and surveillance of home health services in their district and will be advisory to areawide comprehensive health planning agencies.*

   b. *Area home health committees inventory all existing home health agencies, classify them according to the criteria established by the state committee, and submit to the state committee recommendations for improving home health services in their districts.*

(Objective #2)

4. *ESTABLISH A STATEWIDE COMMITTEE REPRESENTING HOME HEALTH AGENCIES, MEDICAL SOCIETIES, AND INSURANCE CARRIERS TO DEVELOP A PEER REVIEW MECHANISM FOR HOME HEALTH SERVICES.*

Method

Oregon Association of Home Health Agencies, in cooperation with Oregon Medical Association, Oregon Association of Hospitals, and other related organizations, appoint a peer review committee consisting of representatives of Oregon Medical Association, Oregon Association of Home Health Agencies, Blue Cross of Oregon, Oregon Physicians' Service, and private insurance carriers. The peer review committee will be charged to:

a) study the relationship of medical self care to home health care;

b) develop and publish a peer review plan for home health services;

c) integrate home health services into the overall medical review system.

5. *DEVELOP A MECHANISM UTILIZING HOSPITAL ADMISSIONS DATA, INSURANCE AND WORKMAN'S COMPENSATION RECORDS TO IDENTIFY AS WELL AS DETERMINE APPROPRIATE PATTERNS OF USE OF HOME HEALTH SERVICES.*

Methods

a. *Peer Review Committee develop guidelines to abstract and correlate from existing records pertinent information to develop a profile of those patients who can benefit from home health services and a profile of those providing the services. (see Exhibit 4 for suggested types of data.)*

b. *Peer Review Committee, in cooperation with Comprehensive Health Planning, contract for and supervise the collection and organization of profile reports from a representative sample of patients and providers in the state.*

c. *Peer Review Committee analyze the profile information and develop a peer review system for home health services.*

6. *INTEGRATE THE PEER REVIEW SYSTEM FOR HOME HEALTH SERVICES INTO THE LOCAL MEDICAL REVIEW SYSTEM SUCH AS THE PROPOSED PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) AND THE PEER REVIEW ORGANIZATION (PRO).*

7. *DEVELOP A UNIFORM MEDICAL RECORD SYSTEM FOR ALL HOME HEALTH SERVICES COMPATIBLE WITH THE SYSTEM USED BY INSTITUTIONAL PROVIDERS.*

Methods

a. *Peer Review Committee contract with a medical records librarian to develop a uniform medical records system to be used in all home health agencies.*

b. *Using the results of the study, the Peer Review Committee outline and publish the standard record system, distribute it to all home health agencies, and encourage its adoption.*

(Objective #3)

8. *DEVELOP A STATEWIDE PLAN TO IMPROVE AND ORGANIZE THE DELIVERY OF HOME HEALTH SERVICES AS AN INTEGRAL PART OF THE HEALTH CARE DELIVERY SYSTEM.*

Methods

a. *State Home Health Services Committee assemble and analyze the results of the inventory and develop a statewide plan for home health services.*

b. *State Home Health Services Committee publish the state plan for home health care and, in cooperation with Oregon Medical Association and Oregon Association of Hospitals, distribute the plan to professional health personnel.*

c. *State Home Health Services Committee publish the results of the inventory in the form of a classification directory of Home Health Services in Oregon. The directory will be periodically updated.*

9. *DEVELOP MECHANISMS FOR COORDINATING AND CONSOLIDATING ALL HOME HEALTH SERVICES IN OREGON TO MINIMIZE DUPLICATION, GAPS IN CARE, DIVIDED LOYALTIES, LACK OF COOPERATION, AND IGNORANCE OF AVAILABLE SERVICES.*

Methods

a. *Comprehensive Health Planning, in cooperation with the State Home Health Services and the Peer Review Committees, initiate planning efforts to establish regional core agencies to provide centralized administrative services for home health care to: 1) provide home health care to areas not now receiving service and 2) assist existing agencies to expand their delivery mechanism. This would make it possible for small agencies to take advantage of available financial resources by having a cooperative arrangement with the core agency who would provide the administrative and clerical functions such as claims processing and supervisory requirements defined in the standards and regulations.*

b. *Areawide comprehensive health planning committees review and approve all grants or proposals for expansion of home health services or the establishment of new home health agencies to achieve a coordinated system of care.*

c. *Comprehensive Health Planning conduct a study to determine how home health services can be utilized in other program areas such as mental health and vocational rehabilitation.*

d. *Comprehensive Health Planning, in cooperation with Division of Vocational Rehabilitation, Workman's Compensation Board, and home health agencies, develop a demonstration project to determine the medical cost savings derived from using home health services in homes, halfway houses, and other residential facilities as an alternative to institutional care.*

10. *DEVELOP A COORDINATED REFERRAL SYSTEM COVERING THE STATE SO THAT ALL PERSONS IN NEED OF HOME HEALTH SERVICES WILL BE REFERRED FOR CARE.*

Methods

a. *Area home health committees, in cooperation with local public, private, and voluntary organizations, implement a multi-agency, multi-disciplinary system to identify and refer persons who need and would benefit from home health care.*

b. *Area home health committees establish an information center with a well-publicized telephone number where professionals and the public can receive information on home health services.*

(Objective #4)

11. *EXPAND EXISTING AND ESTABLISH NEW FEDERAL FINANCING PROGRAMS FOR HOME HEALTH SERVICES IN OREGON.*

Methods

a. *Medicare fiscal agents in Oregon encourage greater use of home health services through their claims and utilization review programs.*

b. *Public Welfare Division implement Medicaid for the medically indigent in Oregon to take advantage of the costs saving generated by using appropriate home health services in the medical care system.*

c. *Public Welfare Division expand their contract with the Physician Association of Clackamas County to include the new "Comprehensive Health Care Coverage" policy for all welfare recipients in Clackamas County effective July 1, 1971.*

d. *Public Welfare Division implement the incentive increase of 25% matching federal monies for home health services (HR 17550) as soon as funds are available.*

12. *EXPAND STATE PROGRAMS THAT SUBSIDIZE OR DELIVER HOME HEALTH SERVICES.*

Methods

a. *Establish a line item for home health services in budgets of all agencies that subsidize or deliver home health services such as Oregon State Board of Health, Mental Health Division, Public Welfare Division, Division of Vocational Rehabilitation, Motor Vehicle Accident Fund, and Office of Economic Opportunity.*

b. *State Accident Insurance Fund and Workman's Compensation Board include home health services in their payment schedule.*

c. *Division of Vocational Rehabilitation utilize 301 federal matching funds obtained from compensation claims to develop a payment mechanism for utilization of home health services for clients that are homebound and in need of medical assistance.*

d. *Oregon State Board of Health actively seek funding for the delivery of home health services in remote areas of the state.*

13. *DEVELOP OTHER SOURCES OF FUNDING FOR HOME HEALTH SERVICES.*

Methods

a. *Oregon Association of Home Health Agencies encourage health insurance companies to develop comprehensive health insurance plans covering home health services and encourage consumer subscription to these plans.*

b. *Comprehensive Health Planning, through the A-95 process, review, and approve all grants for home health services from all agencies (including Model Cities, Office of Economic Opportunity) prior to funding of the program.*

c. *All comprehensive health insurance programs such as proposed Health Maintenance Organizations be required to include home health services prior to approval.*

14. *DEVELOP PRIVATE COMMUNITY FUNDING MECHANISMS FOR ALL ASPECTS OF HOME HEALTH SERVICES.*

Methods

a. *Comprehensive Health Planning explore alternate means to reduce the cost of home health services (such as the use of paramedical personnel, etc.).*

b. *Local home health committees encourage United Fund to finance meals-on-wheels, transportation, homemaker services, and other special needs of homebound patients.*

(Objective #5)

15. *DEVELOP PUBLIC EDUCATION AND INFORMATION PROGRAMS TO MAKE THE PUBLIC, LEGISLATORS, AND HEALTH CARE PROVIDERS AWARE OF THE POTENTIAL OF HOME HEALTH SERVICES AS AN INTEGRAL PART OF THE HEALTH CARE DELIVERY SYSTEM.*

Methods

a. *State Home Health Services Committee develop an informational program for the public on home health care including a cost benefit analysis of home health services as compared to other kinds of care.*

b. *Areawide comprehensive health planning committees implement community programs to inform individuals and their families of the possible benefits of home health services.*

16. *EXPAND PROFESSIONAL EDUCATIONAL PROGRAMS FOR ALL HEALTH PERSONNEL EMPHASIZING THE BENEFITS OF HOME HEALTH CARE.*

Methods

a. *Oregon Regional Medical Program and Oregon Medical Association, in cooperation with the Oregon Association of Home Health Agenices, develop seminars and circuit courses on home health care for all physicians, nurses, and other allied medical personnel in Oregon.*

b. *University of Oregon Medical School include in the curriculum topics on medical self care and home health services and their relationship to the entire scope of medical care.*

OPERATIONAL PROBLEMS

In addition to the general problems inherent in any program of change such as resistance to change, lack of funds, manpower and community services, certain basic operational problems which alter the effectiveness of home health services include:

1. Lack of coordination between home health agencies and the overall health care delivery system.

2. Lack of public and professional understanding of what home health services entail.

EVALUATION CRITERIA

1. Establishment of home health services in every district by 1973.

2. Provision of home health services to all potential patients regardless of their ability to pay by 1974.

3. Establishment of an informational program on home health services by 1972.

4. Establishment of guidelines and standards for home health services flexible enough to apply to regional home health programs by 1972.

5. Development and publication of a classification directory of home health services by June 1972.

6. Establishment of uniform medical records for home health agencies by 1973.

7. Establishment of provider, patient, and physician profiles by 1972.

8. Full integration of the home health services peer review mechanism into the community peer review system by 1975.

9. Inclusion of home health services representatives on the Advisory Boards of state agencies such as the Division of Vocational Rehabilitation, Public Welfare Division, State Accident Insurance Fund, and Workman's Compensation Board as openings occur or as Boards are reorganized or developed.

PRIORITY

To be determined.

EXHIBIT 1
OREGON CERTIFIED HOME HEALTH AGENCIES
IDENTIFIED BY COUNTY AND DISTRICT

District	Population	Home Health Agency	Services Offered	Geographical Area Served
District 1	46,660			
Clatsop	28,800	Public Health Department	Nursing, Physical Therapy	Entire County
Tillamook	17,860	No Home Health Service Available--Withdrew from Home Health Program in 1970		
District 2	897,740			
Clackamas	164,800	Public Health Department	Nursing, Home Health Aide, Physical Therapy, Speech Therapy--Medical Social Worker	Entire County
Columbia	30,140	No Home Health Service Available--Withdrew from Home Health Program in 1969		
Multnomah	559,500	Public Health Department	Nursing, Physical Therapy, Home Health Aide	Entire County
		Visiting Nurse Association	Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Worker	Multnomah, Clackamas, and Washington Counties
		Kaiser Foundation Hospital	Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, Medical Social Worker	All areas within 15 miles from Bess Kaiser Hospital
		Associated Home Health Services, Inc.	Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Worker	All Multnomah County, including Portland, plus Clackamas County to Rhododendron, Estacada, Molalla, Wilsonville and Washington County to Tigard, Beaverton, Bonny Slope
Washington	143,300	Public Health Department	Nusing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy	Entire County

District	Population	Home Health Agency	Services Offered	Geographical Area Served
District 3	229,440			
Marion	155,600	Public Health Department	Nursing., Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy, Medical Social Worker	Entire County
Polk	32,820	Public Health Department	Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy	Entire County
Yamhill	41,020	Public Health Department	Nursing, Home Health Aide, Physical Therapy	Entire County
District 4	145,010			
Benton	51,000	Public Health Department	Nursing, Home Health Aide, Physical Therapy	Entire County
Lincoln	25,130	Public Health Department	Nursing, Home Health Aide, Physical Therapy	Entire County
Linn	68,880	Public Health Department	Nursing. Home Health Aide, Physical Therapy	Entire County
District 5	209,400			
Lane	209,400	Home Health Service Agency for Lane County, Inc.	Nursing, Home Health Aide, Physical Therapy, Speech Therapy, Occupational Therapy	Entire County
		Health Services, Inc.	Nursing, Physical Therapy	Eugene, Springfield--30-mile Radius from Eugene
District 6	74,150			
Douglas	74,150	Public Health Department	Nursing. Home Health Aide, Physical Therapy	Entire County

District	Population	Home Health Agency	Services Offered	Geographical Area Served
District 7	70,380			
Coos	57,200	Public Health Department	Nursing, Home Health Aide	Entire County
Curry	13,180	Public Health Department	Nursing, Physical Therapy	All of County except Marial, Agnes, and Illahe
District 8	129,690			
Jackson	93,700	Public Health Department	Nursing, Physical Therapy, Medical Social Worker	Entire County
Josephine	35,990	Public Health Department	Nursing, Home Health Aide, Physical Therapy, Speech Therapy	Entire County
District 9	38,070			
Hood River	14,130	No Home Health Service Available		
Sherman	2,370	No Home Health Service Available		
Wasco	21,570	No Home Health Service Available		
District 10	47,985			
Crook	9,725	Home Health Services Provided by Contract with Tri-County Home Health Agency		
Deschutes	29,220	Tri-County Home Health Agency	Nursing, Physical Therapy	All of Deschutes County Provides Services by Contract to Crook and Jefferson Counties
Jefferson	9,040	Home Health Services Provided by Contract with Tri-County Home Health Agency		

District	Population	Home Health Agency	Services Offered	Geographical Area Served
District 11	56,580			
Klamath	49,760	Public Health Department	Nursing, Physical Therapy, Medical Social Worker	Entire County
Lake	6,800	No Home Health Services Available		
District 12	61,940			
Gilliam	2,695	No Home Health Services Available		
Grant	7,395	No Home Health Services Available		
Morrow	4,600	No Home Health Services Available		
Umatilla	45,370	No Home Health Services Available--Withdrew from Home Health Program in 1970		
Wheeler	1,880	No Home Health Services Available		
District 13	42,440			
Baker	16,410	No Home Health Services Available		
Union	19,590	Public Health Department	Nursing, Physical Therapy, Speech Therapy	Entire County
Wallowa	6,440	No Home Health Services Available--Withdrew from Home Health Program in 1969		
District 14	32,175			
Harney	7,275	Public Health Department	Nursing, Physical Therapy	City of Burns and 15-mile Radius from Burns
Malheur	24,900	Public Health Department	Nursing, Home Health Aide, Physical Therapy	20-mile Radius from Ontario, Vale, Nyssa

State Population: 2,081,640

Population figures of state and counties are based on information provided December 31, 1969, by Center for Population Research and Census, Portland State University. Source: Oregon State Board of Health, Public Health Nursing Section.

EXHIBIT 2

HOME HEALTH AGENCY SERVICE STATISTICS BY DISTRICT

DISTRICT	YEAR	MEDICARE OR NON-MEDICARE	PATIENTS ADMITTED	VISITS BY TYPE OF SERVICE						
				Nursing	Home Health Aide	Physical Therapy	Medical Social Ser.	Occupational Therapy	Speech Therapy	TOTAL
1	66-67	Med	*	1132	0	65	0	0	0	1197
		Non	*	0	0	0	0	0	0	0
	67-68	Med	38	1324	0	62	0	0	0	1386
		Non	13	40	0	0	0	0	0	40
	68-69	Med	66	1452	0	112	0	0	0	1564
		Non	16	204	0	0	0	0	0	204
	69-70	Med	62	1553	0	107	0	0	0	1660
		Non	14	321	0	0	0	0	0	321
2	66-67	Med	*	5145	10274	204	0	0	0	15623 **
		Non	*	0	0	0	0	0	0	0
	67-68	Med	1879	26630	19874	7744	413	526	300	55487
		Non	1049	11987	4011	720	52	83	98	16951
	68-69	Med	2112	29492	23908	7729	310	246	379	62064
		Non	1139	15127	6373	1687	68	145	170	23570
	69-70	Med	1903	29653	21719	7113	293	466	377	59621
		Non	673	12569	6531	845	79	108	125	20257
3	66-67	Med	*	561	1480	102	0	13	2	2158
		Non	*	0	0	0	0	0	0	0
	67-68	Med	219	2979	2658	1149	0	13	2	6801
		Non	63	1245	1067	0	0	0	0	2312
	68-69	Med	365	4252	4978	1941	68	27	65	11331
		Non	53	1072	365	114	37	0	3	1591
	69-70	Med	399	4416	3958	2381	162	430	139	11486
		Non	83	1150	274	29	35	1	0	1489
4	66-67	Med	*	1877	1295	82	0	0	0	3254
		Non	*	0	0	0	0	0	0	0
	67-68	Med	189	3302	3241	155	0	0	0	6698
		Non	14	439	332	0	0	0	0	771
	68-69	Med	172	3155	4378	238	0	0	0	7771
		Non	26	478	443	0	0	0	0	921
	69-70	Med	169	3241	4925	539	0	0	0	8705
		Non	27	450	499	0	0	0	0	949

EXHIBIT 2
HOME HEALTH AGENCY SERVICE STATISTICS BY DISTRICT

DISTRICT	YEAR	MEDICARE OR NON-MEDICARE	PATIENTS ADMITTED	VISITS BY TYPE OF SERVICE						
				Nursing	Home Health Aide	Physical Therapy	Medical Social Ser.	Occupational Therapy	Speech Therapy	TOTAL
5	66-67	Med	*	0	0	0	0	0	0	0 ***
		Non		0	0	0	0	0	0	0
	67-68	Med	503	9871	7842	604	0	0	103	18480
		Non	1	29	0	0	0	0	0	29
	68-69	Med	495	9994	9033	1433	0	12	234	20706
		Non	0	30	0	0	0	0	0	30
	69-70	Med	506	7822	7631	2286	0	7	609	18405
		Non	5	16	17	35	0	0	0	68
6	66-67	Med	*	42	2	0	0	0	0	44
		Non		0	0	0	0	0	0	0
	67-68	Med	9	110	144	0	0	0	0	254
		Non	1	12	0	0	0	0	0	12
	68-69	Med	26	382	181	0	0	0	0	563
		Non	2	12	0	0	0	0	0	12
	69-70	Med	20	587	448	0	0	0	0	1035
		Non	1	9	0	0	0	0	0	9
7	66-67	Med	*	247	444	0	0	0	0	691
		Non		0	0	0	0	0	0	0
	67-68	Med	42	523	1945	0	0	0	0	2468
		Non	12	125	438	0	0	0	0	563
	68-69	Med	65	1214	2272	0	1	0	0	3486
		Non	18	360	248	0	0	0	0	608
	69-70	Med	50	1632	1903	5	1	0	0	3541
		Non	17	318	33	7	0	0	0	358
8	66-67	Med	*	1061	1059	16	0	0	62	2198
		Non		0	0	0	0	0	0	0
	67-68	Med	124	2675	1782	2	0	0	54	4513
		Non	16	294	5	0	0	0	0	299
	68-69	Med	170	3587	2223	1	0	0	1	5812
		Non	15	429	19	0	0	0	0	448
	69-70	Med	158	4034	1868	3	2	0	0	5907
		Non	30	991	19	0	0	0	0	1010
9				NO HEALTH SERVICES AVAILABLE						

EXHIBIT 2
HOME HEALTH AGENCY SERVICE STATISTICS BY DISTRICT

DISTRICT	YEAR	MEDICARE OR NON-MEDICARE	PATIENTS ADMITTED	VISITS BY TYPE OF SERVICE						
				Nursing	Home Health Aide	Physical Therapy	Medical Social Ser.	Occupational Therapy	Speech Therapy	TOTAL
10	66-67	Med	*	644	0	173	0	0	0	817
		Non		0	0	0	0	0	0	0
	67-68	Med	58	3273	0	132	0	0	0	3405
		Non	2	141	0	0	0	0	0	141
	68-69	Med	63	4304	0	49	0	0	0	4353
		Non	2	148	0	0	0	0	0	148
	69-70	Med	74	4703	0	43	0	0	0	4746
		Non	1	15	0	0	0	0	0	15
11	66-67	Med	*	137	0	11	0	0	0	148
		Non		0	0	0	0	0	0	0
	67-68	Med	20	458	0	76	0	0	0	534
		Non	6	52	0	0	0	0	0	52
	68-69	Med	17	349	0	14	0	0	0	363
		Non	7	192	0	0	0	0	0	192
	69-70	Med	22	637	0	168	0	0	0	805
		Non	6	324	0	0	0	0	0	324
12				NO HOME HEALTH SERVICES AVAILABLE AS OF JULY 1970						
	66-67	Med	*	115	0	0	0	0	0	115
		Non		0	0	0	0	0	0	0
	67-68	Med	7	112	0	1	0	0	0	113
		Non	0	0	0	0	0	0	0	0
	68-69	Med	8	176	0	0	0	0	0	176
		Non	0	0	0	0	0	0	0	0
	69-70	Med	9	113	0	0	0	0	0	113
		Non	0	0	0	0	0	0	0	0
13	66-67	Med	*	34	0	95	0	0	0	129
		Non		0	0	0	0	0	0	0
	67-68	Med	12	180	0	121	0	0	0	301
		Non	4	44	0	17	0	0	0	61
	68-69	Med	14	148	0	61	0	0	0	209
		Non	5	73	0	0	0	0	0	72
	69-70	Med	9	258	0	15	0	0	0	273
		Non	5	71	0	2	0	0	0	73

EXHIBIT 2

HOME HEALTH AGENCY SERVICE STATISTICS BY DISTRICT

DISTRICT	YEAR	MEDICARE OR NON-MEDICARE	PATIENTS ADMITTED	VISITS BY TYPE OF SERVICE						
				Nursing	Home Health Aide	Physical Therapy	Medical Social Ser.	Occupational Therapy	Speech Therapy	TOTAL
14	66-67	Med	*	200	575	182	0	0	0	957
		Non		0	0	0	0	0	0	0
	67-68	Med	37	547	1228	83	0	0	0	1858
		Non	3	5	8	0	0	0	0	13
	68-69	Med	58	1062	1126	210	0	0	0	2398
		Non	2	2	1	0	0	0	0	3
	69-70	Med	48	687	1143	128	0	0	0	1958
		Non	2	2	0	26	0	0	0	28
* No statistics available										
** No statistics available for voluntary non-profit agencies (3)										
*** No statistics available for voluntary non-profit agencies (2)										
STATE	66-67	Med	*	11,195	15,129	930	0	0	64	27,318
		Non	*	0	0	0	0	0	0	0
	67-68	Med	3,137	51,984	38,714	10,129	413	539	519	102,298
		Non	1,184	14,413	5,861	737	52	83	98	21,244
	68-69	Med	3,631	59,567	48,101	11,788	379	285	679	120,799
		Non	1,285	18,127	7,449	1,801	105	145	173	27,800
	69-70	Med	3,429	50,336	42,502	12,788	458	903	1,125	117,112
		Non	864	16,236	7,373	944	114	109	125	24,901

EXHIBIT 3

SUGGESTED CLASSIFICATION GUIDELINE FOR HOME HEALTH AGENCIES

1. Special Service Agency

   a. Recommended standards

      1) that each special service agency should maintain an adequate staff to serve the local special area i.e., counseling services to be done by qualified workers.

      2) this would include all home health service programs that are not a certified home care agency.

2. Standard Service Center

   a. Recommended standards - each standard service center should limit their certified services according to the availability of other areawide programs.

      1) Staff registered nurses available to make home visits.

      2) Staff of either a speech, occupational, or physical therapist available to make home care visits.

      3) When available this center should use the comprehensive service center for claims processing, utilization review, various records forms, and administrative functions.

3. Comprehensive Service Center

   a. Recommended standards

      1) Full time staff consisting of registered nurse, physical therapist, occupational therapist, speech pathologist, medical social worker, home health aide.

      2) Have available by working arrangements the services of a laboratory and pharmacy; nutritional, vocational guidance; medical equipment rental; outpatient therapy services; community referral center; and where possible, other related medical services.

      3) Maintain a centralized claims processing, medical and financial record keeping system capable of medical audit, financial audit and area or local utilization review screening.

4) Maintain adequate backup personnel to provide standby services for standard and special service centers.

5) Have a peer review mechanism operational.

6) There should be no more than one comprehensive center in any one area under 150,000 population.

EXHIBIT 4

SUGGESTED GUIDELINES FOR INFORMATION FOR PEER REVIEW

A. PATIENT CHARACTERISTICS:

1. Diagnostic categories of patients transferred to the home care program.

2. Age grouping of patients.

B. COSTS:

1. Estimated number of hospital days saved per case.

2. Cost per patient day while on home care program.

3. Cost per patient day while in hospital.

4. Estimated reduction in cost per case for using home care services.

5. Estimated reduction or increase in payments made by third party carrier for patient utilizing home care services.

6. Methods of payment, i.e., private health insurance, Medicare, Medicaid, self, other.

7. Home care charges.

8. Estimated effect on overall cost of health care - such as what is the influence on premiums third party carriers must charge.

C. UTILIZATION:

1. Number of days hospitalized prior to discharge into the home care program.

2. Estimated number of hospital admissions made possible by patients transferred into home care programs (Divide estimated number of hospital days saved by average length of stay in M/S section.)

3. Number of patients served.

4. Length of stay while on home care.

5. Number of physicians participating and percent of total medical staff.

6. Length of time each physician participates. -If he discontinues participation, then why.

D. ATTITUDES:

1. Attitudes and recommendations of physicians as to functioning of the program.

2. Attitudes of patients.

3. Coordinating procedures and working relationships with any other organization providing health services in the home.

E. OTHER:

1. Should point out the needs for proper staffing patterns.

2. Evaluate possibilities for other administrative arrangements for home care operation.

ORGANIZATION AND FINANCING FOR LOCAL PUBLIC HEALTH SERVICES

GOAL PROVIDE COMPREHENSIVE COMMUNITY PUBLIC HEALTH SERVICES TO ALL OREGON RESIDENTS.

CONDITION

Local public health services in Oregon are provided primarily under the auspices of county government. Exceptions are those counties under 10,000 population which receive environmental sanitation and preventive medical services from the Oregon State Board of Health (unless served by other units of government under special agreement). In a few instances where State specialists are able to provide services more efficiently, the staff of the Oregon State Board of Health works together with county agencies to furnish community health services (e.g., staffing community Tuberculosis Control Chest Clinics). In general, the role of the Oregon State Board of Health is to provide technical and supportive assistance and to assure state-wide protection of the public's health.

County health departments carry out traditional public health services as provided for by Oregon law and governmental regulation. State agencies promulgating rules and regulations affecting county health departments include the Oregon State Board of Health, the Department of Environmental Quality, the Department of Agriculture, and the Mental Health Division. Home Rule Counties can adopt ordinances for some programs; all counties have been legislatively authorized to adopt health service rules.

Organization

The organizational structure set up for city, county, and state boards of health more than 50 years ago was based on a sparsely populated agrarian society with very limited means of travel and communication. Population growth, urbanization, improved transportation and communications systems, and shortages of trained health manpower now require more rapid and complete collection and dissemination of information and more centralized and responsive local organization, while still maintaining accessibility of services at the local level. Minimum standards for provision of local health services are not being met, and there is much wasted effort in (a) inefficient use of available manpower and statistics; (b) independent action by multiple official and non-official health agencies without consideration of their effects on each other; and (c) lack of clear organizational responsibilities and objectives.

The number of counties with full-time health administrators has declined from 26 in 1950 to 18 in 1970, of which only 8 have special training in public health and nearly one-half are over age 65. In the other 18 counties, there are no staff members designated and trained to provide

full-time direction to public health; three of these counties have no full-time public health workers of any kind.[1] Under Oregn law, the role of the city health department officer is vague. There are no full-time city health personnel (with the singular possible exception of the city/county consolidation of public health services in Portland/Multnomah County), and cities conduct few, if any, public health activities. The lack of clarity between the roles of the city and county health departments has resulted in misunderstandings and inadequate enforcement of public health laws and regulations.

Oregon Revised Statute 431.414 provides that two or more contiguous counties may combine resources in the interest of providing more comprehensive health services. In the absence of a State fiscal incentive, however, only one health district (made up of Wasco and Sherman Counties) exists today. The Tri-County District Health Department, serving Crook, Deschutes, and Jefferson Counties, was dissolved as a District Health Department in 1970 (primarily due to a fiscal crisis and the desire for local autonomy). In the past, health districts have also existed for Yamhill-Washington, Lincoln-Tillamook, Baker-Union, Benton-Polk, and Coos-Curry Counties.

Most local health departments are organized under ORS 431.405, with the county governing body serving as the local board of health, ex-officio. Each county board of health appoints a health officer; a physician licensed by the State Board of Medical Examiners. (In half of the counties, the health officer's primary occupation is private physician. Wheeler County has no resident physician at this time; consequently, it has not been possible to appoint a county health officer.)

Under ORS 431.412, through a vote of the people there can be established a representative board of health comprised of one member of the governing body of the county, the mayor of the largest city, a representative of the schools, a private physician, a dentist, and two others. Fiscal responsibility remains with the county budget committee. This type of board of health exists in Benton, Clackamas, Jackson, Josephine, and Yamhill Counties.

Under Oregon law, local health agencies can limit their services to control of communicable diseases and (if over 10,000 population) to enforcement of some sanitation laws. This can mean that any local health department is "at risk" for reduction of staff to a part-time health officer and a part-time sanitarian. In recent years, provision of only limited county public health services (in the presence of increasing community health problems) has resulted in the development of other public agencies offering over-lapping and more costly services. In other words, local public health as presently structured has oftentimes proven to be too weak to respond to community health problems.

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1. See Exhibit 1, which shows the public health staff support in Oregon counties.

The fragmentation of health services has not only confused the public, but has resulted in poorly integrated community health efforts, where typically; (1) the less costly preventive aspects of health care are not performed; (2) problems are attacked on an individual rather than a community approach; and (3) the health aspects of environmental problems are overlooked.

The structure for delivery of community health services should be (1) community based; (2) flexible enough to meet the diverse needs of the various localities in Oregon; (3) large enough so that specialized services can be equitably offered to all of Oregon's citizens; and (4) responsive to the special health problems of high risk groups. The establishment of Public Health Regions would serve to bring together contiguous counties to form manageable service populations and allow better allocation and control of available resources. In the formation of Public Health Regions, planning groups should be sensitive to county boundaries, local trade areas, hospital catchment areas, patient referral patterns, and the State's administrative districts. Single county health departments are most suitable where at least 100,000 persons are served and even in such circumstances, overlapping communities of interest may make consolidation with mutually interacting counties highly desirable. In all health departments there should be available a qualified team of public health administrative personnel, physicians, nurses, sanitarians, health educators, and mental health specialists.

Financing

Any restructuring of community health services must be accompanied by a stabilizing base of new fiscal support and reasonable assurance that services will be available on an equitable basis in all communities in Oregon.

The financial resources of different areas of the state vary widely, as does the perception of health problem priorities and the use of available resources.[1] Environmental pollution and the spread of communicable disease exemplify the effect that the activities of one area or group of people may have on the health of every other.

Problems of environmental pollution cannot be solved without population control, public education, local inspection and enforcement of personal hygiene, and sanitation; soaring venereal disease rates cannot be lowered without available personnel to locate, diagnose, and treat cases and contacts; rampant dental caries can be more efficiently controlled by community water fluoridation procedures than by dental care clinics, etc. Oregon should have a commitment to ensure the

1. See Exhibit 2, which shows the total Health Department budgets and per capita ratio by district and county for 1969-70; reflecting a range of $1.39 to $8.34 per person in Oregon counties.

availability of a "basic level" of health services to all of the people in the state. Much of this basic level is already expressed in State laws and public health regulations, but enforcement and provision of services depends on stable and adequate financing. Almost complete dependence on financing through local appropriations from the county general fund has resulted in gross inequities and general failure to provide the minimum stable financial resources necessary to meet the stated goal.

Currently, the Oregon State Board of Health administers federal health monies which assist communities in the provision of public health services. These include Maternal and Child Health, Family Planning, Migrant Health, Indian Health, and Comprehensive Health Service 314(d) funds. Only Comprehensive Health Service funds are unrestricted for support of basic public health services. Unfortunately, costs of services have increased at a much greater rate than have federal funds, and in fiscal year 1969, these monies supported only 6.2% of the cost of local public health services. Social Security "Medicare" funds supported an additional 8.1% of county public health services (for the Home Health Agency programs). The Local Health Services Division of the Oregon State Board of Health reports that, based on a University of Michigan survey, Oregon ranks comparatively low among the 50 states in providing state financial support for local public health services; in fact, Oregon is one of only five states which did not provide General Fund assistance for such programs. State funds for partial support of county autopsy costs (administered by the State Board of Health) and 50% matching support of community mental health clinics (administered by the Mental Health Division) are the only examples of state assistance to community public health. In fiscal year 1969, these sources of state funds added up to 8.2% of local health costs. Various fees and miscellaneous sources accounted for another 8.7%. Balance of 68.8% came from local government (primarily property tax) funds.

A review of data available through the Oregon State Board of Health reveals significant inequities among services for Oregon's citizens, such as:

1. Thirteen counties do not provide immunization services to all age groups.

2. Home Health Agency services are not available in thirteen counties.

3. Family Planning services are not given in twenty counties.

4. In twenty-four counties, Well-Child Clinic services are not provided.

5. Prenatal services are provided in only two counties.

6. Venereal Disease Program services are not readily available in nineteen counties.

In April, 1970, the Governor's Comprehensive Health Planning Committee issued a report based on a statewide survey of local public health services. About 80% of its respondents indicated that the public health programs in their local area were neither adequately staffed nor funded to provide the services to the people in need in the community. One of the reasons cited for staffing problems at the local level was the discrepancy between the salary scales recommended under the merit system administered by the State Board of Health and the lower salaries paid by the individual counties. There is general agreement that state funds should be allocated to the counties to support local public health programs.

CURRENT PROGRAMS AND ACTIVITIES

By statute and regulation, the Oregon State Board of Health, the Conference of Local Health Officers (CLHO), and local government share responsibilities for community health. The Oregon State Board of Health has direct supervision of all matters relating to the preservation of the life and health of Oregon's population. The local health officer (ORS 431.418) acts as official agent for enforcing state laws and rules and regulations of the Oregon State Board of Health. In the event of his failure to do so, the Oregon State Board of Health can take steps to remove him (ORS 431.420) or he can be removed by the local board of health.

ORS 431.330 - 350 directs that the Conference of Local Health Officers "shall adopt minimum standards governing organization, operation, and extent of activities which are required to carry out their responsibilities in implementing the public health laws of the state and the rules and regulations of the State Board of Health." By regulation, the Oregon State Board of Health Director of Local Health Services serves as Executive Secretary of the Conference of Local Health Officers. Preliminary steps have been taken to adopt program standards for local health departments which will require written program plans to be developed by all county health departments (and filed with the Oregon State Board of Health) by March, 1972.

By tradition, the local health officer not only is responsible for carrying out the public health laws of the state but for: (1) assessing the unmet health needs of the community; and (2) seeking resources to meet these needs.[1]

AUTHORITIES

Authorities in this section have been incorporated into Current Programs and Activities and Condition statement above.

1. The organizational chart attached as Exhibit 3 reflects the typical structure of the local health departments.

OBJECTIVES

1. By 1972, restructure the present local public health organizations into public health regions with viable regional health departments responsive to local health problems.

2. Establish an adequate fiscal support base for these regional health departments to provide public health services on an equitable basis for all Oregon communities, regardless of size or population density.

RECOMMENDATIONS AND METHODS

1. *PROVIDE THE ORGANIZATIONAL STRUCTURE AND FUNDING MECHANISM FOR THE MOST EFFECTIVE AND EFFICIENT DELIVERY OF ALL HEALTH SERVICES FOR WHICH PUBLIC AGENCIES HAVE RESPONSIBILITY, AND WHICH ARE CONSISTENT WITH THE ROLE OF THE PUBLIC SECTOR IN THE MEDICAL CARE DELIVERY SYSTEM.*

   Methods

   a. *Comprehensive Health Planning develop and submit a legislative proposal which provides for and encourages replacement of existing city and county public health departments, with regional health departments responsible for delivering "basic level" health services within predetermined geographic boundaries. Proposal to include provision for:*

      1) *Establishment of a public health region by any county, or combination of counties whose boundaries are contiguous, subject to approval by the State Board of Health after public hearing.*

      2) *Establishment of regional health departments administered by representative regional boards of health to provide the entire range of basic health services provided by public agencies, including communicable disease control, vital statistics, public health education, public health nursing, mental health,[1] and environmental sanitation. Duties, responsibility, and authority of regional boards of health to correspond with and be subject to that of the State Board of Health. Regional boards to have authority to enforce all public health laws and regulations within the region.*

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1. *The incorporation of mental health services into the regional public health service delivery system is not to be construed as a recommendation for change in existing mental health service programs, funding, or authority. Regional level consolidation of all health-related functions for local administration and possible sharing of facilities is viewed as complementary to the Mental Health Division's proposed district-based program for a community mental health delivery system and is not intended to disturb existing structure for programs and funding of the Mental Health Division.*

3) *Appointment of qualified medical or non-medical regional health directors by the regional board, under criteria established by the State Board of Health, to supervise the activities of the regional health department in accordance with program and policy decisions of the regional boards of health.*

4) *Dissolution of existing city and county boards of health within established public health regions at the time regional boards of health are constituted with concurrent transfer of health functions and authority.*

b. *The State Board of Health and Mental Health Division develop estimates of program costs (not only for existing programs but also for new or expanded services proposed by separate regional programs, less savings that may result from more comprehensive or centralized services) and seek legislative approval and appropriations to provide the following amount of State financial aid to recognized public health regions for conduct of regional health programs designed to provide the "basic level" of public health services on a state/region matching basis:*

50% of annual financial requirements for 1973-75 biennium;
66% of annual financial requirements for 1975-77 biennium; and
75% of annual financial requirements for 1977-79 biennium.

1) *To be eligible for receipt of such funds, each regional board of health shall provide a "basic level" of health services, as determined by the State Board of Health.*

2) *The State Board of Health shall include in its biennial budget request the amount of financial assistance necessary to support the regional boards in performance of their functions.*

3) *The local matching funds necessary to support and maintain "basic level" health services for the region will be provided by the counties on a pro rata basis (using population and assessed property valuation) to be determined by the region.*

Note: This proposal will not preclude individual public health regions from obtaining additional funds for selected projects in excess of the amounts provided to public health regions for "basic level" health services.

c. *By 1973, the State Board of Health develop a proposal and seek legislative approval and appropriations for 100% state-subsidized programs providing those essential public health services having inter-regional consequences (e.g. preventive programs for communicable disease control, etc.).*

2. *THE STATE BOARD OF HEALTH ESTABLISH STANDARDS AND DEFINITIVE EVALUATION CRITERIA FOR A "BASIC LEVEL" OF PUBLIC HEALTH SERVICES ESSENTIAL TO GOOD HEALTH, AS WELL AS DEVELOP MECHANISMS TO COORDINATE AND EVALUATE REGIONAL BOARD OF HEALTH PROGRAMS.*

3. *THE STATE BOARD OF HEALTH, TOGETHER WITH THE OREGON MEDICAL ASSOCIATION, DEVELOP A STATEWIDE PUBLIC EDUCATION AND INFORMATION PROGRAM DESIGNED TO ATTAIN PUBLIC AND LEGISLATIVE SUPPORT AT BOTH THE LOCAL AND STATE LEVELS FOR THE PROPOSED REGIONAL PUBLIC HEALTH SERVICE DELIVERY SYSTEM.*

OPERATIONAL PROBLEMS

Structure for community public health services has been weak and fragmented; there have been few good models for winning public support. As one of the very few states which does not provide financial support (except for mental health) for community health services, there has been no stable base on which to build viable health services. Change in structure, without providing the financial base, will result in little change in services. Furthermore, the "basic level" of health services must be delineated by the Oregon State Board of Health prior to any attempt to develop estimates of program costs.

The biggest problem will be overcoming concerns about local autonomy and the sharing of resources for resolving problems of the larger community of concern. There is little chance that additional property tax funds will be forthcoming to support changes in the community health structure. Community health leadership to spearhead change is lacking in most areas.

EVALUATION CRITERIA

The State Board of Health will be responsible for evaluating the regional health department programs against the statewide "basic level" of health service standards as determined by the State Board of Health. Interim evaluation will be based on successful establishment of public health regions and regional health departments for every community of the state, staffed by teams of full-time community health professionals (including public health administrators, physicians, nurses, sanitarians, health educators, and mental health specialists).

PRIORITY

To be determined.

Note: Establishment of regional health service organizations and the provision of adequate financial support are interdependent.

EXHIBIT 1

STATE OF OREGON

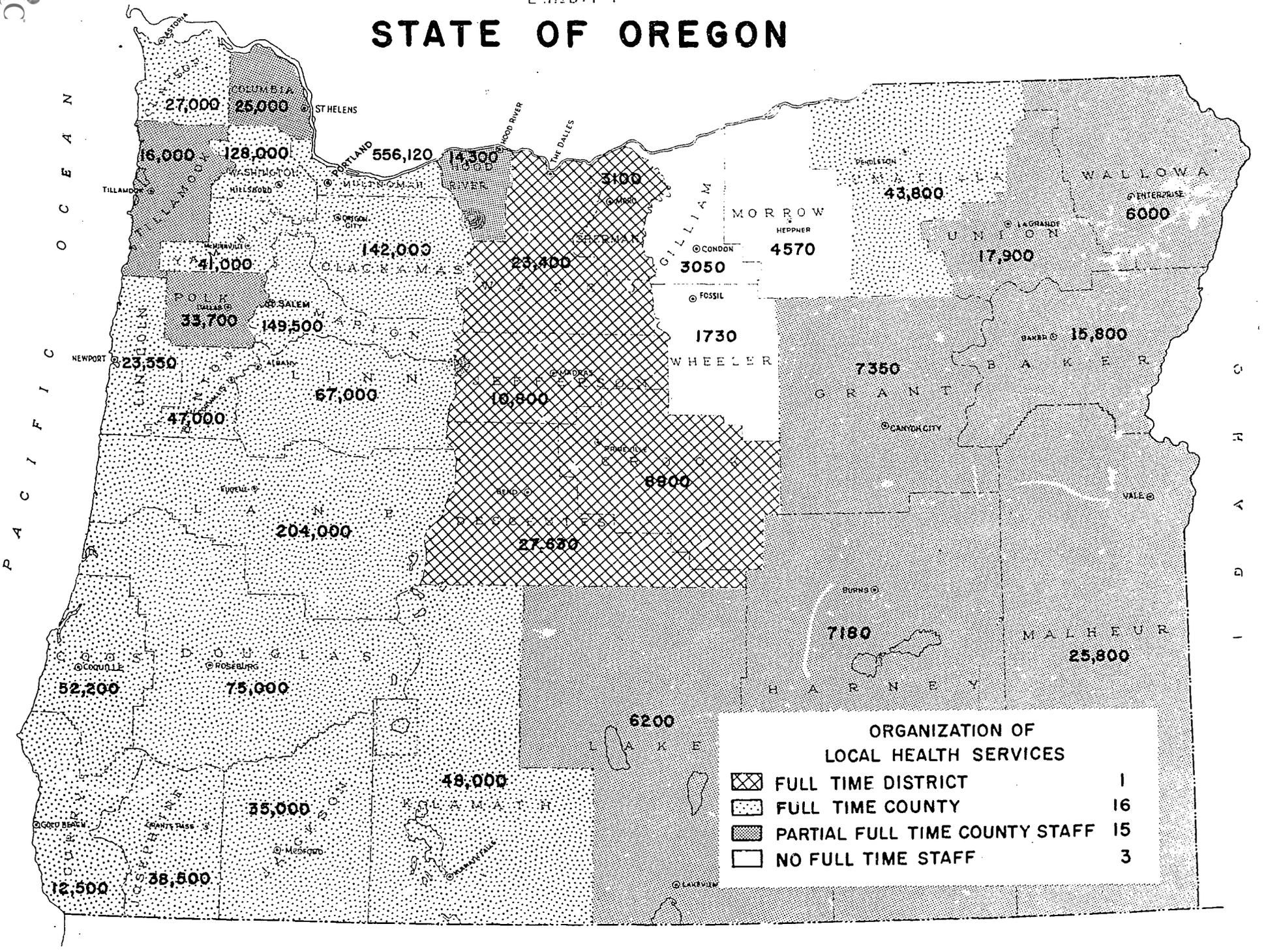


EXHIBIT 2

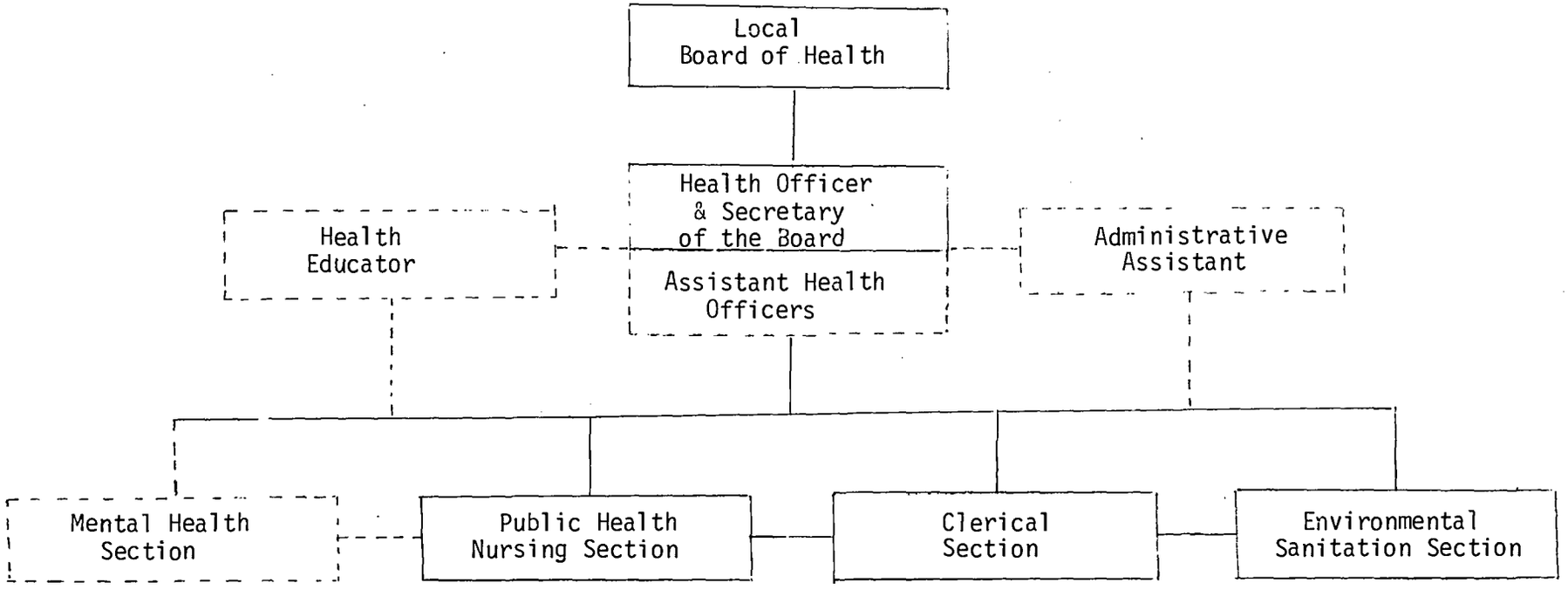
Total Health Department Budgets and Per Capita Ratio by District and County: State of Oregon, 1969-70.

	Estimated Population[1]	Health Dept. Budget	
		Amount[2] (Dollars)	Per Capita Ratio
State of Oregon	2,075,640	$11,736,776	$5.65
District 1	46,660	183,997	3.94
Clatsop	28,800	124,421	4.32
Tillamook	17,860	59,576	3.34
District 2	897,740	5,601,769	6.24
Clackamas	164,800	354,378	2.15
Columbia	30,140	125,523	4.16
Multnomah	559,500	4,668,977	8.34
Washington	143,300	452,891	3.16
District 3	229,440	1,366,288	5.95
Marion	155,600	935,627	6.01
Polk	32,820	128,007	3.90
Yamhill	41,020	302,654	7.38
District 4	145,010	576,810	3.98
Benton	51,000	282,633	5.54
Lincoln	25,130	142,184	5.66
Linn	68,880	151,993	2.21
District 5			
Lane	209,400	1,190,985	5.69
District 6			
Douglas	74,150	514,184	6.93
District 7	70,380	389,071	5.53
Coos	57,200	292,153	5.11
Curry	13,180	96,918	7.35
District 8	129,690	683,408	5.27
Jackson	93,700	419,622	4.48
Josephine	35,990	263,786	7.33
District 9	38,070	202,194	5.31
Hood River	14,130	89,416	6.33
Sherman	2,370	)	)
Wasco	21,570	112,778)	4.71)
District 10	47,985	278,997	5.81
Crook	9,725	)	)
Deschutes	29,220	278,997)	5.81)
Jefferson	9,040	)	)
District 11	56,560	244,372	4.32
Klamath	49,760	221,944	4.46
Lake	6,800	22,428	3.30
District 12	61,940	225,332	3.64
Gilliam	2,695	4,321	1.60
Grant	7,395	10,495	1.42
Morrow	4,600	9,325	2.03
Umatilla	45,370	198,585	4.38
Wheeler	1,880	2,606	1.39
District 13	42,440	128,750	3.03
Baker	16,410	50,839	3.10
Union	19,590	65,651	3.35
Wallowa	6,440	12,260	1.90
District 14	32,175	150,618	4.68
Harney	7,275	52,172	7.17
Malheur	24,900	98,446	3.95

[1] Estimates as of 7-1-69 (Center for Population Research)
[2] Figures may not add due to rounding

EXHIBIT 3

ORGANIZATION OF LOCAL HEALTH DEPARTMENTS IN OREGON*



Partial List of Programs

1. Community Health Planning
2. Diagnosis & Interpretation of Community Health Problems
3. Disease Prevention and Control of:
   a. Chronic Diseases
   b. Tuberculosis
   c. Venereal Disease
   d. Other Communicable Diseases
4. Emergency Medical Services
5. Environmental Health Services
   a. Inspection of Care Facilities, Farm Labor Camps, Foster Homes, Food Services Facilities, Schools, Swimming Pools, Travelers, and Tourist Facilities
   b. Investigation of Nuisance Complaints
   c. Supervision of Private & Semi-Public Water Supplies & Sewage Disposal Facilities, Solid Waste Disposal, & Subdivision Approval
   d. Vector Control (Rodents & Insects)
6. Family Health Services
   a. Crippled Children
   b. Dental Health
   c. Family Health Supervision
   e. Maternal & Child Health
   f. Nutrition
7. Health Education & Information
8. Home Health Agency Services
   a. Home Nursing Care & Rehabilitation
   b. Home Health Aide, Occupational, Physical & Speech Therapy, & Medical Social Services
9. Laboratory Service
10. Medical Investigation of Deaths and "Battered Child" Cases
11. Mental Health
12. School Health Services
13. Vital Statistics

*Note: Solid line indicates basic organization in all local health departments; broken line indicates additional staff and organizational structure found in some departments.

11/66 - 500 Division of Local Health Services, Oregon State

PRICES AND PAYMENTS FOR DRUGS AND MEDICINES

GOAL ASSURE AVAILABILITY OF NEEDED DRUGS AND MEDICINES TO ALL OREGONIANS REGARDLESS OF SOURCE OF PAYMENT.

CONDITION

State statutes allow pharmaceuticals to be dispensed only by licensed physicians or pharmacists. Certain injectibles and other specific drugs may only be dispensed and/or administered in physicians' offices or clinics and administered by staff to inpatients of medical facilities such as hospitals, nursing homes, state institutions, and at various public health clinics.

Although most pharmaceuticals are dispensed by chain and discount or privately-owned pharmacies, they may also be dispensed directly by specific medical programs such as the Veterans' Administration, proprietary health plans, union, and other association pharmacies.

Utilization of medicinal preparations varies by the prescribing habits of physicians and the orientation and utilization characteristics of patients. There is a trend for increased drug and medicinal usage due to new and improved therapeutic agents for specific diseases, longer life span (there is increased usage with age), increased advertising causing patients to request that their doctors prescribe medicines, and the possible easy availability of medicines at no cost to the patient through non-payment programs.

Factors affecting costs include wholesale drug costs which often vary widely among types of customers, the differential cost for specific brand names as opposed to generic equivalents, and wide cost differentials between over-the-counter items and similar prescription drugs. Many medicinal preparations are controlled by patents and the costs of these drugs often reflect heavy research, advertising, and marketing expenditures. Non-patented items produced by several companies under their own brand names tend to be less costly, but still reflect heavy advertising expenditures. Medicinal preparations marketed under the generic name tend to be less costly; however, there is diverse opinion as to their efficacy. The quality of generic medicinals must be established before being released to the public in commerce.

The majority of drug costs are paid by individual patients, either through direct purchasing, deductibles, co-insurance or premium costs on insurance policies, or as taxes paid to government. Other drug costs may be reimbursed through tax-supported medical programs such as Title V (Maternal and Infant Health, Crippled Children's Division, Head Start, etc.); Title XIX (Medicaid); CHAMPUS (Armed Forces and Dependents); and Veterans' Administration. Other drugs are provided by tax-supported (but free to the recipient) State Board of Health programs such as tuberculosis, immunization, and venereal disease.

Many insurance plans and programs either fail to cover drug needs or do so inadequately.

CURRENT PROGRAMS AND ACTIVITIES

State Board of Pharmacy enforces provisions of the state pharmacy laws.

The State Department of General Services arranges for the provision of drugs and medicines for state institutions and medical and dental schools. (This is usually done through price agreements to obtain a desired low cost.)

AUTHORITIES

Oregon statutes fund the Public Welfare Division's Medicaid and General Assistance programs; State Board of Health; Mental Health Division; Vocational Rehabilitation Division; and Motor Vehicle Accident Fund.

Federal statutes fund Medicare, Medicaid, Maternal and Infant Health, Crippled Children's Division, Office of Economic Opportunity, Public Health Service, Indian Service, Veterans' Administration, and Armed Forces Medical Program.

Voluntary agencies are funded by public donations.

OBJECTIVES

1. Assure that quality pharmaceuticals are available to all who need them.
2. Assure equitable pricing of pharmaceuticals.
3. Assure that quality pharmaceuticals are purchased at the lowest possible cost.
4. By 1973, all medicines must be properly labeled, showing the commercial name of the drug, except where specifically ordered deleted by the prescribing physician.

RECOMMENDATIONS AND METHODS

Recommendations and Methods are being developed by Comprehensive Health Planning, in cooperation with Oregon State Pharmaceutical Association, Board of Pharmacy, and others.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

To be determined.

PRIORITY

To be determined.

PREPAID HEALTH CARE

GOAL PROVIDE FINANCING OF ADEQUATE COMPREHENSIVE HEALTH CARE FOR ALL OREGONIANS THROUGH PREPAID MEDICAL CARE PLANS.

CONDITION

Adequate financing of health care encompasses manpower, facilities, and supplies; it should provide preventive treatment, rehabilitative, long-term care, and home health care services to meet the needs of all Oregonians.

The financing mechanisms include both private funds (personal payments for doctor bills, hospitalization, drugs, donations to help health-related charitable organizations, individual and group health insurance plans), and those monies paid as taxes which fund public health, welfare, and other government administered health and health-related programs. These services are rendered not only to the general population, but are also aimed at target groups (aged, welfare recipients, veterans, military personnel, the American Indian population, etc.) utilizing public health and community mental health resources, Title XVIII (Medicare), and Title XIX (Medicaid).

There are a number of areas that warrant study. Some are reflected by the following statements.

1. Welfare programs provide the poor with medical care services and facilities as need is determined, but provide dental care, drugs, and supplies only on an emergency basis.

2. There are those poor who receive few services because of lack of knowledge of available programs or reticence to seek public aid. Since the typical welfare programs are not "outreach" oriented, some poor people do not get the medical service they need.

3. Some low-income persons cannot afford or will not purchase adequate prepaid medical care plans.

4. There are many low-income people who, while able to maintain financial independence while healthy, can quickly become impoverished and unable to pay for necessary medical care when ill. At the present time, the Welfare Department will not provide medical assistance separate from maintenance and general social work.

5. A large proportion of Oregon citizens, although protected by conventional individual or group health protection plans, may

almost as quickly become impoverished when a severe and/or long-term illness strikes them and costs outstrip the provisions of their policies.

6. Some prepaid health care plans do not provide benefits in the areas of preventive health, ambulatory medical care, rehabilitation, home health care, long-term care, and illnesses that can be cared for in public institutions. When benefits for rehabilitation are available, they do not provide incentives for early rehabilitation (at the time a person can be most easily motivated).

7. Exclusions and/or difficult-to-understand provisions of some health care plans may cause financial hardships. Contrarily, many persons are double covered for some benefits and uncovered for others; this unnecessarily increases protection costs without providing more coverage.

8. The requirement for hospitalization to collect benefits under some prepaid health care plans encourages the unnecessary use of more expensive health care facilities and an overall increase in health care costs.

9. Some rural areas are without adequate health services because of population densities insufficient to support complete services; in addition, some community sizes and geographic locations are not conducive to attracting medical, dental and allied manpower.

CURRENT PROGRAMS AND ACTIVITIES

Health care insurance is provided by private insurance companies licensed to market health insurance in the State of Oregon. Benefits paid in Oregon from this source in 1969 amounted to $77 million dollars. Other prepaid health-care plan benefits paid by the following plans in 1969 amounted to $64 million dollars:

1. Blue Cross provides individual and group health-care contracts and operates in cooperation with the health-care facilities in the State of Oregon.

2. Blue Shield Plans are sponsored by physicians in the territory in which they operate.

3. Kaiser Foundation, Hospital and Health Group Prepayment Plan, operates under the Kaiser Foundation and offers health care through its Permanente clinics and hospitals.

Workmen's Compensation health-care coverage for work-related injuries and injuries and diseases is provided under plans offered by the state and private insurance companies.

Oregon Dental Service provides individual and group dental care contracts and operates in conjuction with health care facilities in the State of Oregon, employer groups, and Federal funded programs; it is sponsored by the American Dental Association and the Oregon Dental Association.

State Institutional and Non-Institutional Health Care: State Mental Health Division, Corrections Division, Vocational Rehabilitation Division, Motor Vehicle Accident Fund, Medical School, etc.

Local public health offices provide a variety of public and individual health services involving communicable diseases, occupational or radiological health hazards, maternal and infant health problems, family planning, home health, and migrant health services. Multnomah County also provides hospital services.

County mental health programs generally provide personal and family counselling services.

Private agency health associations may provide special health education, community orientation, and therapy in their individual areas of health concern (e.g. Easter Seal, March of Dimes, Kidney Association of Oregon, Oregon Tuberculosis and Respiratory Disease Association, American Cancer Society, Oregon Heart Association, Multiple Sclerosis Association.)

Federal government health programs provide care services for the health needs of special groups of persons through Office of Economic Opportunity (OEO), Veterans' Administration, Indian Health Service, etc.

Medicare, under the jurisdiction of the federal Social Security Administration, provides for health care for individuals age 65 and over. Physicians' services are provided under prepaid plans. No dental service (except for dental surgery in the hospital setting) is provided.

Medicaid (Medical Assistance Program) has been established under Federal legislation and Oregon statutes; it is administered by the State Public Welfare Division. Payments in fiscal year 1969-70 were approximately $25 million. The program can be on a prepayment basis; in Oregon a project study is being evaluated.

AUTHORITIES

State law and regulations of the Insurance Division of the State Department of Commerce control the operation of private health insurance companies, Blue Cross, Kaiser, Blue Shield, and other prepaid health plans.

Medicare and Medicaid were created by and are subject to federal law; the administration of claims for Medicare is assigned to specific insurance organizations while Oregon Medicaid is administered through the State's Welfare Division.

Oregon Revised Statutes authorize state hospitals, local public health and community mental health services.

OBJECTIVES

1. By 1973, implement Medicaid for all Oregonians qualifying as medical indigents.[1]

2. By 1973, provide for prepaid extended illness insurance for all Oregonians through private and public financial resources.

3. By 1975, provide mechanisms to finance prepaid health care insurance for all Oregonians regardless of their financial resources.

RECOMMENDATIONS AND METHODS

1. *PROVIDE ADEQUATE HEALTH CARE SERVICES FOR THE INDIGENT THROUGH PREPAID PLANS.*

   Methods

   a. *By 1971, Legislature appoint an interim committee to design procedures for instituting a prepaid medical/dental care plan (Medicaid) and develop eligibility criteria to be acted upon at the 1973 Session of the Oregon Legislature.*

   b. *Congressional delegation encourage federal legislation to finance a larger percentage of the costs of Medicaid.*

2. *SUPPORT A PROGRAM OF EXPANDED PRIVATE HEALTH INSURANCE COVERAGE TO BE TRULY COMPREHENSIVE OFFERING PREVENTIVE, CATASTROPHIC, REHABILITATIVE, HOME HEALTH, AND LONG-TERM SERVICES AT REASONABLE COSTS AND ENCOURAGE CONSUMER SUBSCRIPTION TO THESE MORE COMPREHENSIVE INSURANCE PLANS.*

   Methods

   a. *The Department of Commerce, Insurance Division, together with leaders in the health insurance industry, develop alternative proposals for providing comprehensive health insurance coverage for policy holders.*

   b. *Governor's Health Planning Committee and the State Board of Health develop plans and encourage legislation which would provide incentives to carriers to broaden the scope of coverage.*

   c. *Health Insurance Council for Community Health Action-Planning (HiCHAP) encourage health insurance industry to promote the sale of policies with a lower co-insurance feature (10% policy holder payment) and "no limit" maximums for Major Medical.*

1. Criteria for "Medical Indigency" to be determined by the Oregon Legislature.

d. *Health Insurance Council for Community Health Action-Planning encourage employers to make group prepaid health plans available to employees from time of hire.*

e. *Employment Division provide health care coverage for recipients of unemployment insurance.*

f. *Oregon Dental Service and other insurance companies develop plans and encourage consumer subscription to comprehensive dental health policies at reasonable cost.*

OPERATIONAL PROBLEMS

1. Present programs lack standardization of definitions, benefit coverage and financial support; they lack unification of administration, operation, or planning; there is a lack of purposeful and coordinated direction and goals; there is overlapping of responsibilities with some responsibilities for service uncovered and/or unavailable; reimbursement to medical care providers varies; differing billing procedures cause providers difficulty and unnecessary expense.

2. Fragmentation and differences in benefits and standards inherent in a multi-administered program generate additional costs and reduced benefits.

3. Professional organizations are reluctant to redefine their functions and allow ancillary persons to do more routine medical services. (Such programs as the dental nurse program in New Zealand and the pediatric nurse program in Colorado are innovations to lower costs, provide more services, and release professionals for more demanding functions.)

4. The public and providers have difficulty in understanding the services and benefits provided by some prepaid medical care plans.

5. To prevent hardship to persons moving from locality to locality, prepaid medical care plans should be national, statewide, or by specific groups within a state. Regardless of the method used to provide service, the service itself should be equitable nationwide.

6. Present prepaid medical care plans are incomplete as they do not provide indemnity for employment counselling, social service, and vocational training services. (Motivation to a fully productive life depends on more than the ability to obtain medical care.)

EVALUATION CRITERIA

1. Prepaid health care plans make both fiscal and program evaluations based upon cost/benefit statistics and personal satisfaction.

   a. Evaluation should be closely tied in with research into innovative methods of new technology, new procedures, new administrative methods, etc. It should encourage projects to develop improved services.

   b. Evaluation should encourage prevention of disease, thereby enabling the criteria of success to be measured by morbidity, employment, productive work, and ability to enjoy a more active and fruitful life.

2. Health Insurance Council for Community Health Action-Planning review and report on the above evaluations.

3. Insurance Commissioner determine and report on percent of people with prepaid health care coverage in Oregon.

PRIORITY

To be determined

A COMPARISON OF SIX MAJOR PROPOSALS

June 1, 1970	COMMITTEE FOR NATIONAL HEALTH INSURANCE PLAN	CONGRESSWOMAN MARTHA GRIFFITHS PLAN	SENATOR JACOB JAVITS PLAN
Concept	Comprehensive national health insurance for all Americans.	A financial mechanism to pay health care costs for all people.	A health care plan similar to Medicare. Option for employers and individuals to elect out of the government program by purchasing an approved private insurance plan.
Advocates and Supporters	The Committee of 100 for National Health Insurance. Members include: Mrs. Mary Lasker, Dr. Michael DeBakey, Whitney M. Young, Jr., Leonard Woodcock, Senators Kennedy, Cooper, and Yarborough; and other prominent leaders from health, business, labor, civil rights, and public life.	AFL-CIO; Congresswoman Martha Griffiths (D-Mich.), as legislative sponsor.	Senator Jacob Javits (R-N.Y.)
Benefit Pattern	Comprehensive personal health care with limitations on drug and dental coverage in the beginning. "Active treatment" coverage of mental health services.	Hospitalization, physician services in the office, home or hospital, extended care in nursing homes; home health services, out-patient and in-patient psychiatric services, eye exams and prescriptions, plus physicals or multiphasic screening tests.	Approved regional plans which would include preventive diagnostic, ambulatory and rehabilitative care, as well as physicians' and acute hospital treatment; also free consumer choice between competing plans where they exist.
Financing	Employer, employee, self-employed and Federal government share in the costs; projected cost in FY 1969 figures is $40 billion. Social Security-type tax on employer and employee but division of tax burden subject to union-negotiated and other employer-employee arrangements; 40% of total costs met by general Federal revenue contributions.	Employer, employee and Federal government share in cost; Payroll tax of 1% on employee earnings ($15,000 ceiling), 3% of employer payroll, .4% of self employment income ($15,000 ceiling) and a Federal general revenue contribution of 3%. Projected cost in FY 1969 figures, 37.5 billion.	Employer and employee contributions for the working group; buy-in by federal government for the needy and unemployed.
Administration	A health program administered by Department of Health, Education, and Welfare; significant operational authority vested in regional and local offices.	Department of Health, Education, and Welfare.	Private insurance companies act as fiscal agents for the government plan and as insurers and underwriters for private plans. National standards with state monitoring of insurance companies. Option exists for federally chartered corporation.
Effect on Health System Organization	Provides financial levers to restructure health delivery system. Strong emphasis on development of group practice programs. Substantial grants available to develop innovative health systems and assure availability of care in local communities.	Strong emphasis on pre-paid group practice. Requires incentives for moderating hospital charges.	Financial and technical assistance provided for planning comprehensive health service systems. Increased government financing of capital hospital construction.
Quality	High national standards for participating providers and facilities, including Board standards for major surgery and other specialist services; requirements for continuing medical education, national minimum licensure standards.	Encourage effective peer review. Forbids hospitals from discrimination in granting staff privileges.	Board standards for major surgery and other specialist services, requirements for continuing medical education, national minimum licensure standards.
Manpower	Financial support provided for systems which efficiently organize and utilize all levels of medical manpower. Special funds available to subsidize the training and initial utilization of new types of professional manpower and paraprofessional personnel.	Financial rewards to systems of care which utilize manpower effectively.	Encourage better utilization of manpower through comprehensive group practice.

Source:

U. S. Department of Health, Education, and Welfare, Public Health Service, "The CHScene", November, 1970.

FOR NATIONAL HEALTH INSURANCE

June 1, 1970	GOVERNOR NELSON ROCKEFELLER PLAN	AMERICAN MEDICAL ASSOCIATION PLAN	AETNA INSURANCE COMPANY PLAN
Concept	Health insurance purchased from private insurance companies; all Americans required to enroll in some type of plan.	A voluntary income tax credit plan.	Subsidizes private insurance companies by abolishing Medicare, Medicaid and other public programs and amending Federal tax law to provide tax disadvantages to individuals not enrolled in a private health insurance plan.
Advocates and Supporters	Governor Nelson Rockefeller of New York.	American Medical Association; similar plans introduced by Rep. Richard Fulton (D.-Tenn.) and Sen. Paul Fannin (R.-Ariz.)	Aetna and other private health insurance companies.
Benefit Pattern	Would enforce a "floor" for health coverage in employer groups; this same level of coverage would replace Medicaid for medically indigent.	Medicare would remain intact for aged, but the new "Medi-credit" plan would replace Medicaid for all people under 65; private insurance plans must qualify by providing 60 days of inpatient hospital service, plus full range of out-patient and physician services in hospital, home or office. Patient responsible for deductible and co-insurance payments.	Private health insurance companies will offer a "minium benefit package" of institutional and professional services. Custodial care could be included. Drugs, dental services and appliances are excluded. Beneficiary responsible for deductible, 20% co-insurance, and a charge per visit for professional services. (May buy supplementary policies to cover these costs, but no tax credit would be given for supplementary policies.)
Financing	Employer-employee contributions through payroll deductions for all workers; for self-employed and unemployed persons above the poverty level, full payment by individuals; for those below poverty level, government would purchase private insurance; elderly remain under Medicare.	Income tax credits for purchase of private insurance. Percentage of allowed credit based on personal income tax liability. Ranges from 100% (liability of $400) to 10% (liability over $1300). Government purchase certificates issued for family with tax liability under $400. Estimated cost to federal government $16 billion.	Federal, state and local governments pay premiums for the indigent. Social Security Administration pays premiums for over 65 population. Income tax credit given for purchase of individual policies (sliding scale with those having lower earnings obtaining greater percent credit). Lower premium rates established for indigent, disabled, aged and other high risk groups.
Administration	No change from present Medicare intermediary system; private carriers continue as they do today.	No change; Medicare continues to be handled by intermediaries; private insurers handle their own participants under age 65. Federal Health Insurance Advisory Board establishes standards for insurance carriers.	Private insurance companies (Blue Cross, Blue Shield, and commercial companies).
Effect on Health System Organization	No change.	No change.	No change.
Quality	No change.	No change.	Relaxation of Federal standards
Manpower	No change.	No change.	No change

HEALTH SERVICES

ACCIDENTS - MOTOR VEHICLE

GOAL REDUCE MOTOR VEHICLE TRAFFIC ACCIDENTS, INJURIES, AND DEATHS.

CONDITION

During 1969, there were 171,624 persons involved in 81,000 motor vehicle traffic accidents in Oregon. These accidents resulted in injury to 32,000 people and killed 713.

The state's mileage death rate for 1969 was 5.5. This compares with a national mileage death rate of 5.3. Since 1958, Oregon's mileage death rate has been higher than the national average every year, except 1968. Its population death rate of 32.3 also is higher than the U.S. rate of 27.6, and its registration death rate of 5.1, while lower than the national average, is the highest of the three Pacific Coast states.

Table 1

Mileage Death Rates

Year	Oregon	U.S. Rate
1959	6.2	5.4
1960	5.8	5.3
1961	5.8	5.2
1962	5.4	5.3
1963	6.0	5.5
1964	5.9	5.7
1965	6.4	5.6
1966	6.2	5.6
1967	5.8	5.4
1968	5.4	5.5
1969	5.5	5.3

Sources: Oregon Motor Vehicles Division and
National Safety Council

At the end of 1969, Oregon motor vehicle registrations were approaching the 1-1/2 million mark and the number of licensed drivers was 1,200,000. Studies indicate that 896 of 1,000 persons eligible to hold a driver's license are licensed

With respect to fatal crashes, the alcoholic or very heavy drinker appears to be a major part of the problem and needs special attention in future efforts directed toward reduction of fatal crashes. Based on reports received, 50% of all fatalities involve a drinking driver, many of them with levels well above the legal level for intoxication. (See Tables 2, 3, and 4) However, this type of driver does not appear to be the major factor in accidents and injuries of all types, since there is a wide variation of accident causation factors in reported accidents. The exact extent of alcohol in non-fatal, property damage accidents is not readily distinguished due to inadequate information received from drivers. Unfortunately, the public is not generally aware of the role the alcoholic plays in traffic accidents.

During 1969, there were 719 people killed in traffic accidents. Of these, 259 (36%) were tested for blood alcohol readings. The findings of those tested are shown in Table 2.

Table 2

Traffic Fatalities Tested for Blood Alcohol Readings, 1969

	Number	Percent of Total Tested	Percent of Positive Readings
Total	259	100.0	
No Reading	128	49.4	
Positive Reading	131	50.5	100.0
0.20 or More	43	16.6	32.8
0.15 - 0.19	34	13.1	25.9
0.10 - 0.14	29	11.2	22.1
0.05 - 0.09	20	7.7	15.3
0.01 - 0.04	5	1.9	3.8

Source: Motor Vehicle Division, State of Oregon

Table 3

Positive Blood Alcohol Readings by Age: Oregon Traffic Fatalities, 1969

Age	.01-.04	.05-.09	.10-.14	.15-.19	.20 or More	Total
15	-	-	1	-	-	1
16	-	2	3	-	-	5
17	1	3	4	2	-	10
18-19	-	4	1	2	1	8
20-24	2	3	10	12	5	32
25-34	-	1	4	4	13	22
35-44	-	3	3	1	7	14
45-54	1	1	2	6	10	20
55-64	1	2	-	2	5	10
65+	-	1	1	5	2	9
Total	5	20	29	34	43	131

Source: Motor Vehicle Division, State of Oregon.

During 1969, 371 drivers were killed in traffic accidents. Of these, 177 (47.7%) were tested for blood alcohol reading. The findings of those drivers tested are shown in Table 4.

Table 4

Traffic Fatalities Involving Drivers Tested for Blood Alcohol Readings, 1969

	Number	Percent of Total Drivers Tested	Percent of Drivers With Positive Readings
Total	177	100.0	
No Reading	84	47.4	
Positive Reading	93	52.5	100.0
0.20 or More	36	20.3	38.7
0.15-0.19	24	13.5	25.8
0.10-0.14	20	11.3	21.5
0.05-0.09	11	6.2	11.8
0.01-0.04	2	1.1	2.1

Source: Motor Vehicle Division, State of Oregon

CURRENT PROGRAMS AND ACTIVITIES

Oregon Traffic Safety Commission coordinates state participation in federal highway safety programs and approves project requests submitted to National Highway Safety Bureau.

Motor Vehicles Division of the Department of Transportation determines eligibility of applicants for a driver's license; determines qualifications of applicants to hold licenses based on reports of Board of Health with respect to physical conditions; maintains driver records; suspends or restricts licenses.

Oregon State Board of Health reviews reports on drivers' physical conditions submitted by medical authorities; makes reports to the Motor Vehicles Division, including recommendations based on established guidelines; determines manner of conducting chemical test analyses; conducts training courses on use of equipment; tests and certifies accuracy of equipment; issues permits to individuals to conduct tests; and develops statewide emergency medical services program.

Mental Health Division notifies Motor Vehicles Division as to released licensed operators who, in opinion of superintendent of hospital for mentally ill or mentally retarded, should not drive because of mental conditions; conducts programs to rehabilitate alcoholics.

County Medical Examiners conduct blood tests of traffic accident victims to determine blood alcohol content (voluntary).

Local Health Officers forward reports on medical referrals to State Health Officer.

Law Enforcement Agencies detect persons driving while under influence of liquor; request re-examination of questionable drivers; conduct breath tests.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1974, reduce the percentage of total traffic fatalities caused by drinking drivers from 53% in 1969 to 43%.
2. Reduce the average response time of emergency medical services to traffic accident victims.
3. Improve information base of alcohol-caused traffic accidents.

RECOMMENDATIONS AND METHODS

1. *REDUCE LEGAL BLOOD ALCOHOL LEVEL FOR INTOXICATION TO 0.10.*

   Method

   Traffic Safety Commission submit legislation during the 1971 session to reduce legal blood alcohol level for intoxication from 0.15 to 0.10.

2. *DEVELOP AND IMPLEMENT A PLAN FOR A STATEWIDE EMERGENCY MEDICAL SERVICES PROGRAM.*

   Methods

   a. *Traffic Safety Commission, in conjunction with the Department of Emergency Services and the Oregon State Board of Health, develop a plan for a statewide emergency medical communications system, incorporating the universal emergency telephone number (911).*

   b. *Oregon State Police procure a helicopter equipped for traffic control enforcement, Driving Under the Influence of Liquor (DUIL) enforcement, and emergency air transportation for victims not readily accessible to surface ambulances.*

3. *IMPROVE PROGRAMS TO COPE WITH DRINKING DRIVER PROBLEMS.*

Methods

a. *Motor Vehicles Division develop a predictability scale to determine in advance drivers who may be problem drinkers, based on study of the driving records of the Motor Vehicles Division.*

b. *Motor Vehicles Division administer the Michigan Alcohol Screening Test to drivers with certain patterns of driving behavior at the driver improvement interview.*

c. *Community Mental Health Clinics expand specialized treatment facilities for problem drinkers who drive.*

d. *Traffic Safety Commission submit legislation requiring an open-ended revocation of a driver's license, if the individual has more than two convictions within five years for driving while intoxicated. License would not be reinstated until such person had undergone successful treatment of alcohol problem.*

e. *Mental Health Division encourage voluntary use of antabuse in the treatment of alcoholism.*

4. *TRAFFIC SAFETY COMMISSION SUBMIT LEGISLATION IN 1971 TO REQUIRE ADMINISTRATION OF BLOOD TESTS TO ALL PERSONS OVER 15 KILLED IN TRAFFIC ACCIDENTS, WHEN SUCH TESTS CAN BE ADMINISTERED WITHIN FOUR HOURS. REQUIRE BOARD OF HEALTH TO FORWARD DATA TO MOTOR VEHICLES DIVISION FOR CORRELATION WITH TRAFFIC ACCIDENT STATISTICS.*

5. *TRAFFIC SAFETY COMMISSION SUBMIT LEGISLATION REQUIRING ALL SURVIVING DRIVERS IN FATAL CRASHES TO SUBMIT TO A BREATH TEST.*

OPERATIONAL PROBLEMS

1. Shortage of treatment facilities for treatment of alcoholics.
2. Shortage of trained staff to treat alcoholics.
3. Shortage of trained staff to administer Michigan Alcohol Screening Tests (MAST) in Motor Vehicles Division.

EVALUATION CRITERIA

Reduction in the rate of accidents, injuries, and deaths due to motor vehicles.

PRIORITY

To be determined.

CONSUMER PROTECTION AND INJURY CONTROL

GOAL REDUCE DEATHS, INJURIES AND DISABILITIES IN THE HOME, IN THE WORK PLACE, ON THE HIGHWAY, AND IN PUBLIC PLACES; AND PREVENT INJURIES AND DEATHS FROM CONSUMER PRODUCTS.

CONDITION[1]

Accidental injuries and deaths are "public health" problems of major significance. In terms of cost to the state, human suffering, lives lost and disabilities produced, accidental injuries and deaths rank with the leading "killer" diseases. In 1969, there were 1,361 accidental deaths in Oregon, and for the past 20 years, accidental deaths in Oregon have ranged between 1,056 and 1,401 per year with a death rate (per 100,000 population) of 60.8 to 80.6. Nationwide, accidents are the leading cause of death for individuals aged 1-44. More deaths result from motor vehicle accidents in Oregon than from all other types of accidents combined. (Table 1)

Table 1

ACCIDENTAL DEATHS BY CAUSE, OREGON, 1969

Motor Vehicle	735
Watercraft	46
Aircraft	32
Poisoning	18
Suffocation	32
Falls	194
Burns	72
Drowning	66
Firearms	19
Electric Current	15
Other Causes	132
TOTAL	1,361

Source: Oregon State Board of Health, 1969 Statistical Report.

Accidents causing death and injury cost the nation at least $25 billion in 1969. Based on this figure, Oregon's share would be $250 million. A breakdown by state of the accidental death rates for 1969 showed Oregon having the 17th highest death rate in the nation, and the 4th highest rate of increase in deaths. The National Center for Health

1. See Exhibits.

Statistics and the National Safety Council estimate that as a result of home injuries each year, 30,000 people are killed; 110,000 are permanently disabled; 585,000 are hospitalized; and more than 20 million are injured seriously enough to require medical treatment or be disabled for a day or more. Most of these casualties are associated with consumer products. A significant number could be spared, if more attention were paid to hazard reduction. The annual cost to the nation of product-related injuries exceeds $5.5 billion; however, in terms of dollars cost, pain and suffering, or by any standard of measurement, the exposure of consumers to unreasonable product hazards is excessive.

Accident reduction programs to reduce home injuries can be aimed at: 1) individual awareness, attitudes and actions; 2) the environment, where hazardous products are used; or 3) product design, construction and quality control. Significant attention has been given by both public and private agencies to the first two areas.

Attention in this report is concentrated on product design, which holds the greatest promise for reducing accidents and injuries. Manufacturers alone cannot do all that is needed to achieve optimum safety; but with government stimulation, they can accomplish more with less effort and expense than any other body; more than educators, the courts, regulatory agencies or individual consumers. The capacity of individual manufacturers to devise safety programs, without undue extra cost, has been demonstrated in such products as safety glass, double insulated power tools, baffles on rotary mowers, non-combustible television transformers, and releases on ringer washers.

There are innumerable examples of products which may be designed, constructed, or used in such a manner as to constitute an "unreasonable" hazard to the consumer, a few of which are listed here:

1. The glass door is a classic example of a product which produces an unreasonable risk and whose danger is foreseeable and avoidable. The state of Oregon is one of the few states which has recently passed an effective safety glazing law which will prevent many unnecessary injuries and possible deaths.

2. Color television sets have often caused fires in the home. Oregon, which has been averaging about 50 television fires a year during 1966-1968, reported a marked increase to 175 fires in 1969.

3. Fireworks continue to cause unnecessary injuries. Even those states which have tried to eliminate their use are handicapped by a patchwork of ineffective federal, state and local laws regulating their transportation, sale and use.

4. Floor furnace grilles account for one of every five burns to children under fifteen and are the leading cause of burns to

children under five. Because the heating unit is centrally located even adults are subjected to the hazard. Many adult burns are associated with falls, especially among the elderly or infirm. Nationally, there are between 30,000 to 60,000 medically treated burns each year.

5. Insurance companies report more claims related to glass bottles than to any other consumer product. Hospital records confirm that glass bottles consistently rank high among products connected with injuries treated in emergency clinics. At present, there is no industry-wide standard regulating bottle wall thickness or permissible number of trips for returnable bottles.

6. Infant furniture may present a variety of hazards. In cribs and playpens, too much space between the slots may be a death trap for children who catch their heads in openings which admit the body but not the skull. According to a recent study of 215 injuries involving infant furniture, the product was determined to be at fault in 2/3 of the cases investigated (84% of which involved children under 5 years old). There are no federal, state, or local rules regulating infant furniture construction or design, and the industry has no internal safety standards (although it voices a common safety policy). Unfortunately, the infant furniture industry has neglected to assess the needs and nature of children who use their products.

7. Injuries from toys often result from predictable misuse. A child can be expected to put the wrong end of a blow gun in his mouth or to dismember a doll and expose the sharp pins that secure the arms and legs. Children will continue to be exposed to unreasonably hazardous toys unless regulatory methods are improved.

8. Many football and motorcycle helmets are designed, manufactured, and marketed without careful consideration of the force of blows which should be anticipated. No state has prescribed standards for protective headgear for athletes, although some states, including Oregon, require vehicular headgear under given conditions.

9. About 70% of the injuries from power mowers are lacerations, amputations, and fractures that result from the cutting and crushing action of the fast whirling blade. In addition, there are high velocity ejections of wire, glass, stones, and debris that can puncture vital body parts. One-quarter of the 216 models recently examined did not comply with the industry's own safety standards, notwithstanding a self-certification program under which the models profess to meet standards.

The National Commission on Products Safety, following two years of study, has determined that state and local governments, in general, offer consumers little or no overall protection from hazardous household

products. The Commission recommended to the President and Congress implementation of a consumer product safety act and the establishment of an independent consumer product safety commission. The National Commission on Product Safety indicated that without central leadership the states and municipalities will remain unable to chart broad spectrum product safety programs.

Consumers assume that the federal government exercises broad regulations in the interest of their safety, and yet, in actuality, the federal authority to curb hazards in consumer products is virtually non-existent. Federal product safety legislation consists of a series of isolated acts treating specific hazards and narrow product categories. No governmental agency possesses general authority to ban products which harbor unreasonable risks or to require that consumer products conform to minimum safety standards.

In Oregon, as in some other states and cities, where consumer concerns have led to the creation of a consumer protection agency, efforts are currently directed primarily to fraudulent operations with scant attention shown to product safety. Seldom is authority exercised with regard to hazardous products beyond receiving and referring complaints.

CURRENT PROGRAMS AND ACTIVITIES

Accident prevention and injury control activities are spread over a wide range of governmental, private, and professional and voluntary agencies.

Federal Programs

The Public Health Service Injury Control Program is concerned exclusively with national problems of accidental death and injury. This is a public health field related to almost all of the medical specialties, as well as to many fields of engineering, behavioral sciences and education. The program focuses on two principal aspects of the problem: 1) prevention of the injury or accident, and 2) reduction of the severity of injuries which are incurred.

The Bureau of Medical Services provides suitable systems of emergency medical services.

Various units of the National Institute of Health conduct basic research on the biological response to injury and the effects of injury.

The Food and Drug Administration administers the Federal Hazardous Substances Act, which is closely related to injury control programs and functions. They are responsible for the prevention of accidental poisonings and consumer product safety.

The National Institute for Mental Health is responsible for programs of alcoholism and drug abuse.

The National Center for Radiological Health is responsible for establishing procedures dealing with radiation hazards.

The Occupational Health Program in the National Center for Urban and Industrial Health conducts programs designed to reduce health and injury hazards in industry.

The Department of Labor is responsible for preventing industrial accidents.

The National Highway Safety Bureau is responsible for reducing highway traffic injuries.

The United States Coast Guard is primarily responsible for preventing injury and drowning involving boats on navigable waterways.

The Atomic Energy Commission is responsible for establishing procedures for protection against radiation hazards.

The Interstate Commerce Commission investigates accidents and publishes and enforces safety regulations involving railway and motor carriers.

The Civil Aeronautics Board and the Federal Aviation Administration combine to conduct research, develop and enforce standards, and promulgate safety procedures for commercial and private aircraft.

State Programs

Accident Prevention Division, Workmen's Compensation Board is responsible for enforcing state safety laws through periodic inspections of places of employment to assure compliance with code regulations. A field force of 70 is supplemented by engineering, industrial hygiene and educational programs to reduce industrial injuries in Oregon. The Accident Prevention Division works closely with the State Board of Health, the State Fire Marshal and the Bureau of Labor.

The Department of Agriculture administers a consumer services program which enforces the federal standards on food sanitation, purity, and labeling. The Food and Dairy Products Section handles the inspection, sampling, and label checking in food and dairy processing plants, food markets, food storage warehouses, bakeries, and soft drink plants throughout the state.[1] The Veterinary Division is responsible for the inspection of livestock, meat products and meat processing plants.

1. Excludes the City of Portland, which has its own program located in the Health Department.

The state inspects the poultry slaughtered by the large producers (20,000 chickens and/or 5,000 turkeys per year). Effective January, 1971, the federal government implemented a program of inspecting all commercially sold poultry.

During past years, the State Board of Health has had a number of federally assigned accident prevention specialists working full-time on injury control programs. Currently, there is one state employee assigned part-time in accident prevention activities with the Occupational Health Section. The State Board of Health also conducts a program in occupational health responsible for reducing or alleviating those factors causing illness, disability and death of industrial workers; maintenance of an industrial hygiene and toxicology laboratory; administration of the recently adopted safety glazing law requiring installation of safety glass in hazardous areas; impaired driver program to identify and evaluate the capability of marginal drivers to safely operate motor vehicles; and implied consent program to train law enforcement personnel in detection and evaluation of drinking drivers, periodically test and certify the accuracy of equipment, and determine qualifications and competence of individuals to conduct analyses.

The University of Oregon Medical School operates a Poison Control Registry and surveillance system to determine numbers and causes of poisonings and provides consultative services for physicians. Staff is limited and funding inadequate.

The Oregon Game Commission, in cooperation with the National Rifle Association, conducts classes in firearm safety.

The Executive Department, Personnel Division employs a Fire and Safety Coordinator to promote safety in working areas among state employees.

The Executive Department, Economic Development Division receives and refers consumer complaints primarily on fraudulent business operations.

The Executive Department, Public Safety Division is responsible for consultation and planning in areas of emergency services, law enforcement and traffic safety.

The State Accident Insurance Fund provides informational and educational materials, as well as safety consultants to assist in the safety programs of state agencies and private employers insured by the State Accident Insurance Fund.

The State Fire Marshal and Bureau of Labor are responsible for conducting educational and enforcement programs in the areas of fire and electrical hazards respectively.

The Oregon Board of Education is responsible for the development of curriculum materials and providing consultation at the elementary, high school, and community college level.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1973, establish an effective statewide safety program for accident and injury control.

2. By 1973, establish an effective statewide program designed to provide consumer protection against "unreasonable" product hazards.

RECOMMENDATIONS AND METHODS

1. *DESIGN AND IMPLEMENT A COMPREHENSIVE INJURY CONTROL PROGRAM TO EFFECT A SUBSTANTIAL REDUCTION IN ACCIDENTAL INJURIES AND DEATHS. THIS PROGRAM DESIGN TO INCLUDE THE DELINEATION OF AGENCY RESPONSIBILITIES, SCOPE OF PROGRAM ACTIVITIES, AND FUNDING REQUIREMENTS.*

   Methods

   a. *The Oregon State Board of Health, in cooperation with the Workmen's Compensation Board and the Traffic Safety Commission, design a comprehensive injury control program aimed at:*

      1) *systematically interposing protective barriers between man and his environment, such as seat belts, safe storage of household poisons, protective headgear for cyclists;*

      2) *improving skills (driving automobiles and using tools);*

      3) *updating statutes and ordinances; and*

      4) *recommending home and industrial environment modifications and improving the safety characteristics of a host of agents, such as safety glazing, fire-retardant fabrics, guarded machinery, padded dashboards, and fenced swimming pools.*

   b. *The Injury Control Program should:*

      1) *Encourage research, investigations, and studies to identify the basic factors that contribute to injuries.*

2) *Develop effective public information programs to transmit injury control information down to the grass-roots level where the individuals who have accidents may be motivated, conditioned, and trained to live more safely.*

3) *Provide information for and assistance in the formulation of appropriate codes and standards at local and state levels to achieve a safer living and working environment.*

4) *Establish a specific, target-oriented concept of injury control rather than relying on broad, vaguely defined campaigns against "accidents." Each population segment can best be appealed to by using an approach aimed toward that group's particular interest.*

5) *Conduct fact-finding activities to seek additional knowledge about known injury producing hazards so that methods of control can be improved and implemented.*

c. *The Oregon State Board of Health provide support and assistance to develop accident and injury control programs at the local level through increased use of 314(d) funds.*

d. *Oregon State Board of Health establish an injury control policy committee made up of all organizational units of the state involved in injury control. The injury control policy committee to:*

1) *Review program activities.*

2) *Evaluate the effectiveness of the injury control program, especially the reduction of morbidity and mortality resulting from injuries.*

3) *Review costs, especially the costs of treating injuries and Workmen's Compensation.*

4) *Advise on coordination and utilization of community resources.*

2. *THE GOVERNOR APPOINT A TASK FORCE CHARGED WITH DETERMINING THE ROLE OF STATE AND LOCAL GOVERNMENTS IN PROTECTING THE CONSUMER FROM PRODUCT HAZARDS. CONSIDERATION SHOULD BE GIVEN TO:*

A. *PLACING BROAD RESPONSIBILITY FOR CONSUMER SAFETY FROM UNREASONABLE PRODUCT HAZARDS IN A NEWLY ESTABLISHED STATE REGULATORY AGENCY.*

B. *CHARGING THIS AGENCY WITH SECURING VOLUNTARY COOPERATION OF CONSUMERS AND INDUSTRY TO ADVANCE PRODUCT SAFETY.*

C. AUTHORIZING THIS AGENCY TO:

1) DEVELOP MANDATORY SAFETY STANDARDS TO REDUCE UNREASONABLE HAZARDS IN A WIDE RANGE OF CONSUMER PRODUCTS.

2) ENJOIN DISTRIBUTION OR SALE OF UNREASONABLY HAZARDOUS CONSUMER PRODUCTS WHICH VIOLATE FEDERAL OR STATE SAFETY STANDARDS.

3) MAKE PERIODIC INSPECTIONS AT MANUFACTURING FACILITIES TO INSURE COMPLIANCE WITH PRODUCT SAFETY STANDARDS AND REGULATIONS.

4) BRING SELECT CIVIL LIABILITY COURT ACTION AGAINST MANUFACTURERS, IN BEHALF OF CONSUMERS INJURED BY UNREASONABLY HAZARDOUS PRODUCTS.

5) ESTABLISH AN INJURY INFORMATION CLEARINGHOUSE TO COLLECT AND ANALYZE DATA ON DEATHS AND INJURIES ASSOCIATED WITH CONSUMER PRODUCTS; TO ALERT MANUFACTURERS OF NEEDED MODIFICATIONS IN PRODUCT DESIGN; AND TO INFORM THE PUBLIC ABOUT PRODUCT FAILURES, PRODUCT HAZARDS, AND NON-COMPLIANCE BY MANUFACTURERS WITH CONSUMER SAFETY STANDARDS.

6) COOPERATE WITH AND ASSIST NATIONAL AND LOCAL PROGRAMS GERMANE TO CONSUMER PRODUCT SAFETY.

3. ESTABLISH A STATEWIDE EPIDEMIOLOGIC AND SURVEILLANCE SYSTEM TO RAPIDLY AND CONTINUOUSLY OBTAIN INFORMATION ON ACCIDENTAL INJURIES AND DEATHS.

Methods

a. Oregon State Board of Health establish effective working relationships with the medical community, hospital emergency and admitting departments, law enforcement agencies, and public health officials to develop a climate in which in-depth investigations of injury producing events can be conducted.

b. Oregon State Board of Health develop procedures for evaluating information about accidental injuries and deaths to identify possible points of intervention.

4. REQUIRE THAT ALL DRUGS MARKETED IN OREGON MEET ESTABLISHED CRITERIA OF PURITY, EFFECTIVENESS, AND TOXICITY AND BE LABELED INDICATING CONTENTS.

Methods

a. The Oregon State Board of Pharmacy establish standards of purity, effectiveness, and toxicity and develop procedures

providing for laboratory analysis of all drugs marketed in Oregon to assure compliance with standards.

b. *The Oregon State Board of Pharmacy require that all prescription drugs be labeled so as to indicate their contents, except where specifically ordered deleted by the prescribing physicians.*

5. *ASSURE THAT ALL FOODS MARKETED IN OREGON CONFORM TO FEDERAL AND STATE STANDARDS OF PURITY, LABELING, AND SANITATION IN PROCESSING, STORAGE, AND MARKETING OPERATIONS.*

Method

Maintain adequate surveillance over quality of foods and meats produced in Oregon. Consumer Advisory Council of the Department of Agriculture should develop improved food and meat standards and propose legislation to assure compliance by food producers in Oregon.

OPERATIONAL PROBLEMS

The inequities in the bargaining position and resources of the small consumer in relation to the big manufacturer make it infeasible for the victimized consumer, without the aid of government, to successfully bring suit and/or in any other way apply sufficient pressure against the negligent manufacturer to induce substantial charges in the reduction of product hazards.

The "Common Law" is not primarily concerned with prospective enforcement of product safety, but with post-injury remedies. For various reasons, too complex to deal with here, application of the "Common Law" has not been effective to date in providing reliable restraints on product hazards.

Surveys conducted by the National Commission on Product Safety indicate that current state and local regulation of consumer products is limited by narrow scope, diffuse jurisdiction, small budgets, absence of enforcement, mild sanctions and casual administration. There is no funded state program for consumer product safety in Oregon.

EVALUATION CRITERIA

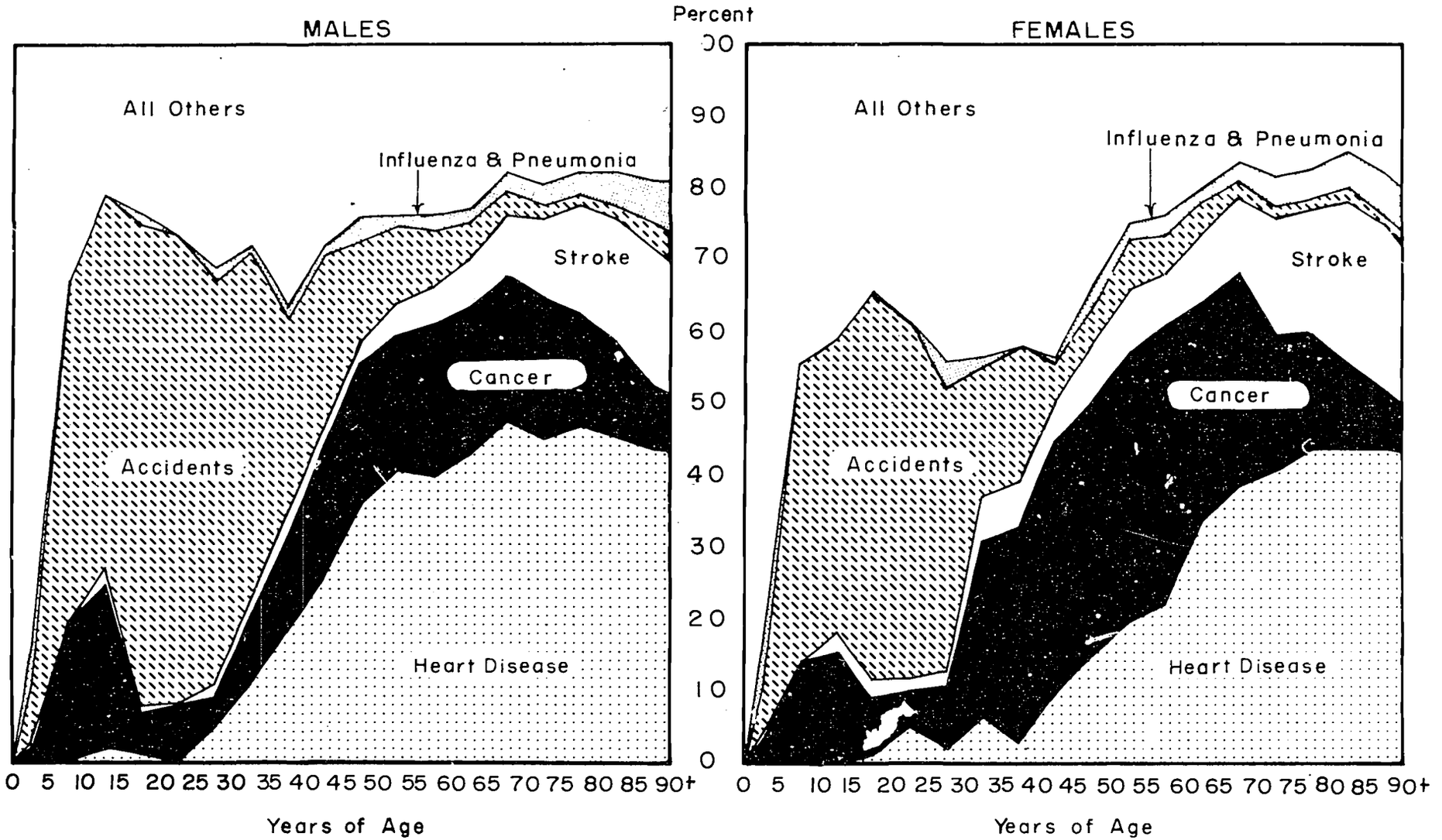
To be determined.

PRIORITY

To be determined.

EXHIBIT 1

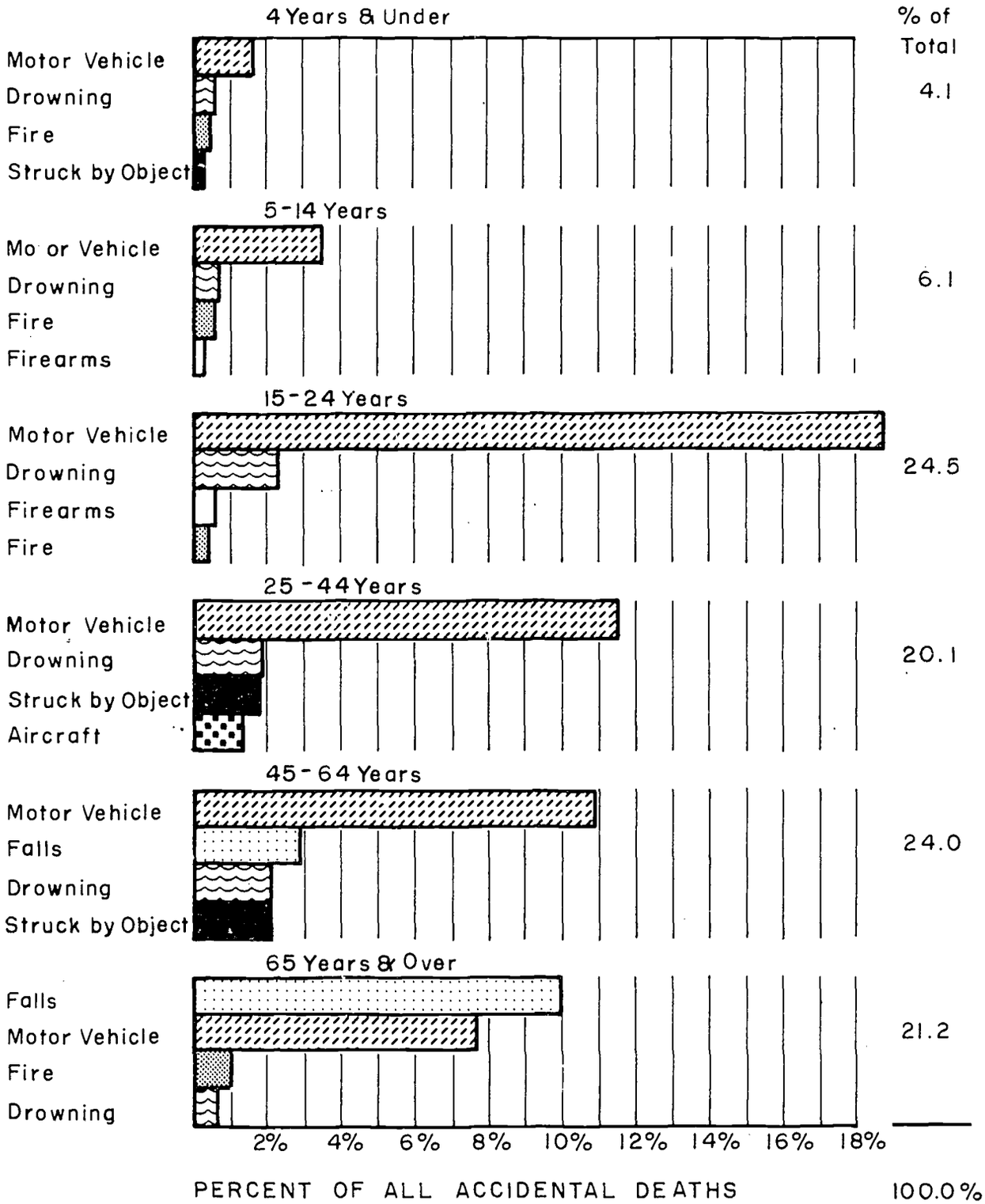
PERCENT OF DEATH FROM LEADING CAUSES BY SEX AND AGE - 1969



Source: OSBH, 1969 Statistical Report, p. 62

EXHIBIT 2

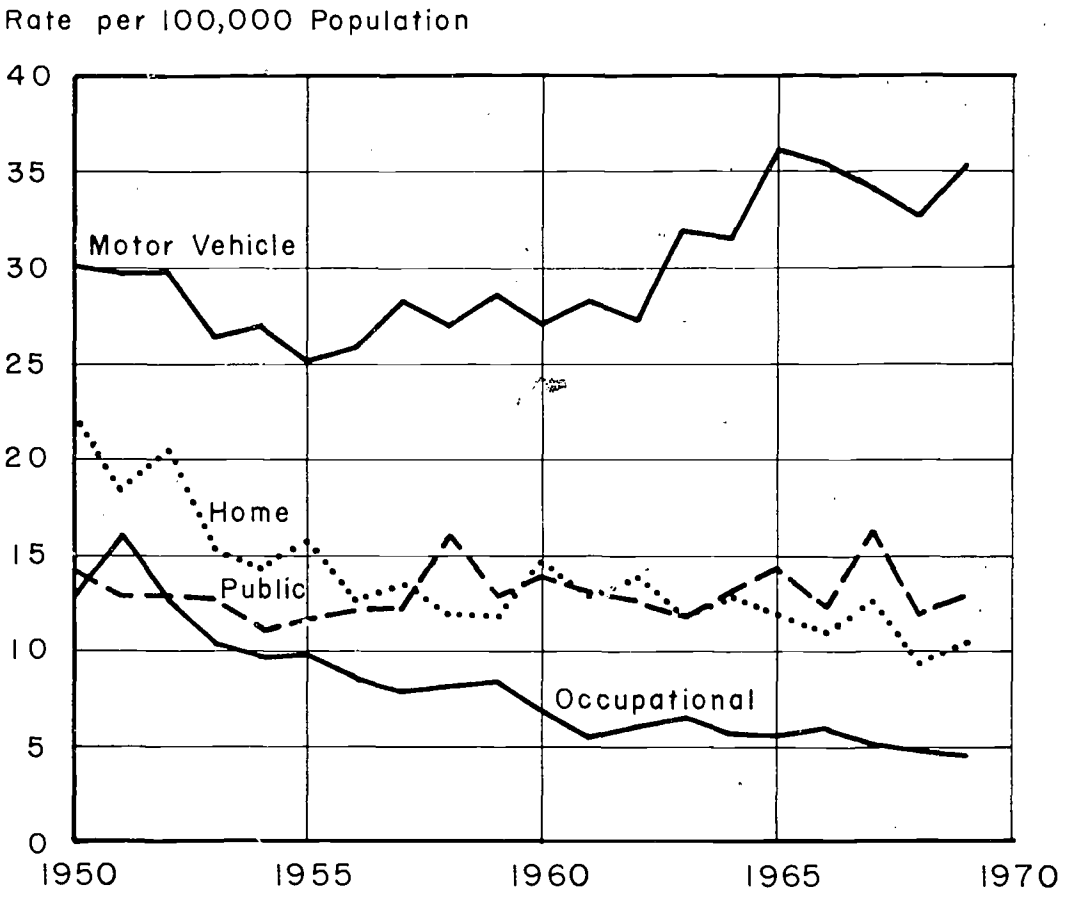
PERCENTAGE OF ALL ACCIDENTAL DEATHS BY THE FOUR LEADING SOURCES BY AGE-GROUPS, OREGON, 1969



Source: OSBH, 1969 Statistical Report, p. 96.

EXHIBIT 3

ACCIDENTAL DEATH RATES BY PRINCIPAL CLASSES
OREGON, 1950-1969



Source: OSBH, 1969 Statistical Report, p. 94.

EXHIBIT 4

ACCIDENTAL DEATHS BY TYPE OF ACCIDENT AND BY AGE GROUP, OREGON, 1969

TYPE OF ACCIDENT	TOTAL		AGE						
	Number	Rate	Under 1	1-4	5-14	15-24	25-44	45-64	65+
TOTAL	1,361	65.4	11	45	83	333	274	326	289
HOME ACCIDENTS	217	10.4	4	16	15	9	22	53	98
Falls	103	4.9	-	2	-	1	-	18	82
Fires	58	2.8	-	4	7	4	12	19	12
Suffocation, Ingestion	10	0.5	2	-	-	-	2	6	-
Suffocation, Mechanical	6	0.3	1	-	3	2	-	-	-
Poisoning - Gas	3	0.1	-	-	-	2	1	-	-
Poisoning - Other	6	0.3	-	2	-	-	1	3	-
Firearms	8	0.4	-	1	4	-	2	1	-
Drowning	6	0.3	-	3	-	-	-	3	-
Other & Unspecified	17	0.8	1	4	1	-	4	3	4
MOTOR VEHICLE	735	35.3	4	18	48	255	157	148	105
Injury to Pedestrian	87	4.2	-	1	21	9	11	18	27
Collision with Other Motor Vehicle	279	13.4	2	4	9	80	71	66	47
Other Collision	109	5.2	-	1	11	56	19	16	6
Non-Collision	223	10.7	2	7	6	99	46	43	20
Non Traffic	17	0.8	-	4	1	1	5	4	2
Unspecified	20	1.0	-	1	-	10	5	1	3
PUBLIC ACCIDENTS	266	12.8	-	11	20	58	53	66	58
Water Transportation	46	2.2	-	1	-	7	17	16	5
Air Transportation	32	1.5	-	-	-	6	17	9	-
Railway Transportation	11	0.5	-	2	-	1	2	5	1
Other Transportation	5	0.3	-	-	1	2	1	1	-
Drowning	57	2.7	-	4	10	24	8	8	3
Falls	58	2.8	-	-	2	3	2	11	40
Firearms	8	0.4	-	-	-	5	1	1	1
Other & Unspecified	49	2.4	-	4	7	10	5	15	8
OCCUPATIONAL ACCIDENTS	96	4.6	-	-	-	9	39	41	7
Logging	30	1.4	-	-	-	5	13	12	-
Manufacturing	15	0.7	-	-	-	-	8	6	1
Agriculture	12	0.6	-	-	-	-	5	4	3
Construction	13	0.6	-	-	-	2	6	4	1
Other & Unspecified	26	1.3	-	-	-	2	7	15	2
UNCLASSIFIED	47	2.3	3	-	-	2	3	18	21

All rates per 100,000 population

Source: OSBH, 1969 Statistical Report, p. 97.

EXHIBIT 5

ACCIDENTAL DEATHS BY PRINCIPAL CLASSES AND COUNTY OF ACCIDENT, OREGON, 1969

COUNTY OF ACCIDENT	TOTAL		HOME	MOTOR VEHICLE	PUBLIC	OCCUPATIONAL	UNCLASSIFIED
	Number	Rate 1/					
STATE	1,339	64.3	218	719	263	94	45
Baker	13	79.2	1	8	4	-	-
Benton	17	33.3	3	11	1	2	-
Clackamas	98	59.5	14	56	21	5	2
Clatsop	25	86.8	10	9	6	-	-
Columbia	25	82.9	3	15	4	3	-
Coos	56	97.9	11	24	15	5	1
Crook	10	102.8	2	3	4	1	-
Curry	12	91.0	1	5	3	1	2
Deschutes	18	61.6	2	10	4	1	1
Douglas	84	113.3	12	46	15	9	2
Gilliam	5	185.5	2	2	1	-	-
Grant	9	121.7	3	3	1	2	-
Harney	10	137.5	2	7	-	1	-
Hood River	3	21.2	-	2	1	-	-
Jackson	69	73.6	10	42	7	9	1
Jefferson	16	177.0	2	12	2	-	-
Josephine	23	63.9	4	14	4	1	-
Klamath	37	74.4	3	23	6	4	1
Lake	9	132.4	2	6	1	-	-
Lane	119	56.8	20	70	22	7	-
Lincoln	38	151.2	5	14	16	2	1
Linn	68	98.7	7	48	9	4	-
Malheur	20	80.3	2	11	5	2	-
Marion	90	57.8	8	57	20	2	3
Morrow	5	108.7	-	2	3	-	-
Multnomah	226	40.4	54	111	39	16	6
Polk	20	60.9	5	11	4	-	-
Sherman	8	337.6	-	4	4	-	-
Tillamook	21	117.6	2	8	9	2	-
Umatilla	36	79.3	7	17	8	4	-
Union	13	66.4	5	3	3	2	-
Wallowa	6	93.2	-	3	1	2	-
Wasco	19	88.1	4	6	5	4	-
Washington	50	34.9	5	40	3	2	-
Wheeler	4	212.8	3	1	-	-	-
Yamhill	29	70.7	4	15	7	1	2
Unknown	28		-	-	5	-	23

1/ Rate per 100,000 population

Source: OSBH, 1969 Statistical Report, p. 101.

Costs of accidents in 1969

The accidents in which the deaths and injuries occurred, together with noninjury motor-vehicle accidents and fires, cost the nation in 1969, at least

$25,000,000,000

These costs include:

Wage losses due to temporary inability to work, lower wages after returning to work due to permament impairment, present value of future earnings lost by those totally incapacitated or killed ——— $6,700,000,000

Medical fees, hospital expenses ——— $2,700,000,000

Insurance administrative and claim settlement costs (claims are not identified separately but losses for which claim payments are made are included in other items in this table—see note below) $5,300,000,000

Property damage in motor-vehicle accidents ——— $4,300,000,000

Property destroyed by fire ——— $1,952,000,000

Money value of time lost by workers other than those with disabling injuries, who are directly or indirectly involved in accidents ——— $4,000,000,000

Notes on certain accident costs

There are alternative ways of identifying certain costs of accidents. The items in the table above represent one of the ways. All measurable costs have been included, and none have been included twice. See comments below under insurance costs.

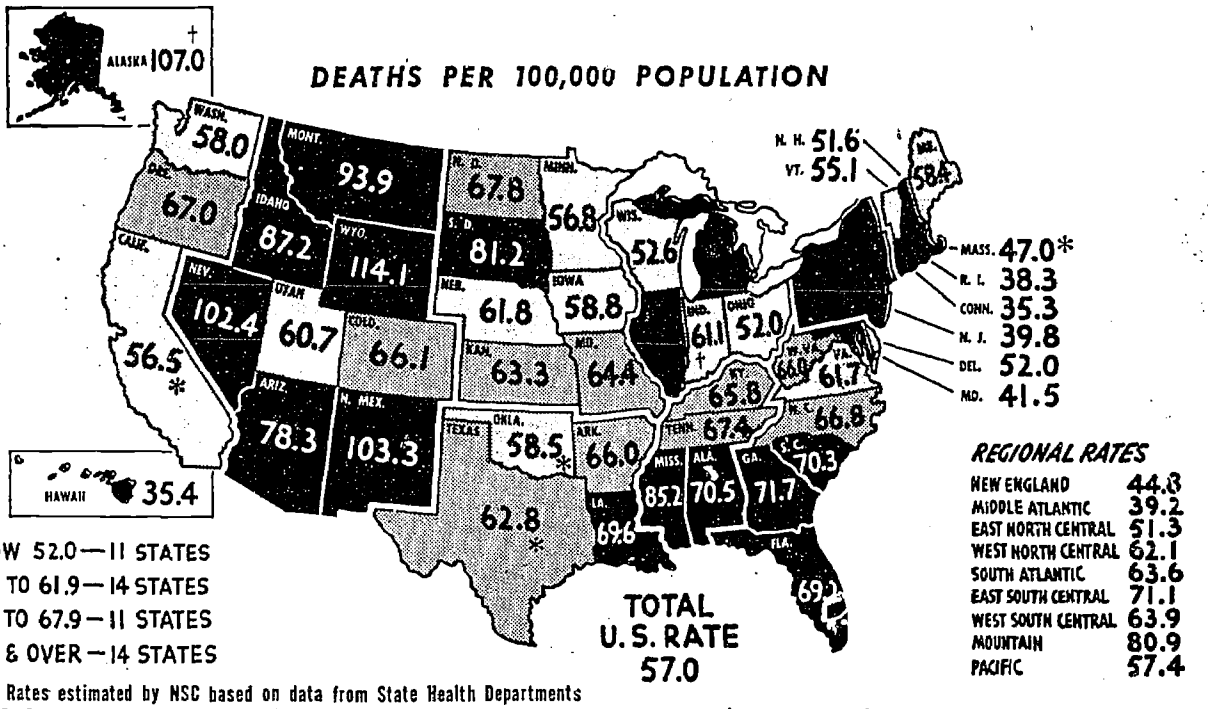
Wage losses. Loss of productivity by injured or killed workers is a loss to the nation. Since, theoretically, a worker's contribution to the wealth of the nation is measured in terms of wages, then the sum total of wages lost due to accidents provides a measure of this lost productivity. For nonfatal injuries, actual wage losses are used; for fatalities and permanently disabling injuries, the figure used is the present value of all future earnings lost.

Insurance administrative and claim settlement costs. This is the difference between premiums paid *to* insurance companies and claims paid *by* them; it is their cost of doing business and is a part of the accident cost total. *Claims* paid by insurance companies are not identified separately in the total. Since every claim is paid to a claimant for such losses as wages, medical and hospital xpense, etc., losses for which claims are paid are already included in various items in the table.

Accidental Deaths by States, 1969 and Rate Changes from 1968

State	Deaths		Death Rates	
	1969	1968	1969**	Change from 1968
Total U.S.	**115,000**	**115,000**	**57.0**	**— 1%**
Alabama	2,489	2,500	70.5	— 1%
Alaska	...	290†	107.0†	...
Arizona	1,326	1,249	78.3	+ 5%
Arkansas	1,317	1,451	66.0	—10%
California	...	10,843	56.5*	...
Colorado	1,389	1,346	66.1	+ 2%
Connecticut	1,059	1,156	35.3	— 9%
Delaware	281	274	52.0	+ 1%
Dist. of Col.	363	409	45.5	—11%
Florida	4,396	4,220	69.2	+ 2%
Georgia	3,329	3,341	71.7	— 2%
Hawaii	281	294	35.4	— 7%
Idaho	626	567	87.2	+ 9%
Illinois	5,132	5,362	46.5	— 5%
Indiana	...	3,094	61.1*	...
Iowa	1,634	1,741	58.8	— 6%
Kansas	1,469	1,340	63.3	+ 8%
Kentucky	2,128	2,291	65.8	— 7%
Louisiana	2,605	2,703	69.6	— 5%
Maine	571	582	58.4	— 2%
Maryland	1,562	1,693	41.5	— 9%
Massachusetts	...	2,558	47.0*	...
Michigan	...	4,318†	50.2†	...
Minnesota	2,103	2,111	56.8	— 1%
Mississippi	2,010	1,704	85.2	+18%
Missouri	2,995	3,005	64.4	— 1%
Montana	652	571	93.9	+15%
Nebraska	896	931	61.8	— 4%
Nevada	468	480	102.4	— 4%
N. Hampshire	370	396	51.6	— 8%
New Jersey	2,846	2,953	39.8	— 5%
New Mexico	1,027	956	103.3	+ 7%
New York	6,873	7,879	37.5	—13%
N. Carolina	3,476	3,563	66.8	— 4%
N. Dakota	417	408	67.8	+ 4%
Ohio	5,587	5,141	52.0	+ 7%
Oklahoma	...	1,486	58.5*	...
Oregon	1,361	1,251	67.0	+ 7%
Pennsylvania	4,875	5,589	41.3	—13%
Rhode Island	349	365	38.3	— 5%
S. Carolina	1,893	2,048	70.3	— 8%
S. Dakota	535	528	81.2	+ 2%
Tennessee	2,687	2,502	67.4	+ 6%
Texas	...	6,918	62.8*	...
Utah	634	596	60.7	+ 5%
Vermont	242	282	55.1	—16%
Virginia	2,883	2,810	61.7	+ 1%
Washington	1,972	2,007	58.0	—15%
W. Virginia	1,201	1,252	66.0	— 4%
Wisconsin	2,228	2,190	52.6	+ 1%
Wyoming	365	345	114.1	+ 7%
Puerto Rico‡	...	1,071	39.3*	...
Virgin Islands‡	52	48	93.5	+ 8%

Accidental death rates, by states, 1969



Source: Rates estimated by NSC based on data from State Health Departments and U. S. Census Bureau. See page 64 for map showing motor-vehicle death rates. † 1967 NCHS. *1968

10,800,000 disabling* injuries in 1969

	Deaths	*Change from 1968*	*Disabling Injuries**
	115,000	**0%**	**10,800,000**

The death total in 1969 was unchanged from 1968. Motor-vehicle and public deaths increased, while home and work deaths decreased. **See page 12 for effect of ICD Eighth Revision on 1968 and 1969 death totals.** The death rate per 100,000 persons was 57.0, down 1 per cent from 57.5 in 1968.

Principal classes of accidents:

	Deaths	*Change from 1968*	*Disabling Injuries**
Motor-Vehicle	**56,400**	**+2%**	**2,000,000**
Public non-work	52,800		1,900,000
Work	3,300		100,000
Home	300		20,000
Work	**14,200**	**—1%**	**2,200,000**
Non-motor-vehicle	10,900		2,100,000
Motor-vehicle	3,300		100,000
Home	**27,000**	**—5%**	**4,100,000**
Non-motor-vehicle	26,700		4,100,000
Motor-vehicle	300		20,000
Public†	**21,000**	**+2%**	**2,600,000**

NOTE: Deaths and injuries shown for the four separate classifications total more than national figures shown at the top of the page because some deaths and injuries are included in more than one classification. For example, 3,300 work deaths involved motor vehicles and are in both the work and motor-vehicle classifications; and 300 motor-vehicle deaths occurred on home premises and are in both the home and motor-vehicle classifications. The total of such duplication amounted to about 3,600 deaths and 100,000 injuries in 1969.

***Disabling beyond the day of accident.** Injuries are not reported on a national basis, so the totals shown are approximations based on ratios of disabling injuries to deaths developed from special studies. The totals are the best estimates for the current year; however, they should not be compared with totals shown in previous editions of ACCIDENT FACTS to indicate either year-to-year changes or trends. Exceptions are the work injury estimates, for which broad representative reporting and long established standardization of "disabling injury" give reliability to no change from 1968 to 1969.

†Excludes motor-vehicle and work accidents in public places. Includes recreation (swimming, hunting, etc.), transportation except motor-vehicle, public building accidents, etc.

Source: Accident Facts 1970 Edition

FAMILY PLANNING

GOAL EXPAND FAMILY PLANNING SERVICES TO FOSTER HEALTHY, WANTED, WELL-CARED-FOR CHILDREN IN OREGON

CONDITION

There are about 441,000 women of childbearing age among the total Oregon population of 2,050,900. These women, who could all be considered potential users of family planning services can be classified into three groups: (1) sexually active women who are at risk of becoming pregnant out of wedlock; (2) young married women who desire to delay their families or space their children until they are financially, emotionally, or physically able to assume the responsibilities of parenthood; and (3) women who have achieved their desired family size and who must control their fertility until the end of their childbearing years. Although all of the above women require the same type of family planning services, the methods used to reach and educate each of these target groups will differ.

Family planning services are available through both the private and public medical sectors. There are no estimates of the use of birth control methods prescribed by private physicians or those available from druggists without prescription. Estimates of women who seek family planning services through the public health sector, however, can be made. The Oregon State Board of Health has estimated that there are approximately 44,000 medically indigent women who would potentially benefit from use of contraceptives. During 1968, however, only 7% of this number received contraceptive care.

Traditionally the economically disadvantaged and the medically indigent women have less success in controlling contraception, as evidenced by a larger average family size among the poor. That the poor desire the same number of children as other socio-economic groups has been shown in a national fertility survey.[1] The inability of low income women to control contraception can be due in part to the inaccessibility of contraceptive services, their lack of knowledge about the more successful methods of contraception, and their inability to afford a contraceptive program.

Illegitimacy

One measure of the extent of unwanted childbearing is the prevalence of illegitimate births. During 1969, there were 33,834 live births in Oregon, of which almost 9% were illegitimate. Since 1960, the illegitimacy ratio has more than doubled from 32.6 per 1,000 live births in 1960 to 88.7 per 1,000 live births in 1969.

1. P.K. Whelpton, A.A. Campbell, J.E. Patterson. Fertility and Family Planning in the United States. Princeton, N.J., Princeton University Press, 1966.

Table 1

RESIDENT ILLEGITIMATE BIRTHS AND RATIOS, OREGON AND THE UNITED STATES

	Oregon		United States	
Year	Number	Ratio per 1,000 births	Number	Ratio per 1,000 Births
1960	1,250	32.6	224,300	52.7
1961	1,433	38.2	240,200	56.3
1962	1,499	40.5	243,100	58.8
1963	1,708	49.0	259,400	63.3
1964	1,754	52.4	275,700	72.5
1965	2,094	63.5	291,000	77.4
1966	2,330	71.8	302,400	83.9
1967	2,478	78.8	318,000	90.3
1968	2,831	88.1	339,200	96.9
1969	3,000	88.7		

One-half of the illegitimate births in Oregon were to women under age 20. The young age of these mothers, their lack of adequate medical care during pregnancy, the increased abuse of drugs among the young and the tendency for certain youth groups to have their babies at home without proper medical attention all lead to increased health problems for both the mother and the newborn. National data have shown that illegitimate babies more often are of low birth weight and have a greater risk of congenital problems than do legitimate babies.

Compounding the problem of illegitimacy in Oregon is the scarcity of comprehensive health education programs in the schools. Few school districts offer courses in sex education or responsible adulthood.

CURRENT PROGRAMS AND ACTIVITIES

Family planning activities in Oregon can be divided into community education and medical services. Most of the contraceptive care is provided by the private physician, however, several public clinics are available to women of low socio-economic status. A summary of the ongoing activities in family planning are outlined below. A detailed description of family planning services in Oregon is available from the State Comprehensive Health Planning agency.

The Oregon State Board of Health provides family planning consultation to local health departments and other community groups. The staff assists local areas in establishing public education programs and

conducts workshops for the training of local clinic physicians, nurses, and other allied medical personnel in the family planning concept. In addition, the Board allocates Health, Education, and Welfare (HEW) funds to local health departments for the creation and operation of family planning clinics.

Local Health Departments in the following counties have specialized family planning clinics: Benton, Clackamas, Clatsop, Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lane, Lincoln, Marion, Multnomah (three clinics), Polk, Umatilla, Union, Washington, and Yamhill. Contraceptive information and devices are given and the following procedures are included as a routine part of the clinic services: (1) complete physical examination, including pap smear; (2) serology for syphilis identification; (3) gonorrhea smear if indicated; (4) bloodwork and urinalysis; (5) nutrition counseling; and (6) public health nurse follow-up.

All local health departments conduct educational programs in family planning. The extent of these programs is determined, for the most part, by the staff and funds available. As an example of expanded community education, the Marion County Health Department has recently initiated a family planning information service on the maternity ward at Salem Hospital, General Unit. The program is conducted by the registered nurses on the maternity ward as a routine part of their nursing care to mothers during their postpartum confinement. Those women desiring more information are referred to their private physician or the local health department.

The Department of Education prepares state guidelines for the health curriculum in public schools. Each school district, however, has the responsibility for determining what will be included. Some school districts have outlined family planning courses in their curriculum.

The Public Welfare Division is required by law to provide family planning information to all welfare clients requesting such information. If a woman desires contraceptives, the case worker either arranges for a physician visit, with Welfare paying the cost of the care, or refers the woman to the public health nurse.

The Office of Economic Opportunity in Marion and Polk counties, the Mid-Willamette Valley Community Action Program, has established an extensive public education and family planning referral program for low income women. Family planning aides work in the community and arrange appointments with the local health department for women desiring contraceptives.

There are four Planned Parenthood Associations in Oregon, one each in Portland, Lane, Benton, and Jackson Counties. The Associations, working closely with the local health departments and private interested groups in the community, provide counseling and public education programs on

contraceptive methods and make referrals for contraceptive care. Since the passage of the liberalized abortion law in Oregon, Planned Parenthood has expanded its activities to include abortion referral to all women seeking therapeutic abortions. The Planned Parenthood Association in Portland conducts family planning clinics in two locations in the city. These are staffed by paid and voluntary medical personnel and provide services to low income women; pregnancy testing and counseling is being added to the program. From January through September, 1970, the Portland Planned Parenthood clinics have seen a total of 3,593 individual patients with 9,606 patient visits.

The University of Oregon Medical School and the Multnomah County Hospital in Portland conduct family planning services as part of their outpatient obstetrical-gynocology services. Emanuel Hospital conducts a Maternal and Infant Care project and provides family planning counseling to eligible low-income women as part of their program for comprehensive pre and postnatal care to high-risk mothers.

Pregnancy testing for women in Portland is conducted at Outside-In and the People's Clinic. Although these organizations do not conduct formal family planning programs, they do refer women to the Planned Parenthood or the Multnomah County Health Department clinics for ongoing contraceptive counseling.

The Teen Mothers - Teen Parents Program, sponsored by the Young Women's Christian Association (YWCA), in conjunction with several other community agencies in Salem, is a comprehensive counseling, education, and pre and post natal care program for teenage mothers, both married and unmarried. Family planning counseling is included among their services to young mothers. When indicated, referrals are made to the local health department clinic for family planning medical services.

The Sex Information Education Council of the United States (SIECUS) is a national organization to assist state and community groups in planning sex education courses. The organization offers professional consultation to interested groups through planned study groups in the local areas. In addition, SIECUS publishes a periodic newsletter.

American Organization of Sex Educators and Counselors was created to lend assistance in sex education curriculum development and teacher training. The organization is planning to establish a chapter in Oregon in the near future.

The Abortion Information and Referral Service is a non-profit corporation established in March of 1970 to provide a central source where Oregon women seeking legal abortions can receive necessary legal, medical, and practical information, as well as human support.

Two full-time employees and about 40 trained volunteers operate the office located at Westminister Presbyterian Church in Portland. Statewide referrals for abortion are provided free of charge. Inquiries to Abortion Information and Referral Service have averaged about 220 per month.

AUTHORITIES

Oregon State Board of Health - Statutory
Public Welfare Division - Federal Statutory
Office of Economic Opportunity - Federal Statutory

OBJECTIVES

1. Make family planning information available to all Oregonians by 1973.

2. Expand family planning clinic services in Oregon so that by 1975 all medically indigent women have access to free contraceptives, examinations, and counseling.

3. Reduce the illegitimacy ratio in Oregon 25% by 1975.

4. Insure that by 1975 all women who seek a therapeutic abortion and all men and women who desire voluntary sterilization are able to do so regardless of financial status.

RECOMMENDATIONS AND METHODS

1. *ESTABLISH COMPREHENSIVE HEALTH EDUCATION PROGRAMS IN RESPONSIBLE ADULT LIVING IN ALL OREGON SCHOOLS.*

   Methods

   a. *Oregon State Board of Education and State Board of Health develop a standard curriculum for sex education in Oregon schools.*

   b. *State Board of Education require that sex education courses be included in the curriculum of all Oregon schools.*

   c. *Board of Education establish regular training sessions for health teachers, giving special emphasis to the teaching of sex education courses. Teaching assignments for sex education courses should be voluntary and the teachers should be thoroughly qualified.*

   d. *Board of Higher Education, in cooperation with the universities and schools of nursing, require courses in family planning for all health professionals.*

e. *The Council of Churches be encouraged to include sex education courses in their young adult and teen programs.*

f. *Community and other colleges be encouraged to include sex education in adult continuing education programs, so that parents can create an educational climate where relevant sexual responsibility can be taught.*

g. *Public health educators from the state and local health departments and/or Planned Parenthood Association act as consultants to schools, professionals, churches, and other interested groups in establishing comprehensive programs for family planning education. Community education programs should utilize all mass media to publicize family planning.*

2. *EXPAND COUNSELING SERVICES FOR THE SEXUALLY ACTIVE TEENAGER.*

Methods

a. *The Mental Health Division, in conjunction with the Oregon State Board of Health, sponsor a workshop session for guidance counselors in the public schools to train them in the counseling of sexually active youths and to inform them of the services available to youth in the state and their local communities.*

b. *School guidance counselors establish a formal referral system to locally available community services for youth, including Planned Parenthood and the Abortion Information and Referral Service.*

3. *MAKE FAMILY PLANNING INFORMATION AVAILABLE TO ALL APPLICANTS FOR MARRIAGE LICENSES IN OREGON.*

Method

Oregon State Board of Health encourage county clerks to display and distribute family planning information supplied by the local health department or the Planned Parenthood Association upon application for marriage license.

4. *MAKE FAMILY PLANNING INFORMATION AVAILABLE ON ALL MATERNITY WARDS IN GENERAL HOSPITALS IN OREGON.*

Method

Local health departments and Planned Parenthood Association provide leadership in the development of workshop sessions in family planning education for all maternity ward nurses, and programs for family planning counseling as a routine part of postpartum nursing care.

5. *EXPAND FAMILY PLANNING CLINIC SERVICES TO ALL OREGON COUNTIES.*

Methods

a. *Oregon State Board of Health provide funding to local health departments for the establishment and operation of family planning clinics.*

b. *Oregon State Board of Health, in conjunction with Oregon Medical Association, establish itinerant clinics to provide health services, including family planning services, to counties without full-time health departments.*

c. *Local health departments provide pregnancy testing and genetic counseling as part of comprehensive clinic services to clients of family planning clinics.*

6. *INCREASE ACCESSIBILITY OF THERAPEUTIC ABORTIONS FOR WOMEN WHO DESIRE TO TERMINATE THEIR PREGNANCY. THERAPEUTIC ABORTIONS SHOULD BE PROVIDED ON A SLIDING-SCALE FEE ACCORDING TO ABILITY TO PAY.*

Methods

a. *University of Oregon Medical School, in cooperation with the Oregon Medical Association, study the feasibility of reducing or eliminating unnecessary inpatient care for therapeutic abortions.*

b. *Oregon Medical Association and the Planned Parenthood Association submit legislation allowing abortions to be performed in approved clinics (hospitals required now).*

c. *Health insurance carriers be encouraged to provide coverage for therapeutic abortions for the married and unmarried at the option of the subscriber.*

7. *INCREASE ACCESSIBILITY TO VOLUNTARY STERILIZATION.*

Methods

a. *Family planning clinics provide information and counseling on voluntary sterilization as a method of birth control.*

b. *Health insurance carriers in Oregon be encouraged to provide coverage for vasectomies and other sterilization procedures at the option of the subscriber.*

OPERATIONAL PROBLEMS

1. Insufficient staff and funds at the local level to establish or expand family planning programs.

2. Lack of trained health educators adept at community organization.

3. Citizen opposition to sex education.

4. High costs of therapeutic abortions.

5. Legal impediments to performing therapeutic abortions outside of hospitals.

EVALUATION CRITERIA

Successful expansion of family planning services in Oregon can ultimately be evaluated by observing a decrease in completed family size, as well as through reported statistics on: (1) increased family planning services to the medically indigent; (2) decreased illegitimacy ratio; (3) increased number of therapeutic abortions; and (4) increased number of voluntary sterilizations.

PRIORITY

To be determined.

NUTRITION

GOAL IMPROVE THE NUTRITION OF ALL OREGONIANS

CONDITION

Good nutrition is essential to the promotion of optimal health and the control of disease. Even in our affluent society, nutritional deficiencies abound and are not restricted to poverty groups.

Inadequate diet has a profound effect on the health and well being of individuals. Studies have indicated that malnutrition at any time during the life cycle can lead to serious problems in metabolism and growth, can impede learning and can contribute to dental problems. Because malnutrition is not a reportable condition, accurate statistics on the number of Oregonians who are malnourished are not presently available. In the future, however, more efforts will be made to collect accurate nutrition data through university studies and the Oregon State Board of Health. Local health departments have been asked to report the number of public health nursing visits for malnutrition. Although these figures will underestimate the problem, they will help to identify various geographic areas and population groups needing immediate attention.

Indications of malnutrition commonly used are: infant mortality, incidence of tuberculosis, and death rates of cardiovascular disease, diabetes, and renal disease.

In 1969, there were 592 deaths in Oregon of infants under one year of age resulting in an infant mortality rate of 17.5 per 1,000 live births. The United States' rate was 21 per 1,000 live births. Of the 36 Oregon counties, 15 had infant mortality rates above the state average. The counties with the highest rates included: Coos (25.5), Douglas (26.3), Klamath (24.5), Union (38.7), and Yamhill (24.2).

Chronic diseases such as diabetes, cardiovascular-renal diseases, and tuberculosis have important interrelationships with nutrition. During 1969 there were 10,540 deaths due to these chronic conditions for a rate of 506 per 100,000 population. About 54% of all the deaths in 1969 were attributed to these chronic conditions.

Another frequently used indicator of malnutrition is low socio-economic status. In March, 1970, an average of 97,724 persons were receiving public assistance. In addition, there were 64,422 low-income but non-welfare persons eligible for the federally subsidized food programs. Therefore, a minimum of about 160,000 Oregon citizens were in need of public assistance.

Also affecting the nutritional status of all Oregonians is lack of laws relating to enrichment and fortification of foodstuffs produced and sold in the state. There is no way to assure that bread and flour are enriched with thiamin, niacin, riboflavin, and iron; that milk is fortified with vitamins A and D; or that iodine is added to salt.

National Data

A comprehensive survey to assess the nutritional status of people in the United States is in progress. Preliminary results from a 10-state sample of low-income families indicated that: (1) one-third of the children under six had hemoglobin levels diagnosed as anemia and requiring medical attention; (2) one-third of the children under six had less than adequate serum levels of vitamin A; (3) 19% of the people had low levels of urinary riboflavin; (4) 9% had low levels of urinary thiamin; (5) serum vitamin C levels were less than adequate in 12 to 16% of all age groups; (6) 16.3% of all people surveyed had less than adequate serum protein levels; (7) 96% had 10 teeth decayed, filled, or missing; and (8) adults examined had 6 times as many decayed and unfilled teeth as the average American.

More recent data from the Louisiana sub-sample of the survey indicated that among 3,000 individuals in the sample: 16% had unacceptable vitamin C blood levels; 30% had unacceptable vitamin A blood levels; and 44% had unacceptable hemoglobin blood values.

State Data

A few recent studies have been made to evaluate the nutritional level of Oregonians. The Oregon State Board of Health conducted a diet intake and nutrition study in 1969 among migrant children in Polk County. The study indicated a problem of low vitamin A and C blood levels and a low intake of fruits and vegetables, despite the fact that there is an abundant supply of these foods in Oregon at reasonable costs. A similar study of 157 low income elderly residents of Polk County conducted from January 1969 to April 1970 showed that half of the diets were poor. Vitamins A and C, calcium, and riboflavin were the nutrients most often deficient.

A 1965-8 study of 400 low-income pregnant women in Portland showed that 61% of the diets were poor. The nutrients most often lacking were calcium iron, and vitamins A and C. One-fourth of the women had diets low in protein; 39% had anemia when they first came to the clinic for care.

A 1967-8 study of preschool children in a low income Portland area showed 25% of the diets to be low in protein, 36% low in iron, 53% low in vitamin C, and 30% low in vitamin A.

CURRENT PROGRAMS AND ACTIVITIES

Food Assistance Programs provide low income households access to more food than their budget could otherwise provide.

In the Food Stamp Program, low income households, certified to be eligible by the Public Welfare Division, receive stamps which can be used as cash at grocery stores. Participating counties are Baker, Grant, Josephine, Multnomah, Washington, and Yamhill.

In the Abundant Food Program, certified low income households can receive a variety of nutritious foods such as cheese, canned meat, and flour from county distribution centers. All counties, except those in the Food Stamp Program participate.

In the Infant Foods Program, those certified low income households with infants under one year of age are entitled to receive additional foods for the infant. Participating counties are Baker, Deschutes, Grant, Lane, Marion, Polk, and Umatilla.

In the Supplemental Foods Program for High Risk Groups, pregnant and nursing mothers and children under six years of age, from low income households are eligible for foods in addition to those provided through the Abundant Food or Food Stamp Programs. Local county health departments must certify that specific symptoms of poor health bordering on malnutrition are present. Participating counties are Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Douglas, Gilliam, Hood River, Jackson, Jefferson, Lincoln, Linn, Malheur, Morrow, Sherman, Tillamook, Union, Washington, and Wheeler.

The nutrition consultants at the Oregon State Board of Health are responsible for the quality of the nutrition component of all health programs conducted and/or financially supported by the Oregon State Board of Health.

In addition, they point out unmet nutritional needs and serve as the public health nutrition resource of the state, providing information and materials to professional people including physicians, nurses, teachers, social workers, librarians, as well as the public on both normal and therapeutic nutrition. The Oregon Diet Manual, which is kept current and provided to all hospitals, nursing homes, and health departments in the state, is an example of this service. Nutritionists cooperate with local health departments and with other public and private agencies to improve nutrition services in Oregon.

Once a year the nutritionists price the cost of low income food budgets and modified diets. These figures are offered to Public Welfare and other agencies for their use.

Currently, nutrition consultants from the Maternal and Child Health Section are employed in the following special programs:

Inborn Errors Program tests all newborns in the state for a number of inborn errors of metabolism. As modified diet is the only known treatment, the nutritionists plan diets and assist the family, physician, and the public health nurse to provide adequate dietary management. Direct service is given by the nutritionist not only in carrying out the dietary plan, but in the preparation of materials explaining the diet.

The Child Development Clinics in Clackamas, Washington, Polk, and Yamhill Counties utilize nutritionists as a team member of the staff. The nutritionist makes recommendations for improving the diet and encouraging good food habits. In selected cases she continues to work with the families. She meets with parent groups to discuss common nutrition problems such as obesity.

The Maternal and Infant Care Project conducted by the Oregon State Board of Health at Emanuel Hospital for low income women in the Albina and St. Johns sections of Portland employs a nutritionist and a home economist. Mothers are counseled on how to meet the nutritional needs of pregnancy and lactation and how to feed their infants. The home economist assists families with budgeting, food buying and preparation, and general home management. During 1965-70, 2,100 patients were admitted to the project. The nutritionist and the home economist work in the community to assist with nutrition problems of low income families and to cooperate with other groups in attempting to find solutions.

The nutrition consultant in the Chronic Disease Section stimulates development of and participates in educational programs for health professionals (physicians, nurses, dietitians), subprofessionals (nurses' aides, home health aides, food service personnel), and the community, as nutrition relates to the chronically ill and the aged. Programs are centered primarily around diabetes, obesity, heart disease, arthritis, renal disease, and other conditions having a nutrition component.

The nutritionist in the Health Facilities Licensing and Certification Section provides consultation to facilities certified by Medicare to improve dietary services. Lack of time and money limit the availability of this help to Oregon's licensed but non-Medicare certified facilities.

The nutrition program of the local health departments includes the promotion of good normal nutrition as well as the interpretation of therapeutic diets ordered by physicians. Since only one county (Multnomah) has a staff nutritionist, consultants from the Oregon State Board of Health give nutrition assistance as needed. The programs include food selection and buying, promotion of better nutritional health for pregnant women, infants, and children, school children, families with low income, the ill, and the elderly. Many local health departments have home health aides who assist the nurses in giving home care to the sick.

In counties with the Supplemental Foods Program for High Risk Health groups, health departments are responsible for certifying individuals for the supplemental food programs.

The Public Welfare Division provides money for food for recipients of Aid to Dependent Children, General Assistance, Foster Home Care, old age assistance, aid to the blind, and aid to the disabled. Welfare reimburses county governments for 70% of the expenses of the Abundant Food Program and maintains the income guide and eligibility rolls for persons qualifying for the Food Program and maintains the income guide and eligibility rolls for persons qualifying for the family food assistance programs.

The Oregon Board of Education and the public schools in the state are charged, by law, with the responsibility of health education in the schools. Nutrition is a part of the planned health curriculum. High schools which offer vocational education in Home Economics and/or health-related careers include courses in nutrition as a part of these curriculums.

Several of the community colleges, in cooperation with the Oregon Dietetic Association and the Oregon State Board of Health, are offering courses in food service careers and health-related careers such as Practical Nursing; nutrition is one of the subjects taught.

The Oregon Board of Education administers the federal assistance available to local school districts for school food service programs. This assistance is in the form of cash reimbursement for the school lunch, school breakfast, and special milk programs, and the distribution of foods provided by the U.S. Department of Agriculture for schools. The School Food and Nutrition Services of the Oregon Board of Education also provides professional guidance to local districts in improving the administration and operation of the food services programs, in conducting or sponsoring workshops and adult education courses for school food service supervisors or managers on projects to integrate school food service more closely into the total educational program. New amendments to the National School Lunch and Child Nutrition Acts provide funding through grants for nutritional training for workers, cooperators, and participants in these programs and for surveys and studies of requirements for food service programs.

Nutrition education programs in Oregon schools have been limited in scope and effectiveness because most teachers who teach nutrition units in health education do not have an adequate background in nutrition. In addition, the supply of nutritionists who are trained to teach is limited.

The colleges and universities, under the Oregon Board of Higher Education, provide professional and preprofessional education for students entering nutrition-related health, education, and food handling fields. The University of Oregon Medical School and Dental School include a nutrition component in their professional curriculum. Undergraduate and graduate degrees in nutrition and in dietetics are offered at Oregon State University. A dietetic internship program is conducted at the University of Oregon Medical School.

University faculty serve as resource personnel for consultation. In addition, both the medical and the dental schools of the University of Oregon conduct nutrition clinics where dietitians are available for personalized nutrition counseling. The clinics also participate in research and surveys on nutrition in the hospital and community.

Nutrition research studies at Oregon State University focus on the determination of human nutrition requirements and the role of food in maintaining optimum health. Related programs deal with research in the economics, production, selection, preparation, and preservation of food to ensure maximum nutritional quality and food safety. A Nutrition Research Institute has been established at Oregon State University to promote effective teaching and research in the broad field of nutrition and encourage collaboration and cooperation among the several disciplines concerned with nutrition. Research in the basic sciences is also conducted at the University of Oregon, the Medical School, the Dental School, and at the Oregon Regional Primate Research Center. Results of these investigations contribute to an understanding of the role of nutrients in body functions.

The Cooperative Extension Service is involved in nutrition education for all Oregonians. Extension agents located in 33 counties, food and nutrition specialists and trained aides and volunteers are involved in teaching nutrition and related skills needed to implement proper nutrition. These skills include meal planning, food buying, food preparation and storage, preservation, and sanitation. Nutrition-related skills are taught through: special county programs for all citizens with high priority given to young homemakers and low income mothers; specially funded programs for low income families, including the expanded food and nutrition program funded by the U.S. Department of Agriculture in Lane, Malheur, Multnomah, Umatilla, Yamhill, and Polk Counties; 800 study groups, involving 20,000 homemakers throughout the state, who meet regularly to study various home economics topics including nutrition; education progra s for abundant food recipients; 4-H youth groups, involving 9,000 youngsters and 600 adult leaders, in food and nutrition projects; correspondence courses reaching 1,100 young homemakers; and releases to the mass media.

The State Office of Economic Opportunity provides basic foods and medical services, on a temporary basis, to counteract conditions of starvation and malnutrition among the poor. The following Community Action Programs have emergency food grant monies: Columbia County, Jackson County, Coos-Curry Counties, Eastern Oregon Community Action Program (Union, Baker, and Wallowa Counties), and Blue Mountain Community Action Program (Umatiila and Morrow Counties).

The Oregon Dairy Council is a non-profit nutrition education organization whose purpose is to promote optimum health through use of a balanced diet in accord with current scientific recommendations. Home economists

and nutritionists conduct normal nutrition education programs, including workshops for elementary school teachers, and provide teaching aids for leaders in professional, educational, and consumer groups. The Dairy Council works closely with other professional groups in providing speakers and programs.

The purpose of the Nutrition Section of the Oregon Home Economics Association is to initiate and/or participate in local nutrition programs. Plans at this time are to coordinate all efforts through the Oregon Nutrition Council (see below). Specifically, efforts are being made to enlist support of home economists in home-making groups for nutrition programs at the community level; especially promotion of nutrition education for the general consumer in retail stores.

The Oregon Nutrition Council, a voluntary group of interested professionals, was established to promote the nutritional well-being of the people of Oregon. Representation on the Council includes nutritionists, health personnel, educators, and other interested individuals and groups. The objectives of the Council are to: (1) become better informed on current developments in nutrition, research, legislation, and education; (2) provide a means for council members to share information on current nutrition programs and existing nutrition problems through exchange of information and materials by council members; (3) explore and suggest areas of needed study, research, and action related to nutrition in Oregon; (4) acquaint agencies, organizations, and institutions working in health related areas with the important part nutrition plays in maintaining health and to provide representation from the nutrition area in health planning at state and local levels; (5) promote effective nutrition education through cooperation and coordination of the efforts of individuals, agencies, institutions, and organizations engaged in nutrition related programs; (6) further nutrition education in the state by sponsoring conferences, workshops, institutes, and other activities; and (7) provide an opportunity to identify, understand, and act upon the social, economic physiological, political, cultural, and psychological forces that prevent or enhance the adoption of sound nutritional practices.

Oregon Dietetic Association promotes nutrition education through projects of its district or State Community Nutrition Sections, Education Sections, and Diet Therapy Sections. Members of the association are nutrition resource people in their local communities. Pertinent programs of the Association are to:

1. Develop, in cooperation with other agencies, the food service managers course at Portland Community College. (Other community colleges are working toward development of similar courses.)

2. Provide continuing education opportunities for State dietitians. (The American Dietetic Association has recently established a registration program which requires that each Dietitian complete 75 hours of continuing education in each 5-year period in order to be a Registered Dietitian.)

3. Operate the Dial-A-Dietition Program in Portland. By calling a well-publicized number, the public can obtain answers to questions concerning nutrition.

4. Offer community education programs on modified diets; "Without a Grain of Salt" and "Without a Spoon of Sugar", programs about salt-restricted diets and diabetic diets are offered free to the Portland community. These are also being promoted in other communities.

In January, 1970, Loaves and Fishes, Inc. was formed under the sponsorship of the City-County Council on Aging, Portland, with the purpose of offering a nutritious noon-day meal program for the elderly. Four centers located at various churches in Portland are in operation. Financing has been through donations from individuals and churches. A request has been made for an Office of Economic Opportunity grant under the emergency food and medical program. The program is on a "pay as you are able" basis, with the average being about 50 cents per meal. This covers the cost of the food but not the cost of the cook. The cooks are paid but all other services are provided by volunteer workers.

Because of the role of nutrition in its effect on cardiovascular disease, the Oregon Heart Association conducts professional and public education at all age levels; it also provides educational services, in cooperation with other organizations and institutions. It sponsors workshops, seminars, conferences, demonstrations, and meetings pertaining to nutrition and diet. In addition, the Association distributes numerous pamphlets and booklets to physicians, patients, families of patients, schools, and the general public. It also supports studies and research in nutrition to acquire scientific knowledge.

Oregon Council on Hunger and Malnutrition is a volunteer concerned citizens group trying to focus political and social action to achieve their stated purposes: "To assure every Oregon family an adequate diet."

AUTHORITIES

The following agencies have statutory responsibility for nutrition: Oregon State Board of Health, local health departments, Public Welfare Division, Oregon Department of Education, and Cooperative Extension Service.

OBJECTIVES

1. By June, 1973, develop a state nutrition policy that will insure optimum nutrition for all Oregonians.

2. By 1973, establish a comprehensive nutrition education program to reach all Oregonians.

3. By 1975, expand food programs and nutrition services so that all Oregonians, regardless of socio-economic status, will have access to adequate food and knowledge to select well-balanced diets.

RECOMMENDATIONS AND METHODS

1. *ESTABLISH A NUTRITION TASK FORCE TO DEVELOP A LONG-RANGE PLAN FOR THE STATE.*

   Method

   The Governor's Health Planning Committee establish a standing committee on nutrition. Membership on this committee should be drawn from the public and private health sectors, the Legislature, educators, nutrition experts, and other groups concerned with nutrition such as community action agencies and minority groups. The committee will be charged to develop a comprehensive nutrition plan, make recommendations to achieve a high nutritional level for all Oregonians, and recommend appropriate legislation required to achieve this. This committee will be further charged with the coordination of the overall nutrition program, the conduct of periodic reviews to eliminate omissions and duplications, and improve overall quality of nutrition programs.

2. *DEVELOP AND IMPLEMENT A COMPREHENSIVE, ONGOING DATA COLLECTION SYSTEM FOR IDENTIFYING THE SCOPE AND SERIOUSNESS OF MALNUTRITION IN OREGON.*

   Methods

   a. *Oregon State Board of Health develop and coordinate the malnutrition data base, analyze the data, and annually publish measures of malnutrition in Oregon.*

   b. *Local health departments include reporting by public health nurses of suspected cases of malnutrition, including referrals by social workers and aides into the Health Information System.*

   c. *Oregon State Board of Health request all elementary and secondary teachers to report suspected cases of malnutrition among their students to the local public health or school nurse.*

3. *EXPAND RESEARCH ACTIVITIES IN NUTRITION.*

   Methods

   a. *Oregon State Board of Health compile data from nutrition status and dietary intake studies conducted by State resources such as university research groups, Oregon State Board of Health, and Cooperative Extension Service. Annual*

reports of these studies on selected population samples will serve to monitor the effectiveness of the comprehensive nutrition program.

b. Nutrition research activities be expanded to include the effect of poor nutrition on performance.

4. *EXPAND FORMAL EDUCATION PROGRAMS IN NUTRITION IN THE SCHOOLS, COLLEGES, AND UNIVERSITIES IN OREGON.*

Methods

a. Board of Education develop a sequential integrated educational program in nutrition for grades K-12.

b. Board of Education, in conjunction with teacher-training institutions, incorporate nutrition courses into the curriculum for teacher training in Oregon.

5. *INCORPORATE APPROPRIATE NUTRITION COURSES INTO THE CURRICULUM OF ALL HEALTH-RELATED PROFESSIONS.*

Methods

a. University of Oregon Medical School, Dental School, and Schools of Nursing require in their curriculum specific courses in normal and therapeutic nutrition taught by qualified nutrition personnel.

b. Board of Education include nutrition courses in the curriculum of all allied medical and food service professions in the community colleges.

6. *ESTABLISH CONTINUING EDUCATION PROGRAMS IN NUTRITION FOR ALL PROFESSIONAL AND SUBPROFESSIONAL NUTRITION PERSONNEL.*

Methods

a. Each agency and professional organization be responsible for maintaining the professional competency of their nutrition personnel.

b. Oregon Nutrition Council identify sub-standard nutrition programs and personnel and make appropriate recommendations.

7. *ESTABLISH COMMUNITY NUTRITION EDUCATION PROGRAMS FOR THE GENERAL PUBLIC.*

Methods

a. Oregon Nutrition Council, local health departments, Cooperative Extension Service, and nutritionists from Oregon State

Board of Health establish community nutrition councils, comprised of nutrition-related professionals and consumers, to influence local attitudes and identify omissions and duplications in community nutrition education.

b. *Local community nutrition councils survey the mass media to determine how each could be used to better advantage to publicize good nutrition, and to encourage each to provide broadcast time or newspaper space to assure complete coverage of the nutrition education program.*

c. *Local health departments and Planned Parenthood Associations include a nutrition component in their health or clinic programs.*

d. *Public Welfare Division routinely inform all welfare recipients of community nutrition services available to them in home economics education, meal planning, and food preparation.*

e. *Local health departments, working with Oregon State Board of Health nutritionists, the Cooperative Extension Service, and community action groups, make a cooperative effort to expand programs in nutrition education and applied nutrition skills such as food buying, food preparation, and meal planning for low income families.*

f. *Local community nutrition councils provide nutrition information for retail grocers to distribute with food purchases.*

8. *ENCOURAGE STATE FOOD PROCESSORS AND DISTRIBUTORS TO PRODUCE AND PROMOTE NUTRITIOUS FOOD PRODUCTS.*

Methods

a. *The Center for Consumer Protection (Eugene) evaluate the advertising practices of Oregon food processors to determine the detrimental effect of advertising on nutritional levels in the state, and adherence to the Truth in Advertising Law.*

b. *The Center for Consumer Protection, in cooperation with the Oregon Section of the Institute of Food Technologists, develop and promote a color coding system of food packaging which can be understood by illiterate people. The colors used will indicate the food group and nutrient value of the product.*

c. *Oregon Nutrition Council submit legislation requiring all food processors in Oregon to enrich and fortify food products produced and sold in the state.*

9. *INCREASE THE NUMBER AND UPGRADE THE TRAINING OF NUTRITION PERSONNEL IN OREGON.*

Methods

a. *Legislature provide funding for the following additional personnel:*

Oregon State Board of Health - nutritionists to work with local health departments.

Public Welfare Division - nutritionist to assist with food assistance programs, or contract with outside agencies to provide nutrition education for welfare recipients.

State Office of Economic Opportunity - nutritionist to work with local community action agencies.

Local Health Departments - professionals knowledgeable about nutrition for each health department, to implement nutrition programs and to supervise nutrition aides who will assist in nutrition education and community followup.

Oregon Board of Education - specialist in nutrition education.

Cooperative Extension Service - nutritionists to develop nutrition education programs for specific audiences and supervise these programs conducted by county extension agents.

b. *State Board of Education, in cooperation with Oregon State Board of Health, Oregon Dietetic Association, Oregon Home Economics Association, and Cooperative Extension Service establish training programs for nutrition aides in community colleges selected by the Educational Coordinating Council.*

c. *Oregon State Board of Health, in cooperation with other agencies and professional groups, expand workshop sessions for dietary department personnel of hospitals, nursing homes, homes for the aged, day nurseries, and State institutions.*

10. *INCREASE ACCESS TO DIRECT FOOD SUBSIDIES FOR LOW-INCOME GROUPS IN OREGON.*

Methods

a. *Community nutrition councils encourage local school districts to apply for federally subsidized breakfast programs in the schools in low-income areas of the state.*

b. Outreach efforts be made to inform all low-income families (including senior citizens) about food assistance programs and the steps needed to obtain certification for eligibility:

1) Community Action Program agencies provide outreach to families ineligible for welfare but with incomes low enough to qualify them for food assistance programs.

2) Agencies such as county health departments and the Cooperative Extension Service inform low-income f milies about available food assistance and transportation.

c. Counties, in conjunction with State General Services Department, increase access to food assistance programs through: increasing the number of distribution centers strategically located in Oregon; increasing the hours the distribution centers are open; and establishing mobile distribution units in remote areas or utilizing community action agencies and other voluntary groups to provide transportation assistance for those in need.

d. Public Welfare Division simplify certification procedures for food assistance programs and establish reciprocity between counties for certification of eligibility.

e. Public Welfare Division periodically review standards for eligibility for food assistance programs, based on the Oregon State Board of Health's costs-of-food studies.

f. Community Nutrition Councils assist in designing a program providing prepared meals to senior citizens in the community.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

The Oregon State Board of Health evaluate progress toward a high level of nutrition for all Oregonians by analysis of reported cases of malnutrition and increased nutritional services.

PRIORITY

To be determined.

PRE- AND POSTNATAL SERVICES FOR WOMEN OF CHILD-BEARING AGE

GOAL PREVENT CONDITIONS AMONG WOMEN OF CHILD-BEARING AGE THAT ARE DETRIMENTAL TO A NORMAL AND HEALTHY BIRTH AND POSTPARTUM HEALTH OF BABY AND MOTHER

CONDITION

Although Oregon's maternal death rate is low compared to the United States rate (11.8 per 100,000 live births in Oregon as compared to 27.4 per 100,000 live births in the United States), continued vigilance is necessary to maintain a high quality of care within communities, hospitals and among professionals.

There are 441,000 women of child-bearing age among Oregon's population of 2,050,900. Of these, about 44,000 (10%) have an annual family income of $3,000 or less and an equal number have family incomes between $3,000 - $6,000 per year. Therefore, it is reasonable to assume that about one out of five women of child-bearing age in Oregon may need financial assistance for medical care relating to pregnancy.

During 1969, there were 33,834 live births in Oregon, a rate of 16.3 per 1,000 population. There are many high-risk factors that can adversely affect the mother and her offspring. Of these, some of the more serious are pregnancy too early or too late in life, and collateral factors related to illegitimacy, poor nutrition, and poor housing and sanitation conditions. Of special concern is the increased abuse of drugs and the trend among some youth groups to deliver their babies at home. Women exposed to certain diseases, drugs or other toxic substances during pregnancy or prior to pregnancy may give birth to infants with a variety of congenital anomalies. Also, there is a lack of professional and lay understanding of the factors that contribute to poor outcomes of pregnancies and other problems of family health.

The correlation between the lack of prenatal care and complications of pregnancy has been well established. Information on the "number of prenatal visits" and the "trimester medical care began" have been included on the Oregon birth certificate since July, 1969. Preliminary estimates of the level of prenatal care, based on a small sample of births registered during the last half of 1969, indicated that 65% of the women reported to have seen a doctor during the first trimester of pregnancy and 20% during the second trimester. About 60% of the women reported ten or more visits to a doctor for prenatal care. Although the incidence of prenatal care, as reported on the birth certificate, is relatively high for the state as a whole, there may be segments of the population which do not receive adequate medical care during pregnancy. National surveys reporting prenatal visits have

shown that the non-white and the poor are less likely to see a doctor regularly during pregnancy, and usually wait until late in pregnancy to see the doctor for the first time (National Center for Health Statistics, Visits for Medical Care During the Year Preceding Childbirth).

The quality of care a woman has available during pregnancy and birth is also related to the unequal distribution of maternity beds in Oregon. Consolidation of smaller maternities would help to improve the quality of care. The neonatal mortality rate for infants born weighing between 1,000 - 2,500 grams in the maternities delivering less than 100 infants a year is double that in the large maternities in Oregon.

CURRENT PROGRAMS AND ACTIVITIES

The Maternal and Child Health Section of the Oregon State Board of Health provides consultation to local health departments with regard to pre- and postnatal clinic services, nutrition, educational programs for expectant parents, genetic counseling and family planning.

Local health departments provide pre- and postnatal care as part of their public health services. Coos County has established a specialized pre- and postnatal clinic for welfare recipients and low income women, and the Marion County Health Department conducts a special clinic and an infant care program for the women of the Russian community located near the city of Woodburn.

The Maternal and Infant Care Project designed to provide comprehensive care to high-risk women in the low socio-economic area of North and Northeast Portland is conducted at Emanuel Hospital. The program includes nutrition counseling, social work, public health nursing, dental and obstetrical supervision.

Other programs providing pre- and postnatal services to low income women include the Office of Economic Opportunity funded project at Kaiser Foundation and the cooperative program of care at the University of Oregon Medical School--County Hospital.

The Teen Mothers Program sponsored by the Salem YWCA in conjunction with several other community organizations provides a comprehensive counseling, education and health care program for teenage mothers both married and unmarried. Pre- and postnatal care is provided to the mothers by private physicians under contract with the program and by a public health nurse from the Marion County Health Department.

AUTHORITIES

Oregon State Board of Health - Statutory.

Local Health Departments - Statutory.

OBJECTIVES

1. Insure that all women of child-bearing age are knowledgeable about good physical and emotional health habits practiced prior to and during pregnancy.

2. Identify high-risk women and provide quality pre- and postnatal services for women of child-bearing age in Oregon by 1975.

3. Reduce the incidence of pregnancy complications of Oregon women 50% by 1975.

RECOMMENDATIONS AND METHODS

1. *EXPAND PUBLIC EDUCATION PROGRAMS EMPHASIZING THE NEED FOR ADEQUATE MEDICAL CARE AND GOOD HEALTH HABITS DURING PREGNANCY.*

   Methods

   a. *The Oregon Medical Association devise a pamphlet outlining the physical and emotional health practices which a woman should know before getting pregnant, including the psychological adjustment to pregnancy and birth. Oregon Medical Association encourage all physicians to distribute and discuss the information with their patients who are planning pregnancy.*

   b. *Planned Parenthood Association, in conjunction with the Oregon State Board of Health, expand public information programs regarding proper medical care during pregnancy.*

   c. *All family planning clinics in Oregon routinely distribute information on care needed during pregnancy to all women visiting the clinic for contraceptive services.*

2. *ESTABLISH PRE- AND POSTNATAL CARE CLINICS IN ALL LOCAL HEALTH DEPARTMENTS.*

   Methods

   a. *Oregon State Board of Health, Maternal and Child Health Section, assist local health departments to establish pre- and postnatal clinics.*

   b. *In areas lacking full-time health departments, Oregon State Board of Health establish public health mobile units or itinerant clinics to deliver services to areas in need or contract with private physicians in the community for pre- and postnatal services.*

   c. *Local health departments utilize home health aides to follow up on all low-income women giving birth in their area to insure adequate postpartum medical care.*

d. *Local health departments institute classes for expectant parents, initiate pregnancy testing at their clinics, and establish genetic counseling.*

3. *IMPROVE ACCESS TO QUALITY PRE- AND POSTNATAL CARE TO HIGH-RISK PREGNANT WOMEN IN LOW SOCIO-ECONOMIC AREAS OF THE STATE.*

Methods

a. *Oregon State Board of Health enlist the cooperation of the Planned Parenthood Association and other health agencies for the development of a referral system for those women most likely to have complications during pregnancy and to give birth to children with congenital anomalies.*

b. *University of Oregon Medical School establish a perinatal center providing transportation and care of the pregnant woman with potentially serious problems when optimum care is lacking in the community. (Possible alternative use for the University of Oregon Medical School Tuberculosis Hospital).*

c. *Oregon State Board of Health establish programs, comparable to the Maternal and Infant Care Project at Emanuel Hospital in Portland, in the low socio-economic areas of Eugene, Salem, and other population centers of the state.*

d. *Oregon State Board of Health study and apply the findings from the Maternal and Infant Care Project at Emanuel Hospital that relate to care of high-risk pregnancies; and, in cooperation with the physicians, to update the quality of care given to all pregnant women and their infants.*

4. *IMPROVE THE DISTRIBUTION OF MATERNITY BEDS AND THE QUALITY OF MATERNITY WARDS IN OREGON HOSPITALS.*

Methods

a. *Oregon Association of Hospitals, in conjunction with the Oregon State Board of Health and Oregon Medical Association, study the feasibility of consolidating maternity services in Oregon to improve services and the quality of care to all women.*

b. *Oregon Association of Hospitals develop procedures to upgrade hospital maternity wards' standards and insure that they remain high.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around changes of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Evaluation of pre- and postnatal care services in Oregon to be made by the Oregon State Board of Health through: increased patient loads at local health department clinics, increased number of women receiving medical care during pregnancy as reported on the birth certificate, decreased number of reported complications of pregnancy.

PRIORITY

To be determined.

REHABILITATION (PHYSICAL DISABILITIES)

GOAL RESTORE PHYSICALLY DISABLED INDIVIDUALS TO THE FULLEST PHYSICAL, MENTAL, SOCIAL, AND ECONOMIC USEFULNESS TO WHICH THEY ARE CAPABLE.

CONDITION

"Disability" is a general term used to describe a temporary or long-term reduction of a person's activity as a result of illness, injury, or defect.

The focus of this report is on physical disabilities, specifically the following:

1. Major hearing loss affecting an estimated 4% of the population.
2. Cardiopulmonary affecting an estimated 3% of the population.
3. Visually handicapped affecting an estimated 2.5% of the population.
4. Neuromusculoskeletal affecting an estimated 2% of the population.

Rehabilitation programs related to mental-emotional and social-educational disabilities are covered in applicable sections of the Comprehensive Health Plan (Mental Health; Mental Retardation). Specific consideration of speech and hearing problems is contained in the "Speech and Hearing" Section of the Plan.

Unfortunately, there is no data available which would indicate the actual number of physically handicapped persons in Oregon. Estimates range from a little over 100,000[1] to 240,000.[2] The Easter Seal Society also estimates that 4,300 Oregonians become permanently crippled each year as a result of all accidents. According to a report in the Journal of Chronic Disease (1968), 88% of all major disabilities are due to chronic illness; 5% are due to industrial injuries; 5% are due to non-industrial accidents; and 2% are congenital defects.

Whatever the actual number of handicapped persons (i.e., those who could possibly benefit from effective rehabilitation services), the extent of the problem and the unmet needs are unquestionably significant. Inadequate data as to the prevalence of handicapping conditions may well have contributed to the lack of appropriate response to the rehabilitation needs of the handicapped in Oregon.

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1. The table attached as Exhibit 1 is a breakout by age group and type disability of prevalence estimates of the physically handicapped in Oregon, extrapolated from a study prepared by the Governor's Planning Committee on Vocational Rehabilitation ("A Focus on Rehabilitation in Oregon").
2. Easter Seal Society estimate of the number of disabled persons in Oregon.

It should be noted that the number of individuals with physical disabilities is increasing at a rate faster than the population growth, due primarily to more sophisticated life-saving techniques made possible through advanced medical knowledge, skills and technology, as well as to the increasing accident and injury rates.

Existing rehabilitation resources are insufficient to satisfy even current needs. The demand for physical rehabilitation services would far exceed the capabilities of the few existing programs if adequate financing were available and the citizenry better educated to the value of rehabilitation services. Because of the limited availability of financing, as well as other restrictions, there is a disparity in the provision of care to those requiring rehabilitation services. In addition to geographic limitations and variable accessibility, existing programs must limit their services to those individuals for which financing is available. Therefore, existing programs necessarily favor handicapped individuals who are eligible for state and federal financial assistance (e.g., Workmen's Compensation, Medicare, and Crippled Children's Division (under 21)). The employable age group (21 to 65) is usually not covered off the job by personal health insurance for uncommon, but often expensive rehabilitation services. The rising costs of medical care services have made it practically impossible for most people to finance medical care in cases of catastrophic disease or injury which oftentimes result in unique rehabilitation problems requiring long-term care and treatment.

Existing rehabilitation services and programs in Oregon operate autonomously without any mechanism for coordinating their activities. If rehabilitation agencies and programs were properly coordinated, much could be done to maximize utilization of resources, avoid duplication of services, and increase continuity of care and thereby increase efficiency and reduce costs.

There is no one agency, program, or source to provide assistance in meeting the multiple, complex, and varied needs of the physically handicapped. The individual, or his family, has to either do without or attempt to seek out and piece together the various services needed. The task of identifying and gaining access to needed rehabilitation services is extremely complex and difficult. There are many barriers which block the way and often delay or disallow provision of adequate care to the handicapped. Some of these barriers lie within the individual, others are a result of the existing system.

A recent study by the Advertising Council for Health, Education, and Welfare reported: "It is incredible that among the lowest economic group, where incidence of disability is highest, only slightly more than one-third have been reached with information about rehabilitation and the availability of restorative services." Outreach efforts to locate those people most likely to be unaware of existing services

should be emphasized. The Department of Health, Education, and Welfare recently reported that "the disabled are either steered toward rehabilitation very early after the onset of their disability and have a good deal of information and help accessible, or they simply get no services at all."

Other considerations related to problems of the physically disabled include:

1. Architectural barriers in housing, schools, places of employment, stores, and other publicly used buildings which limit access and use of such facilities to the physically handicapped. (e.g., As a rule, the disabled have three choices for a place to live: in a nursing home; with aging parents or relatives; or in sub-standard, physically unsatisfactory, and/or socially isolated types of dwelling units.)

2. Transportation systems which are inadequate to satisfy the needs of the handicapped because of high cost, inaccessible mode, or lack of geographic availability.

3. Health insurance policies which favor the treatment of acute illness at the expense of prevention and rehabilitative care.

In addition, there appear to be significant health manpower shortages in physical medicine, physical therapy, occupational therapy, social work, speech therapy, and nursing, as well as inadequate facilities to meet Oregon's rehabilitation needs. At least one of the few existing rehabilitation facilities is further impeded by an Oregon State Board of Health policy on special hospital licensure (rehabilitation centers). The special hospital qualifies as a federal hospital (i.e., qualifies for federal Medicare certification) but, as a result of a variance of state and federal standards for hospitals, does not qualify as a state general hospital. Federal legislation permits contractual agreements between hospitals to provide such services as radiology, pathology, and surgery in order to meet certification requirements as a federal hospital. However, current state regulations require such services to be on the premises to qualify as state general hospitals and therefore be eligible for benefits paid by private insurance carriers. This policy is not consistent with the principle of "best utilization of existing resources" to keep costs down and conserve health manpower; in fact, it tends to encourage unnecessary duplication of costly services.

It should be noted that legislation exists (ORS Chapter 414) to provide rehabilitative services to both the indigent and the medically indigent through Medicaid. It will require legislative action to make the statute operative by adequate funding. In addition, the Public Welfare Division reports that "there are many other programs besides Medicaid (Title XIX) which are underfunded or restrictive, and are not providing their share of rehabilitation to the physically disabled before they

reach welfare eligibility limits. Such agencies as Crippled Children's Division, Workmen's Compensation, Division of Vocational Rehabilitation, Blind Commission, and others unload their long-term, heavy care cases to Welfare. Part of this difficulty is lack of standard terminology and definitions. For instance, disability under Title XVIII (Medicare) is not the same as under Title XIX (Medicaid). Workmen's Compensation uses "employability" as synonomous with disability. All this tends to throw the discard load upon Medicaid."

CURRENT PROGRAMS AND ACTIVITIES

A detailed discussion and analysis of the various types of rehabilitation facilities, programs, and services available in the state can be found in Chapter IV., C, pages 40-79 of a report prepared by the Governor's Planning Committee on Vocational Rehabilitation: "A Focus on Rehabilitation in Oregon." Exhibit 2 shows the distribution of rehabilitation facilities in the state as reported in that study.

The Oregon State Board of Health has some direct services for the physically disabled. The accident and injury prevention program, the health education program, and the care for high-risk infants program have all been set up to eliminate those conditions which precipitate disabling conditions.

The Mental Health Division provides for the care and treatment of approximately 1,200 individuals who have moderate to severe physical impairments. The greatest concentration is at Fairview Hospital and Training Center where there are 565 physically impaired residents. For this reason, a special program has been developed with a variety of treatment components, including physical and occupational therapy, plus corrective surgery and intensive maintenance care.

The University of Oregon Medical School provides both inpatient and outpatient services to crippled children and adults through the Crippled Children's Division, Doernbecher Hospital, and the general outpatient clinic.

In addition to financial subsidies for those disabled while working, the Workmen's Compensation Board conducts a statewide accident prevention program and provides direct services to disabled workers at its physical rehabilitation center located in Portland.

Auxiliary services to the crippled and disabled are provided through the: 1) State Division of Vocational Rehabilitation which provides for the education and training necessary for employment; 2) Public Welfare Division which provides financial, medical, and auxiliary services to low-income disabled people; 3) Multi-Service Center which combines

the services of the Public Welfare Division, Division of Vocational Rehabilitation, and Employment Division in order to provide a unified service to persons in the low-income area of Portland.

Federal assistance for the crippled and disabled are provided through rent subsidies from the Federal Housing Administration and disability insurance benefits from the Social Security Administration.

The Veterans' Administration Hospital in Portland has a Physical Medicine and Rehabilitation Service, currently maintaining 53 beds on their rehabilitation wards, as well as averaging 146 consultations per month for patients throughout the remainder of the 550-bed hospital. In 1969, inpatient rehabilitation services were provided to 250 eligible veterans with a wide variety of conditions including orthopedic problems, spinal cord injuries, cerebrovascular accidents, peripheral vascular conditions, peripheral neuropathy and nerve injuries, and arthritis. The Rehabilitation Service includes Divisions of Physical Therapy, Corrective Therapy, Occupational Therapy, Manual Arts Therapy and Recreation and conducts numerous training programs in Physical Medicine and Rehabilitation. In addition to a 3-year residency program for physicians wishing to specialize in rehabilitation medicine (which in recent years has had approximately four physicians in training at a time), the Veterans' Administration Hospital offers additional training in research and education for physicians who have already had this specialty training. The Hospital also takes an active part in the training of medical students at the University of Oregon Medical School; provides clinical training as part of the curriculum for Physical Therapy and Occupational Therapy Assistant trainees at Mt. Hood Community College; conducts a 6-week refresher course for registered physical therapists; and provides clinical training in corrective therapy and occupational therapy. Smaller physical medicine and rehabilitation Services are available in the other two Veterans' Administration facilities in Oregon located in White City (Veterans' Administration Domiciliary) and Roseburg (Veterans' Administration Hospital).

The Rehabilitation Institute of Oregon (Portland) is a licensed 38-bed, non-profit rehabilitation center serving a regional population and drawing 38% of its inpatients from outside the greater metropolitan area, with an additional 5% from adjacent states. The Institute participates in statewide educational programs and activities. During the past year, 470 trainees, representing 14 institutions received training from the physicians and allied health professionals of the Institute. The Rehabilitation Institute of Oregon provides inpatient services for over 100 patients per year.

Other inpatient and outpatient services for the physically disabled include: Emanuel Hospital (Portland) 20 beds; Good Samaritan Hospital (Portland) 10 beds and a stroke care unit; Lovejoy Rehabilitation

Hospital (Portland) 20 beds; Shriners Hospital for Crippled Children (Portland) 80 beds; and Sacred Heart Hospital (Eugene) 8 beds.

Additional direct and indirect services for the physically disabled are provided by muscular dystrophy clinics throughout the state; the Holladay Center (Portland); Edgefield Manor (Multnomah County); Center for Hearing and Speech (Portland, Eugene and Medford); the Blind Commission; the State Special Schools Division; and Camp Meadowood Springs (summer speech camp).

The Easter Seal Society for Crippled Children and Adults provides equipment loans; information, referral and follow-up; physical therapy; and special education for the physically handicapped and those with minimal brain damage, as well as recreation activities at a resident camp and special events. Other voluntary agencies which serve the crippled and disabled through counseling and evaluation, public education, equipment, research, home health care, sheltered workshops, and minor patient care are the Muscular Dystrophy Association; Multiple Sclerosis Societies; United Cerebral Palsy Association; National Foundation - March of Dimes; the Arthritis and Rheumatism Foundation; Goodwill Industries; the Council of Churches; the Epilepsy League; and the Visiting Nurse Association. In addition, there are parent groups associated with the various volunteer organizations which serve a useful means of education.

AUTHORITIES

The State Physical Rehabilitation Center operates within the Workmen's Compensation Board - ORS 656.726 - 656.752.

The Crippled Children's Division and its outpatient clinics are a division of the University of Oregon Medical School. The Medical School is an operational unit of the State System of Higher Education. The Crippled Children's program is authorized under ORS 444.010 to 444.050.

The Division of Vocational Rehabilitation is authorized under ORS 344.511 to 344.850.

The Veteran's Hospital is authorized under Federal law.

OBJECTIVES

1. By 1977, eliminate those existing financial barriers which deny essential rehabilitation services to the handicapped.

2. By 1972, establish a coordinated statewide manpower training program to assure an adequate supply of well-trained personnel to staff rehabilitation programs.

3. By 1974, develop a coordinated statewide system of public and private rehabilitation services to insure comprehensive care and to eliminate duplication and gaps in services.

4. Improve utilization of existing rehabilitation resources through increased public and professional education and information programs.

5. Develop a program for prevention of crippling conditions through accident prevention, expanded research programs aimed at correction of factors causing disabling illnesses and injuries, and dissemination of information on preventable medical conditions.

6. Reduce the negative consequences of disabling illness, injury, or defect through early identification and entry into the rehabilitation process.

7. Reduce architectural barriers in public and privately-owned structures which prevent the handicapped from participating in mainstream life activities which should and otherwise would be available to them.

8. Reduce transportation barriers to the physically disabled which prevent the handicapped from participating in mainstream life activities which should and otherwise would be available to them (e.g., employment, schooling, medical care, etc.).

RECOMMENDATIONS AND METHODS

(Objective #1)

1. *IMPLEMENT MEDICAID IN OREGON TO INCLUDE COVERAGE OF REHABILITATIVE SERVICES FOR BOTH THE INDIGENT AND THE MEDICALLY INDIGENT.*

   Method

   The State Public Welfare Division establish priorities and a reasonable timetable and, together with Comprehensive Health Planning, Oregon Medical Association, and the Oregon Association of Hospitals, encourage the State Legislature to provide proper funding to make ORS Chapter 414 operative.

2. *EXPLORE MEANS OF EXPANDING PRIVATE HEALTH INSURANCE COVERAGE FOR PREVENTIVE, AMBULATORY, AND REHABILITATIVE SERVICES AT REASONABLE*

COSTS, AND ENCOURAGE CONSUMER SUBSCRIPTION TO THESE MORE COMPREHENSIVE INSURANCE PLANS.

Methods

a. *The Department of Commerce, Insurance Division, together with leaders in the health insurance industry, develop alternative proposals for providing adequate health insurance coverage for ambulatory, preventive, and rehabilitative services for policyholders.*

b. *Comprehensive Health Planning and the State Board of Health develop plans and encourage legislation which would provide incentives to private carriers to broaden the scope of covered services.*

3. *EXPLORE THE FEASIBILITY OF OBTAINING LEGISLATION PROVIDING FOR MANDATORY PUBLIC LIABILITY AUTOMOBILE ACCIDENT COVERAGE.*[1]

4. *DEVELOP MECHANISMS FOR COORDINATING THE DISTRIBUTION OF STATE AND FEDERAL FUNDS TO MINIMIZE THE PRESENT PIECEMEAL APPROACH WHICH LEADS TO DUPLICATION, GAPS IN CARE, DIVIDED LOYALTIES, LACK OF COOPERATION, AND IGNORANCE OF AVAILABLE BUT COMPLEX SERVICES.*

Methods

a. *Establish a standing Committee on Rehabilitation, Advisory to the Governor's Health Planning Committee, made up of public, private, and voluntary representatives of health agencies and activities involved in rehabilitation services for the physically disabled, to review rehabilitation needs and programs and recommend allocation of resources. This Committee should have representation from the Crippled Children's Division, Department of Vocational Rehabilitation, University of Oregon Medical School, Veterans' Administration Hospital, Oregon Regional Medical Program, Educational Coordinating Council, Oregon Association of Hospitals, Oregon Commission for the Blind, Rehabilitation Institute of Oregon, and appropriate representation from voluntary agencies.*

b. *The Department of Human Resources develop a coordinated planning apparatus, responsive to recommendations of the standing Committee on Rehabilitation, to oversee allocation of those funds of the several Human Resources agencies earmarked for medical/dental rehabilitative services (e.g., Corrections, Motor Vehicle Accident Fund, Welfare, Blind Commission, Division of Vocational Rehabilitation), as well as to monitor utilization and delivery of services.*

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1. *Oregon is one of the few states without this compulsory requirement.*

Funds such as the Motor Vehicle Accident Fund should be considered for additional financing to realistically cover medical services to traffic accident victims requiring long-term rehabilitative care.

c. *Charge areawide comprehensive health planning committees with responsibility for review of local rehabilitation needs and development of specific proposals, in coordination with local agencies and organizations working with rehabilitation problems, for allocation of limited governmental funding support.*

Areawide comprehensive health planning committees implement the following review procedures for rehabilitation services within State Administrative Districts:

1) *Establish an ongoing review committee to make recommendations on proposed rehabilitation facility and program expenditures, whether funded by federal, state or local monies. Technically competent individuals, representatives of existing state and community organizations, and representatives of the needy and disabled must be included on the review committee.*

2) *Develop a process for evaluating programs and facilities utilizing existing methods for determining efficiency and effectiveness, as well as evaluation of staff, program, patient progress, community utilization, and cost effectiveness.*

d. *Eliminate existing exclusions from the A-95 review process for all health-related projects.*

e. *The Oregon Chapter of the National Rehabilitation Association, together with interested voluntary and private agencies, develop and introduce proposals for state funding support of rehabilitation facilities and programs based upon accreditation standards of the Commission on Accreditation of Rehabilitation Facilities (CARF) and other appropriate criteria.*

f. *The Governor's Assistant for Human Resources instruct the Public Welfare Division and the Division of Vocational Rehabilitation to develop a joint proposal for submission to the 1971 Legislative Assembly to reduce the growth rate of Welfare costs due to medically-needy persons, many of whom could be rehabilitated.*

(Objective #2)

5. *DEVELOP MECHANISMS FOR COORDINATING THE HEALTH OCCUPATION TRAINING PROGRAMS, INCLUDING TRAINING FOR MEMBERS OF THE REHABILITATION*

TEAM. (REFERENCE: RECOMMENDATION #3, METHOD A; HEALTH MANPOWER SECTION OF COMPREHENSIVE HEALTH PLAN.)

Method

Governor's Health Planning Committee support legislative proposal by the Educational Coordinating Council expanding their scope and authority to coordinate educational programs (including health) in the state.

6. *EXPAND OR MODIFY AS NECESSARY THE HEALTH MANPOWER TRAINING PROGRAMS WITHIN THE STATE TO ENCOMPASS REQUISITE TRAINING PROGRAMS FOR MEMBERS OF THE REHABILITATION TEAM.*

Methods

a. *The Department of Higher Education establish a physical therapy curriculum, either baccalaureate degree or graduate certificate program, at the University of Oregon Medical School by 1972.*

b. *Establish a physiatry training program as part of a Department of Rehabilitation Medicine at the University of Oregon Medical School by 1972. (This could be a joint residency with the Veterans' Administration Hospital in Portland and other appropriate community rehabilitation units.)*

c. *Develop an accredited graduate school of nursing program, at least to the Masters Degree level, at the University of Oregon Medical School by September, 1971. Opportunity for specialization in public health, rehabilitation, and psychiatric nursing should be provided within this program.*

d. *The Health Manpower Intelligence Facility determine the need for training additional speech pathologists and occupational therapists in Oregon by July, 1971.*

e. *The CHP Health Manpower Committee, together with the Educational Coordinating Council, encourage appropriate training institutions to insure that provision for experience with rehabilitation services is incorporated into the basic training of physicians and nurses as part of their basic education. The opportunity for longitudinal involvement with patients with chronic diseases or serious handicaps should be encouraged and interdisciplinary instruction should be provided.*

f. *The CHP Health Manpower Committee, together with the Educational Coordinating Council, encourage development of a training program for rehabilitation social workers to be used as assistants, fact finders, and coordinators in rehabilitation programs. These rehabilitation social workers should have a working knowledge of the rehabilitation disciplines and be*

aware of the resources available and techniques of physical, emotional, and vocational rehabilitation.

g. The CHP Health Manpower Committee review professional and assistants training programs in rehabilitation and recommend to the Governor's Health Planning Committee and appropriate institutions, necessary changes in basic curricula to enable students to receive academic credit for previous training and to move up the academic ladder. Many graduates of one-year programs (Licensed Practical Nurses, Assistant Physical Therapists, and Occupational Therapists) find that the one year of education is not creditable toward higher levels of training.

h. The CHP Health Manpower Committee, together with the Educational Coordinating Council, encourage development of:

1) joint clinical experiences for trainees from the various training programs to familiarize them with the skills and roles of the other professionals and provide them with skills in group processes and problem solving;

2) a core curriculum with common standards and criteria for different schools so that students can have vertical and horizontal mobility among these disciplines without loss of credit; and

3) procedures, guidelines, and educational opportunities to train physical therapists, occupational therapists, and other rehabilitation specialists in the supervision of new categories of assistants and in management and consultation skills.

7. DEVELOP A MODEL SERVICE (IN SOME WAYS PARALLEL TO THE CRIPPLED CHILDREN'S DIVISION) WHICH WILL BECOME A REHABILITATION CENTER FOR THE STATE WHICH CAN DEMONSTRATE METHODS OF TEAM FUNCTIONING AND ORGANIZATION APPLICABLE THROUGHOUT THE STATE.

Method

Establish a Department of Rehabilitation Medicine at the University of Oregon Medical School by September, 1972, with facilities for inpatient and outpatient services and with faculty representing the following disciplines: 1) Physiatry, 2) Physical Therapy, 3) Occupational Therapy, 4) Psychology, 5) Rehabilitation Nursing, 6) Social Work, 7) Speech Pathology, and 8) Rehabilitation Counseling. In addition, consultants should be available in Neurology, Neurosurgery, Orthopedics, Psychiatry, Internal Medicine, and other medical specialties on a regular basis from other departments.

1) *Combine training activities and clinical experiences of this Department with selected and accredited facilities with appropriate rehabilitation personnel and services.*

2) *Charge this Department with responsibility for consultation and continuing education of those administrators and rehabilitation professionals in other agencies and institutions who are developing rehabilitation services.*

(Objective #3)

8. *THE GOVERNOR'S ASSISTANT FOR HUMAN RESOURCES AND THE EXECUTIVE DIRECTOR OF THE EDUCATIONAL COORDINATING COUNCIL PROVIDE ONGOING COORDINATION OF SERVICES TO THE HANDICAPPED IN AGENCIES WHICH FALL WITHIN THEIR RESPECTIVE PROGRAM AREAS.*

Method

The Department of Human Resources and the Educational Coordinating Council establish formal relationships and procedures for coordinating program planning, implementation, and evaluation of State educational and related rehabilitation services. Advisory assistance for rehabilitation aspects of statewide educational and delivery services is available through:

1) *The Governor's Health Planning Committee and its CHP Health Manpower Committee for educational needs and related services to the handicapped.*

2) *The Interagency Committee for the Multiple-Handicapped for determining placement of multi-handicapped children in either state institutions or public schools programs. This existing Committee should be formalized; membership expanded to include representation from the Crippled Children's Division and the public school programs for handicapped children in addition to current representation of the State Schools for the Blind and Deaf and Fairview Hospital; and given the formal authority to determine placement of multi-handicapped children rather than merely "recommend" placement as is now the case.*

9. *DEVELOP AN OPERATIONAL STATEWIDE SYSTEM OF IDENTIFICATION, DIAGNOSIS, EVALUATION, AND REFERRAL TO INSURE THAT ALL PHYSICALLY DISABLED WILL BE PROVIDED WITH MEDICAL, EDUCATIONAL, AND VOCATIONAL SERVICES DESIGNED TO MAXIMIZE THEIR ABILITY TO BECOME CONTRIBUTING MEMBERS OF SOCIETY.*

Methods

a. *Establish multi-disciplinary, multi-service regional diagnostic, evaluation, and referral centers in all administrative districts*

of the state for both children and adults with physical and mental impairments. Alternatives for implementation of this method include:

1) *Broaden the responsibilities of the Division of Vocational Rehabilitation from rehabilitation planning for the handicapped with vocational potential to include screening and referral of all Oregonians with handicapping conditions. Division of Vocational Rehabilitation offices would then have these responsibilities: a) determine the extent and nature of the person's handicapping conditions with an estimate of potential for optimal functioning; b) referral to appropriate medical care and treatment; c) provide Division of Vocational Rehabilitation services to those people whose potential indicates vocational possibilities; d) referral to appropriate educational programs; e) referral and placement responsibilities for those people with no vocational or educational potential; and f) community follow-up.*

   Local Division of Vocational Rehabilitation offices would be responsible to assure that maximum restoration was achieved and maintained by providing for supportive professional services at the local level. Services of a team of experts from the various medical and educational rehabilitation disciplines could be made available to each community on a regular basis for consultation, evaluation, and diagnostic assistance. This team could be recruited from medical or rehabilitation centers or could be organized from the staffs of other agencies serving the community.

2) *The Crippled Children's Division of the University of Oregon Medical School and the Outpatient Department of Fairview Hospital and Training Center (continue to) work together in establishing regional diagnostic and evaluation teams for both children and adults with physical and mental impairments. These teams should be established in all administrative districts and should include local educators, as well as medical and psychiatric personnel.*

3) *Charge local public health departments under a program established by the State Board of Health, or regional health districts if established, with responsibilities for operating these regional multi-service diagnostic, evaluation, and referral centers.*

b. *Insure that the motivational aspects essential to the rehabilitation process are incorporated into these regional diagnostic, evaluation and referral programs; and that the referral programs include an effective screening procedure for potential development of the disabled to insure the programming of realistic rehabilitation services.*

10. *MERGE THE COMMISSION FOR THE BLIND WITH THE DIVISION OF VOCATIONAL REHABILITATION AND ESTABLISH SPECIALIZED PROGRAMS FOR SPECIFIC TYPES OF HANDICAPPED INDIVIDUALS IN THE DIVISION OF VOCATIONAL REHABILITATION TO INSURE THE SPECIAL NEEDS OF THESE INDIVIDUALS CONTINUE TO BE MET.*

Method

RE: Report December, 1970, by Educational Coordinating Council on "Delivery of Educational Services to the Handicapped in Oregon."

11. *EXPAND REGIONAL REHABILITATION TREATMENT CAPABILITIES FOR THE PHYSICALLY DISABLED.*

Methods

a. *Division of Vocational Rehabilitation, University of Oregon Medical School, and interested voluntary agencies explore the feasibility of establishing facilities for the crippled and disabled in selected regional centers in Oregon.*

b. *The Rehabilitation Committee of the Governor's Health Planning Committee explore the feasibility of public/private agencies establishing mobile units to provide services for the disabled who are homebound and/or who reside in remote areas.*

c. *Voluntary agencies encourage the formation of local "self-help" groups. Those handicapped by disability, or those who have experienced rehabilitation from a handicap must be involved in the planning and evaluation of rehabilitation.*

12. *DEVELOP CLEARLY IDENTIFIED UNITS FOR MEDICAL REHABILITATION WITHIN OR AS A PART OF THE MAJOR MEDICAL CENTERS OF OREGON.*

Method

The Consultant Committee on Rehabilitation Facilities to the Hospital and Medical Facilities Survey and Construction Advisory Council of the State Board of Health, the Oregon Association of Hospitals and the Oregon Chapter of the National Rehabilitation Association work jointly to:

1) Select specific locations for hospital-based medical rehabilitation facilities.

2) *Develop eligibility priorities for federal Hill-Burton construction funds at selected locations.*

3) *Coordinate the construction of necessary facilities as funds for rehabilitation services become available.*[1]

13. *EXPAND HOME HEALTH SERVICES FOR THE SEVERELY DISABLED.*

Method

Areawide comprehensive health planning committees encourage voluntary agencies and community leaders to organize and make available home health services to the disabled.

(Objective #4)

14. *DEVELOP PUBLIC AND PROFESSIONAL EDUCATION AND INFORMATION PROGRAMS DESIGNED TO MAKE THE PUBLIC, LEGISLATORS, AND HEALTH CARE PROVIDERS MORE AWARE OF THE POTENTIAL OF THE REHABILITATION PROCESS AND RESOURCES, AND TO DECREASE EXISTING PUBLIC PREJUDICE AND DISCRIMINATION AGAINST THE HANDICAPPED.*

Methods

a. *The Rehabilitation ad hoc Committee of the Governor's Health Planning Committee be charged with responsibility for coordinating public relations and educational programs of the public and voluntary agencies concerned with the disabled, as well as developing a statewide program to increase public awareness of disabling conditions. They should consult professional public relations counsels, social psychologists, and advertising agencies for an effective program that will promote the capabilities of the disabled, and use the mass communications media.*

b. *Areawide comprehensive health planning committees develop community plans to insure that individuals and families of individuals with rehabilitative potential are made aware of the possible benefits and are properly motivated to seek care.*

c. *The Oregon Association of Hospitals, together with the Oregon Chapter of the National Rehabilitation Association, develop plans to inform the public of the cost-benefit value of rehabilitation to society and to the individual. (For each $1 invested in the individual, there is a return of $10 in taxes and $35 in personal income to the individual.)*

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1. *See Exhibit 3 for suggested guidelines to determine needs and feasibility.*

d. *Division of Vocational Rehabilitation publish annually a Directory of Rehabilitation Services in Oregon and insure the widest possible distribution.*

e. *Voluntary agencies establish information centers in strategically located areas of the state having a well publicized telephone number where the disabled can receive information about mental health, crippling conditions, aging, etc.*

15. *EXPAND IN-SERVICE EDUCATION PROGRAMS AVAILABLE TO PROVIDERS OF HEALTH CARE WITH SPECIAL EMPHASIS GIVEN TO:*

A) PREVENTIVE MEASURES TO AVOID COMPLICATIONS OF INJURIES OR SERIOUS ILLNESSES;

B) RAPID IDENTIFICATION OF PATIENTS LIKELY TO HAVE SEVERE RESIDUAL DEFICITS FROM ILLNESS OR INJURY SO THAT APPROPRIATE TREATMENT MEASURES MAY BE INSTITUTED PROMPTLY.

Method

Division of Continuing Education and Board of Higher Education seek to expand in-service education in coordination with hospitals and nursing homes.

16. *INCORPORATE THE CONCEPT OF PREVENTION AND "THE REHABILITATION PROCESS" INTO ALL CORE COURSES IN BASIC EDUCATION PROGRAMS FOR PROVIDERS OF HEALTH CARE. EXPERIENCE IN A REHABILITATION CENTER SHOULD BE MADE MANDATORY IN THE EDUCATIONAL PREPARATION OF ALL HEALTH PROFESSIONALS.*

Method

The Educational Coordinating Council encourage the channeling of rehabilitation information and experience through appropriate higher education and community college training programs.

17. *ALL AGENCIES INVOLVED IN HEALTH-RELATED PROGRAMS DEVELOP PROCEDURES OF IDENTIFICATION AND FOLLOW-UP WITHIN THE COMMUNITY FOR PERSONS WITH REHABILITATION NEEDS.*

Methods

a. *Regional evaluation centers, local public health departments, and/or local Division of Vocational Rehabilitation offices provide an early multi-disciplinary evaluation of identified individuals to determine the patient's potential for rehabilitation (see Recommendation 9).*

b. *The Division of Vocational Rehabilitation establish a registry of individuals with physical impairments and require reporting*

of: all infants born with skeletal defects of a serious nature; all individuals with spinal injuries, amputations, and major crippling conditions; all cardiovascular disabilities; and serious vision, hearing and speech impairments.

This registry could be computerized and proper steps would have to be taken to insure that information in the registry was restricted to responsible state or local agencies. Summaries of information contained in the registry would be of particular value to agencies responsible for program planning at both the state and local levels.

(Objective #5)

18. ESTABLISH A STATEWIDE ACCIDENT PREVENTION CAMPAIGN.

Methods

a. Oregon State Board of Health, in cooperation with Workmen's Compensation Board and voluntary organizations, develop an educational program in accident prevention and publicize the program through the mass media and through presentations at schools, community groups, etc.

b. Employers and unions be encouraged to sponsor accident prevention campaigns at places of employment.

19. EXPAND RESEARCH EFFORTS AIMED AT THE IDENTIFICATION AND CORRECTION OF FACTORS CAUSING DISABLING ILLNESSES AND INJURIES.

Method

University of Oregon Medical School and other universities in Oregon prepare proposals and seek funding from foundations and voluntary organizations, as well as federal and state governments.

(Other recommendations and methods on educational and informational activities aimed at prevention are contained throughout this report and other sections of this Plan.)

(Objective #6)

20. EXPAND COMMUNITY LEVEL EFFORTS AIMED AT EARLY IDENTIFICATION AND ENTRY INTO THE REHABILITATION PROCESS FOR INDIVIDUALS WITH PHYSICAL HANDICAPS CAUSING DISABILITY.

Methods

a. Comprehensive Health Planning and the Oregon State Board of Health work with the Oregon Medical Association, Oregon

Association of Hospitals, and other interested agencies to develop proposals and applications for federal funding of periodic multiphasic screening projects.

b. The Educational Coordinating Council encourage a program by local school officials, in coordination with interested voluntary agencies, to survey local communities to identify all children in need of special education programs or facilities, and establish special classes for the handicapped as needed.

(Objective #7)

21. ESTABLISH BARRIER-FREE ARCHITECTURAL STANDARDS FOR ALL NEW PUBLIC AND PRIVATELY-OWNED STRUCTURES BUILT FOR PUBLIC USE.

Method

The Oregon Chapter of the National Rehabilitation Association develop and sponsor legislation and/or work with planning and zoning commissions to require that building permits be issued only after compliance with regulations such as the "American Standard Specifications For Making Buildings and Facilities Accessible To, And Usable By, the Physically Handicapped." [1]

22. DEVELOP AND IMPLEMENT A HOUSING PROGRAM FOR THE DISABLED.

Methods

a. Areawide comprehensive health planning committees, together with local councils of government, evaluate housing facilities to determine if sufficient facilities exist and recommend the establishment of new facilities as needed to insure housing for the severely handicapped.

b. Private and public agencies dealing with the disabled encourage all housing authorities to include a substantial number of younger disabled persons in housing projects.

c. Voluntary agencies sponsor a program to enable small groups of ambulatory handicapped to join together for cooperative housing in single dwelling units.

(Objective #8)

23. DEVELOP A SYSTEM OF TRANSPORTATION FOR THE HANDICAPPED THAT WOULD MAKE AVAILABLE TO THEM THE OPPORTUNITIES FOR EMPLOYMENT, SCHOOLING, MEDICAL CARE, REHABILITATION TREATMENT, RECREATION, SHOPPING, ETC.

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1. See Exhibit 4 for extract of referenced specifications.

Methods

a. *Voluntary agencies encourage expansion of public transportation services for the handicapped in those areas of the state with a high concentration of disabled.*

b. *Voluntary agencies or community action program agencies be encouraged to provide transportation services for the disabled in those areas where none exist.*

c. *All new facilities or programs for the disabled requiring transportation of clients for the delivery of services should make provision for transportation in their program budgets.*

d. *Allocate Public Welfare Division funds to provide transportation to places of employment for handicapped people with limited finances where public transportation is not available.*

OPERATIONAL PROBLEMS

1. While there is increasing health care financial assistance for the young and old, as well as selected handicapped groups, there is only limited assistance available to help those in their most productive years (21 to 65). Until such time as there are adequate funds available for health care for all citizens (perhaps through some form of national health insurance) and expanded commitment of our resources for medical facilities, manpower and services, the goal of comprehensive, coordinated medical care will remain severely limited.

2. Most health insurance policies (attributable in some degree to the purchasing practices of buyers of health insurance policies) currently favor protection against losses due to acute illness at the expense of prevention and rehabilitation services, and favor hospitalization at the expense of ambulatory care. This distortion in emphasis, a major factor in the rising costs and in the slow development of preventive and rehabilitative services, may well be due to a lack of public awareness of the inherent advantages and necessity of coverage for preventive and rehabilitative services. Adequate insurance coverage for preventive, ambulatory, and rehabilitative services may well result in a reduction in the incidence of acute illness and thus ameliorate requirements for extensive insurance against acute illness. An educational program should be mounted to make the public aware of the importance of allocating a part of its health insurance funds to the purchase of insurance against the costs of preventive, ambulatory, and rehabilitative care.

3. Extension of prepayment programs for ambulatory and preventive patient care would probably not bring any substantial reduction in the costs of health services. Quite the opposite could occur as people discover that they have diabetes, hypertension, heart disease, emphysema, etc., sooner than they might otherwise. This could permit them to begin an earlier program of rehabilitation and might reduce costs per individual illness, but probably would increase total costs at least initially.

4. Funds and manpower are not available to implement the team concept and model delivery system recommended for rehabilitation training at the University of Oregon Medical School. The estimated cost for staffing such a facility would be $150,000 per year. Joint residency training programs among hospitals have been established in Portland in other specialties, but the specific relationships for the rehabilitation disciplines require further negotiation.

5. At present, the various health professions involved in rehabilitation are being taught independently in widely scattered institutions without any effective coordination. Clinical psychologists are receiving graduate training at the University of Portland and the University of Oregon; social workers (MSW) are trained at Portland State University; nurses at the University of Oregon Medical School, Emanuel Hospital, Good Samaritan Hospital, University of Portland, and numerous community colleges; physical therapy assistants and occupational therapy assistants at Mount Hood Community College, etc.

6. There are no existing programs in Oregon training occupational therapists, physical therapists, or rehabilitation nurses.

7. The evolution of the new associate degree level health personnel in various fields, such as physical therapy, nursing, and social welfare should be encouraged. However, roles must be defined for these individuals and dialogue with existing institutions and personnel must be established to insure optimal utilization of these new members of the health care and rehabilitation teams. The first class of the physical therapy assistant program at Mount Hood graduated June, 1970, however, the program has not yet been accredited by the American Physical Therapy Association.

EVALUATION CRITERIA

The Governor's Health Planning Committee should establish a standing Rehabilitation Committee to develop evaluation criteria and evaluate progress toward each of the eight objectives.

PRIORITY

To be determined.

EXHIBIT 1

ESTIMATES OF PHYSICAL IMPAIRMENT PREVALENCE

IN OREGON BASED ON 1968 POPULATION FIGURES

	64 Years and Under [1]	15 Years and Under [2]
Deaf/Major Hearing Loss	14,710	3,810
Blind/Serious Visual Impairment	8,310	410
Speech Disorders	17,080	14,530
Multiple Handicapped	940	240
Neuromuskeloskeletal, Cardio-pulmonary and other crippling conditions	59,170	2,080
TOTALS	100,210	21,070

1. These estimates were extrapolated from a report prepared by the Governor's Planning Committee on Vocational Rehabilitation, "A Focus on Rehabilitation in Oregon," February 28, 1969.

2. These estimates are based on prevalence rates reported in a publication by Hensley, "Special Education in the West," Western Interstate Commission for Higher Education, 1969, p. 39. (Reference: Report on "The Delivery of Educational Services to the Handicapped in Oregon," December, 1970, prepared by the Educational Coordinating Council.)

EXHIBIT 2

Distribution of Rehabilitation Facilities
(As of December, 1968)

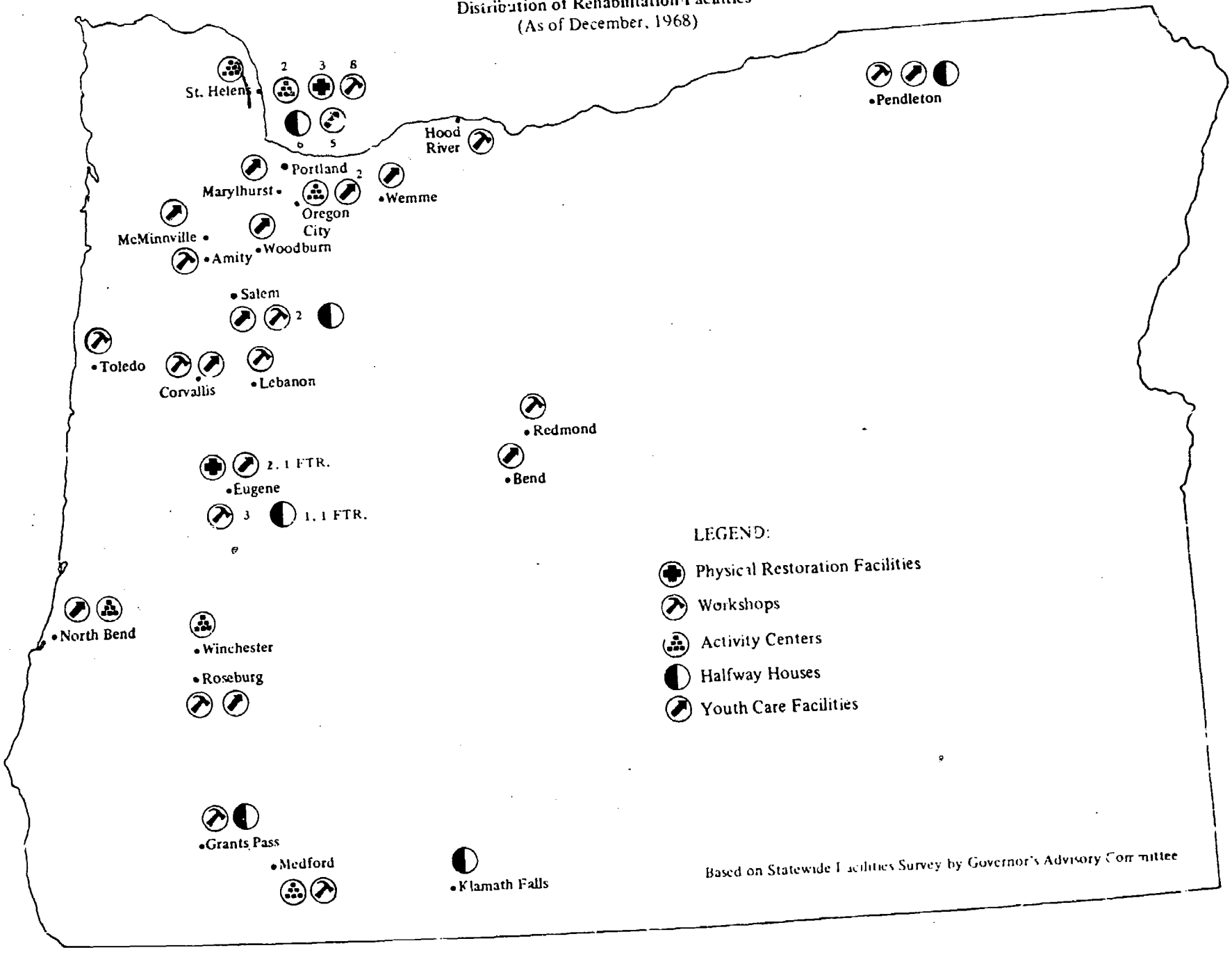


EXHIBIT 3

SUGGESTED GUIDELINES FOR DETERMINING FEASIBILITY AND NEED FOR CONSTRUCTION OF REHABILITATION FACILITIES IN OREGON.

1. In hospitals of 200 beds or more (perhaps fewer in some rural areas), at least 10 percent of beds can be justified for subacute care, with emphasis on rehabilitation. Up to 35 percent of the beds may be assigned to subacute care, rehabilitation, and chronic disability needs. With any greater percentage, the facility would tend to become chronic-disease oriented, and should be so identified. Extended care beds could fit into this 10 to 35 percent grouping.

2. The age of the population using rehabilitation programs must be considered in planning activities. Disabilities occur five to eight times more frequently in the aged than in the general population. (N.H. Survey)[1]

3. Income levels of potential patients should also be considered, since three times as many disabilities occur in the poverty income groups as in middle and upper level income groups. (N.H. Survey)[1]

4. Staffing patterns depend on identified needs and demands for services. Mental illness in the community must be considered as well as physical handicaps There is considerable overlap between these two categories, and the same disciplines (social work, psychology, psychiatry, occupational therapy, and vocational counseling) are involved with both. At times many other medical and allied health professions are needed, including neurology, neurosurgery, orthopedics, urology, physiatry, internal medicine, physical therapy, nursing, etc. (Reference: Standards for Rehabilitation Centers and Facilities, Association of Rehabilitation Centers, Inc., 828 Davis Street, Evanston, Illinois, June, 1965.

5. Comprehensive rehabilitation services include a balanced network of services ranging from acute hospital care to the return of the patient to his home and job when feasible.

6. Home health services should be developed and integrated with all other health care services. Existing home health programs should be expanded and utilized, when appropriate, to fill gaps in care.

1. National Health Survey Series 10, No. 45, 1965-66.

EXHIBIT 4

EXTRACT OF ITEMS INCLUDED IN AMERICAN STANDARDS ASSOCIATION SPECIFICATIONS

1. At least one entrance from the street or parking area must be level or with a suitable ramp.

2. Entrance doors must have a minimum width of 33.1 inches. This rule applies to all interior doors which are for public use.

3. All multi-story buildings are required to have at least two elevators suitable for wheelchairs.

4. Rest rooms for public use must have at least two units accessible for wheelchairs, two in the men's and two in the women's sections.

5. All electric switches and alarm bells should not exceed 48 inches in height.

6. In theaters and public halls a special place for wheelchairs must be constructed. In halls of up to 1,000 seats, it is one for every 150 seats; in halls of above 1,000 seats, it is one for every 250.

7. Restaurants should have tables which are accessible and comfortable for the wheelchair user.

8. Alarm systems must have blinking lights and sirens for the blind and the deaf.

9. Telephones and drinking fountains low-enough for the wheelchair individuals.

TARGET GROUPS

THE AGED

GOAL IMPROVE THE HEALTH OF THE AGED TO PROVIDE FOR A MEANINGFUL AND PRODUCTIVE LIFE.

CONDITION

In 1969 there were 218,557 persons aged 65 and older in Oregon (10.5 percent of the total Oregon population). By 1972, it is estimated that the number of aged in Oregon will increase to 226,230 (Table 1). In general, the distribution of Oregon's older population among the 14 Administrative Districts parallels the distribution of the total population except in Districts 1, 2, 3, and 8, where there is a higher concentration of the aged. The rate of growth in the proportion of the population aged 65 and over will continue to increase as advances in medicine provide the means to prolong life.

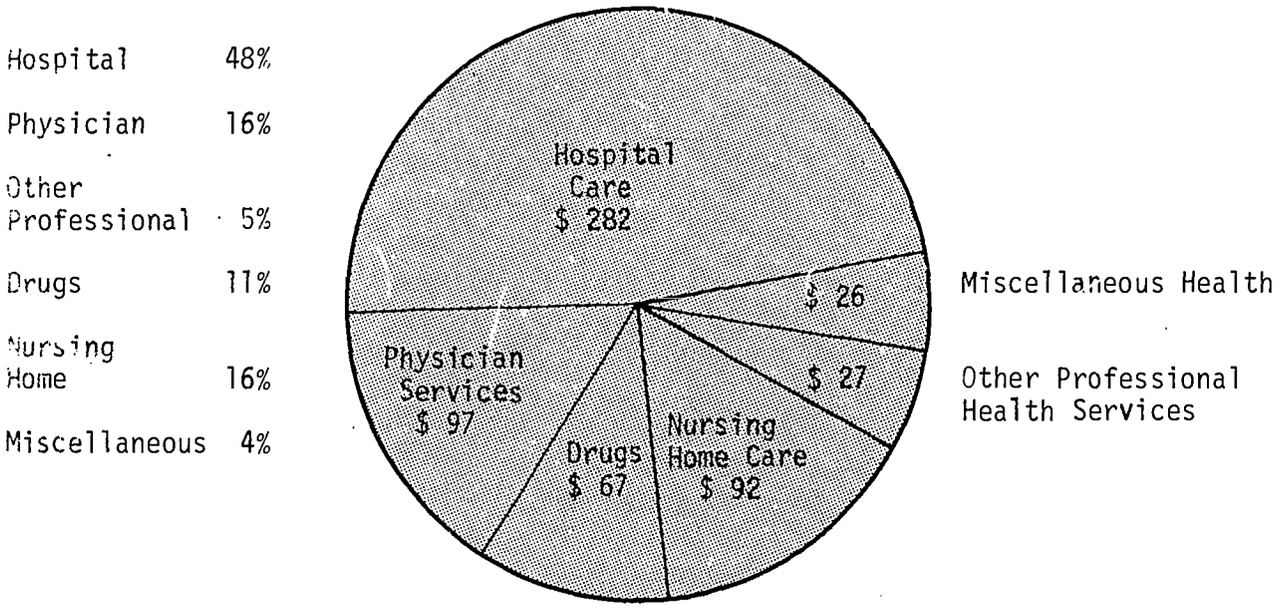
Seven out of every ten persons aged 65 or over live in families. About 25% of the aged live alone or with non-relatives, and the remaining 5% are residents of institutions.

In 1969 the mortality rate among the aged in Oregon was 59 per 1,000, as compared to 9 per 1,000 for the total population. The aged exhibit a greater need for all aspects of medical care than do younger persons. Older individuals are subject to more disability, see physicians more often, and have more and longer hospital stays than the general population. National data from the Health Interview Survey reported that persons aged 65 or over made 6.0 visits to a physician per person per year, as compared to only 4.3 visits for the total population. Likewise, the aged had a higher incidence of short stay hospital episodes and on the average remained in the hospital longer than did younger persons. Persons aged 65 and over had 19.7 discharges from hospitals per 100 persons per year with an average length of stay of 13.5 days. In comparison, the total population reported 12.3 discharges from hospitals per 100 persons per year with an average stay of only 8.5 days. About 86% of the aged population have one or more chronic conditions which may force them to limit somewhat their usual activities.

Health care expenditures per aged person in the United States average about 2-3/4 times higher than for those under age 65. In 1968, older Americans spent a total per capita of $590 for medical expenses. The distribution of medical expenses for the elderly are depicted in Figure 1.

Assuming that the medical expenses for the aged in Oregon remain constant, then by 1972 the estimated expenditures for health care for those aged 65 and over in Oregon would total $133,475,700.

FIGURE 1. DISTRIBUTION OF $590 PER CAPITA MEDICAL EXPENSES FOR THE AGED



Source: Developments in Aging, 1969. Report of Special Committee on Aging, U.S. Senate.

Of the total amount spent for health care for persons aged 65 and over, about $414 (70%) was financed through public sources; however, the elderly still had to pay $176 from their own limited incomes. In general, older persons have less than half the income of persons under age 65.

In 1968, the median annual income of older families was $4,592; however, the median annual income of the aged who lived alone or with nonrelatives was only $1,734. One out of four elderly persons live below the poverty level. Table 2 shows the per capita personal income of those over age 65 for the counties in Oregon. The figures are average income; consequently, they may be inflated by a few aged with high incomes and do not reflect the range of income levels.

Because of inherent limitations, Medicare covers only about 45% of the health care costs of the elderly. The most obvious gaps in coverage under Medicare include out-of-hospital prescription drugs, dental care, eye care, eye glasses, hearing aides, and medical appliances. During 1968, almost 20% of the elderly spent in excess of $100 for prescription drugs alone; 4% spent $250 or more. Only 10% of the persons aged 65 or

Table 1. ESTIMATE OF AGED POPULATION IN OREGON, 1972

	Estimated Aged Population 1972	Percent Distribution	
		Aged Population	Total Population
State of Oregon	226,230	100.0	100.0
District 1	5,840	2.6	2.3
Clatsop	3,950		
Tillamook	1,890		
District 2	101,980	45.1	43.2
Clackamas	16,580		
Columbia	3,410		
Multnomah	69,690		
Washington	12,300		
District 3	28,640	12.7	11.1
Marion	18,490		
Polk	4,400		
Yamhill	5,750		
District 4	14,320	6.3	7.0
Benton	3,740		
Lincoln	3,260		
Linn	7,320		
District 5 - Lane	18,070	8.0	10.1
District 6 - Douglas	6,390	2.8	3.6
District 7	5,540	2.4	3.4
Coos	4,610		
Curry	930		
District 8	17,230	7.6	6.3
Jackson	11,600		
Josephine	5,630		
District 9	4,220	1.9	1.8
Hood River	1,550		
Sherman	170		
Wasco	2,500		
District 10	4,580	2.0	2.3
Crook	960		
Deschutes	2,990		
Jefferson	630		
District 11	4,210	1.9	2.7
Klamath	3,680		
Lake	530		
District 12	7,030	3.1	3.0
Gilliam	310		
Grant	780		
Morrow	560		
Umatilla	5,220		
Wheeler	160		
District 13	5,070	2.2	2.0
Baker	2,180		
Union	2,160		
Wallowa	730		
District 14	3,110	1.4	1.6
Harney	560		
Malheur	2,550		

Source: Prepared by W. L. Myllenbeck (Columbian Research Center) for the State Program on Aging.

Table 2. PER CAPITA PERSONAL INCOME FOR THOSE OVER AGE 65:
1967 AND 1972 ADMINISTRATIVE DISTRICTS AND COUNTIES

ADMINISTRATIVE DISTRICTS AND COUNTIES	1967	1972	ADMINISTRATIVE DISTRICTS AND COUNTIES	1967	1972
District 1	$ 3,238	$ 3,990	District 8	$ 3,033	$ 3,738
Clatsop	3,238	3,990	Jackson	3,083	3,800
Tillamook	3,238	3,990	Josephine	2,928	3,610
District 2	3,301	4,060	District 9	3,096	3,815
Clackamas	3,083	3,800	Hood River	3,083	3,800
Columbia	3,083	3,800	Sherman	3,391	4,180
Multnomah	3,391	4,180	Wasco	3,083	3,800
Washington	3,083	3,800			
			District 10	3,051	3,760
District 3	3,052	3,762	Crook	2,928	3,610
Marion	3,083	3,800	Deschutes	3,083	3,800
Polk	3,083	3,800	Jefferson	3,083	3,800
Yamhill	2,928	3,610			
			District 11	3,083	3,800
District 4	3,083	3,800	Klamath	3,083	3,800
Benton	3,083	3,800	Lake	3,083	3,800
Lincoln	3,083	3,800			
Linn	3,083	3,800	District 12	3,042	3,751
			Gilliam	2,928	3,610
District 5	3,083	3,800	Grant	2,928	3,610
Lane	3,083	3,800	Morrow	2,928	3,610
			Umatilla	3,083	3,800
District 6	3,083	3,800	Wheeler	2,928	3,610
Douglas	3,083	3,800			
			District 13	2,905	3,582
District 7	3,136	3,864	Baker	2,775	3,420
Coos	3,083	3,800	Union	3,083	3,800
Curry	3,391	4,180	Wallowa	2,775	3,420
			District 14	3,054	3,766
			Harney	2,928	3,610
			Malheur	3,083	3,800

Source: Prepared by W. L. Myllenbeck (Columbian Research Center) for State Program on Aging.

older carried private health insurance to cover these health items. For those with auxillary insurance, coverage is generally provided as part of major medical policies involving deductables of $100, $250, or $500.

Another health problem among aged persons is malnutrition. The aged population form the most uniformly malnourished segment of the population. The major causes of the nutritional problems among the elderly include low income, lack of mobility, and increased ailments.

Because of limited mobility, the elderly find it difficult to travel to medical care centers. The clinical services for the aged are oftentimes fragmented, necessitating the elderly to make several trips to receive treatment for their multiple problems.

In Oregon there are 7,771 Medicare beds available in general hospitals, or approximately one bed for every 28 aged persons. In addition, there are 3,436 certified medicare beds in nursing homes and 618 in convalescent hospitals (Table 3). Although the total number of available beds in Oregon seems to be adequate, the uneven distribution of these beds throughout the state causes gaps in services. Some areas of the state show serious shortages while other areas, principally the Portland area, show excesses.

CURRENT PROGRAMS AND ACTIVITIES

The State Program on Aging has the responsibility of coordinating and evaluating the activities of all agencies and organizations having programs dealing with the aged. Funds for planning, coordination, and evaluation are provided by the federal government through Title III of the Older Americans Act on a three to one matching basis. In addition, a bloc grant system makes available to the State Program project grant funds for programs in local communities. Currently 25 projects in local communities throughout the state are funded through the Older Americans Act, providing a variety of service programs for the elderly, such as multi-purpose service centers, transportation in rural areas, in-house assistance, information, and referral.

The Public Welfare Division provides financial assistance for the elderly through the Old Age Assistance, Aid to the Blind, and Aid to the Disabled programs. Assistance is also given to the elderly in locating housing and referral for medical care.

Although they do not have a formal program, the State mental hospitals of the Mental Health Division admit aged senile individuals for treatment. Usually the person is treated nutritionally and then referred to a nursing home or community live-in arrangement.

Table 3. NUMBER OF BEDS AVAILABLE IN GENERAL HOSPITALS, NURSING HOMES, AND HOMES FOR THE AGED IN OREGON, 1970

Administrative Districts and Counties	General Hospitals			Nursing Homes		Homes for the Aged
	Total Beds	General Medicare Beds	ECF Medicare Beds	Total Beds	Medicare Beds	Total Beds
State	8,625	7,324	447	13,334	3,436	2,982
District 1	269	231	24	279	98	30
Clatsop	142	104	24	202	98	30
Tillamook	127	127	-	77	-	-
District 2	4,023	3,536	140	5,013	1,544	1,742
Clackamas	198	192	-	631	93	220
Columbia	80	39	41	116	-	7
Multnomah	3,585	3,169	99	3,553	1,019	1,317
Washington	160	136	-	713	432	198
District 3	677	643	-	2,404	244	441
Marion	490	463	-	1,912	162	292
Polk	28	28	-	197	19	90
Yamhill	159	152	-	295	63	59
District 4	518	398	70	636	184	180
Benton	163	123	-	227	54	33
Lincoln	147	102	38	59	-	30
Linn	208	173	32	350	130	117
District 5 - Lane	647	558	53	1,286	453	87
District 6 - Douglas	332	256	48	255	28	69
District 7	217	171	-	332	103	75
Coos	193	147	-	264	82	75
Curry	24	24	-	68	21	-
District 8	493	437	-	855	202	137
Jackson	374	318	-	559	150	102
Josephine	119	119	-	296	52	35
District 9	154	143	-	614	172	30
Hood River	48	45	-	93	21	30
Sherman	-	-	-	-	-	-
Wasco	106	98	-	521	151	-
District 10	294	240	-	262	119	81
Crook	65	43	-	40	-	20
Deschutes	181	153	-	222	119	61
Jefferson	48	44	-	-	-	

- Continued next page -

Administrative Districts and Counties	General Hospitals			Nursing Homes		Homes for the Aged
	Total Beds	General Medicare Beds	ECF Medicare Beds	Total Beds	Medicare Beds	Total Beds
District 11	160	122	-	264	40	-
Klamath	141	122	-	264	40	-
Lake	19	-	-	-	-	-
District 12	375	250	56	789	130	78
Gilliam	-	-	-	29	-	-
Grant	39	35	-	26	-	30
Morrow	24	22	-	20	-	-
Umatilla	312	193	56	714	130	48
Wheeler	-	-	-	-	-	-
District 13	271	185	18	177	-	29
Baker	99	56	10	55	-	16
Union	112	102	8	122	-	13
Wallowa	60	27	-	-	-	-
District 14	195	154	-	168	119	3
Harney	49	46	-	49	-	-
Malheur	146	108	-	119	119	3

Source: Prepared by W. L. Myllenbeck (Columbian Research Center) for State Program on Aging.

The Community Action Programs, under the auspices of the State Office of Economic Opportunity, have programs for the elderly including counseling, assistance in locating housing and transportation, and emergency food and medical services.

The University of Oregon Medical School provides medical care to the aged at their routine clinic sessions. The Social Services Section of the Medical School works with the families of the aged and assists in locating homemaker services, transportation, help with medication, nursing home placements, and room and board arrangements.

Many private organizations are concerned with serving the needs of the elderly in Oregon. There are nine councils on aging located throughout the state: City-County Council on Aging, Portland; Emerald Empire Council on Aging, Eugene; Rogue Valley Council on Aging, Medford; Yamhill County Council on Aging; Washington County Council on Aging; Lincoln County Council on Aging; Oregon State Council for Senior Citizens; Salem; Tri-County Area Council for Senior Citizens, Wallowa, Baker, and Union Counties; and the Committee on Aging of the Tri-County Community Council, Portland.

These organizations function to identify unmet needs of the older people living in the community; to promote greater and more effective use of existing services for the elderly; to enlist the support and participation of citizens in programs for the aged; and to develop broad policy goals in dealing with the problems and needs of older citizens.

The Home Health Service Agency in Eugene provides home care for the elderly including post hospitalization care, housekeeping services, physical therapy, and medical equipment rental. Individuals served through this agency must be aged 65 and over and be referred by a physician.

In addition, various volunteer services, councils, family counseling programs, visiting nurse programs, and other home health care agencies located throughout Oregon conduct programs for the aged.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1972, establish a unified health management program for the older person providing a broad spectrum of services in order to optimize the health of the elderly in Oregon.

2. By 1975, remove the financial barriers to comprehensive medical care for the aged.

3. By 1973, expand nutrition programs for the elderly.

4. By 1972, develop a public education program to inform Oregonians of the physical and psychological processes of aging in order to eliminate the unnecessary stress and anxiety associated with aging.

RECOMMENDATIONS AND METHODS

1. *CONSOLIDATE MEDICAL SERVICES TO AGED PERSONS IN OREGON.*

   Method

   Oregon State Board of Health, University of Oregon Medical School, Oregon Medical Association, and Oregon Dental Association encourage the establishment of neighborhood-based health delivery facilities for all persons, including the aged, to serve as facilities for prevention, diagnosis, and treatment.

2. *EXPAND THE PREVENTIVE MEDICAL PROGRAMS FOR THE AGED THROUGHOUT THE STATE.*

   Methods

   a. *Local health departments, in cooperation with local councils on aging, establish periodic clinics for the elderly in easily-accessible locations for the purpose of physical examinations, flu and other immunizations, glaucoma screening, and other preventive services.*

   b. *Oregon State Board of Health establish preventive programs in nursing homes and homes for the aged utilizing 314(e) monies.*

3. *EXPAND HOME HEALTH CARE SERVICES FOR THE AGED TO REDUCE THE NEED FOR COSTLY INPATIENT CARE.*

   Methods

   a. *Visiting Nurses Association, home health agencies, and the Oregon Medical Association encourage physicians to utilize home health services for the elderly whenever applicable. Home health services should include homemaker services as well as medical and ancillary care.*

   b. *Oregon State Board of Health, in cooperation with the social service agencies and Public Welfare Division, develop "community care homes" for the elderly. These homes would function as*

"foster homes" for the aged. Public Welfare would screen foster home applicants wishing to cooperate in the program, and evaluate their interest and experience in caring for the chronically ill. Accepted families would attend a training session conducted by Oregon State Board of Health, where public health nurses, dieticians, and other medical personnel would discuss aspects of the care of the chronically ill. Each home would be routinely visited by public health nurses who will supervise the care of the aged person. If possible, the elderly person will pay for his care in the community home; if the patient is eligible for financial assistance, Public Welfare will subsidize his home care.

4. *ESTABLISH GERONTOLOGY TRAINING PROGRAMS FOR ALL MEDICAL AND PARA-MEDICAL PERSONNEL SERVING OLDER PERSONS.*

Method

University of Oregon Medical School, in cooperation with the State Program on Aging and the Oregon State Board of Health, establish continuing education programs for the care of the elderly.

5. *EXPAND THE COVERAGE UNDER MEDICARE AND OTHER PREPAID PLANS FOR THE ELDERLY TO INCLUDE DRUGS, DENTAL CARE, EYEGLASSES, HEARING AIDS, AND NECESSARY MEDICAL APPLIANCES.*

Methods

a. *Congressional delegation support attempts to expand Medicare coverage.*

b. *Legislature provide funds for Public Welfare Division to expand services to the elderly under the Medicaid Program.*

6. *ESTABLISH "HOT MEAL" PROGRAMS FOR THE ELDERLY TO GUARD AGAINST MALNUTRITION AMONG THE ELDERLY.*

Methods

a. *Local community councils on aging encourage school districts to establish free noonday meals for the elderly in the community. Community Action Program agencies should assist in providing transportation to the schools for those in need of assistance.*

b. *Cooperative Extension Service, local health departments, and community action agencies utilize community nutrition aides and home health aides to provide homemaker services and assistance with food buying and preparation for the elderly.*

c. *Public Welfare Division revise the Food Stamp Program in Oregon to allow the elderly to purchase meals with food stamps.*

7. *ESTABLISH STATEWIDE EDUCATIONAL PROGRAMS ON THE PROCESS OF AGING.*

Methods

a. *Oregon Gerontology and Training Center, in cooperation with the State Program on Aging, Mental Health Division, and the Department of Education, develop an educational program to outline sound physical and mental health practices preparing an individual for the process of aging.*

b. *Local councils on aging organize community seminars on aging and the problems of the elderly.*

c. *Local councils on aging encourage unions and other employee organizations to assist their members who are approaching retirement to understand and adjust to the process of aging through planned programs of education and community services.*

d. *Local councils on aging coordinate the employment of people over age 65 as community volunteers and thereby give direction and meaning to the lives of elderly persons.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Evaluation of progress toward relieving the problems of the aged in Oregon will be made by the State Program on Aging, through observing better coordination and increased accessibility to services for the aged, decrease in the number of admissions of elderly to nursing homes and institutions, increased home care of the aged, and increased preventive health services for the elderly.

PRIORITY

To be determined.

MEDICALLY INDIGENT[1]

GOAL ASSURE THAT ALL MEDICALLY INDIGENT PERSONS HAVE ACCESS TO QUALITY HEALTH CARE SERVICES.

CONDITION

According to data received from the Public Welfare Division, 118,000 people receive assistance in Oregon; this represents only 37% of the families below the poverty level and eligible for welfare assistance. (There are at least 318,910 people living below the poverty level as determined by the federal standards. See Table 1). In addition, Public Welfare Division reports that in 1968, at least 47,250 additional persons classified as "medically indigent" would have been eligible, if the Title XIX Medical Assistance Program were implemented fully in Oregon. According to the above data, approximately 366,160 people in Oregon (18% of the population) are financially unable to provide for their own health care.

Table 1

Poverty Level as Defined by Federal Standards

Year	Family of 1	Family of 2	Family of 4
1969	$1920	$2460	$3720
1971	2031	2603	3920
1972	2097	2687	4064

Source: Public Welfare Division, Research Section, October, 1970.

The problems faced by the large number of medically indigent are becoming increasingly important issues throughout the United States. These problems are reaching crisis proportions, as access to services is denied to a large segment of the population. Poor persons (including those on welfare) are increasingly voicing their concern about their inability to find a family physician; difficulties in paying for and obtaining child care services and/or transportation; and with physicians who deny service due to inability to pay.

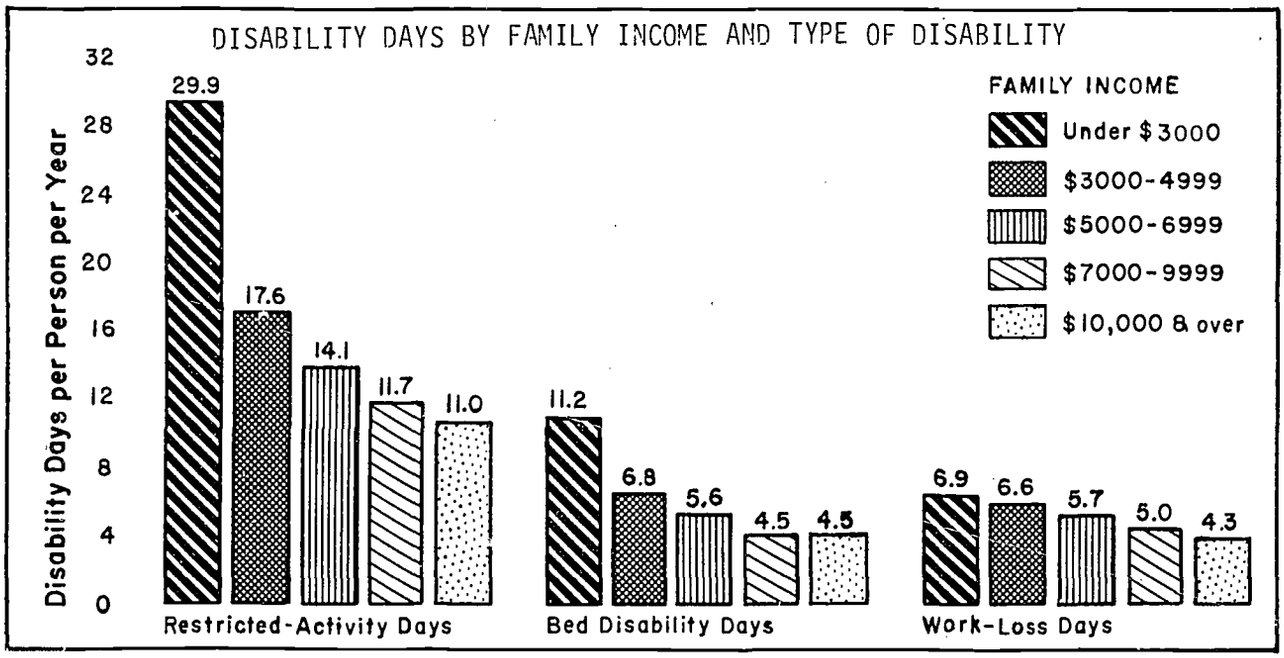
1. The term "medically indigent" in this report refers both to persons who: (1) lack sufficient income to meet their maintenance needs as well as their medical needs; and (2) persons who have sufficient income to meet their maintenance needs but lack sufficient income to meet their total medical needs.

Reports by the National Center for Health Statistics and others indicate that as income decreases, the number of disability days, incidence of chronic disease, and percentage of income spent on personal health services increases, while the extent of health insurance coverage, number of physician and dentist visits, and general utilization of health services decreases. It is this syndrome of greater need and poorer access to health services experienced by the medically indigent that we must find methods to alleviate. The tables on the following pages exemplify these conditions.

Figure 1 indicates that the number of restricted activity days and bed disability days among families with annual incomes below $3,000 was more than twice the number for families with incomes above $7,000. It should be noted that low income families experience more work-loss days than middle income families.

Figure 2 substantiates the impact of income on conditions causing an activity limitation. Families with incomes under $4,000 experience substantially higher rates of conditions causing activity limitations than families with incomes over $4,000. The rates of heart conditions, mental and nervous conditions, arthritis, high blood pressure, and visual impairments among families earning under $2,000 a year are at least twice that of families with annual incomes under $4,000.

FIGURE 1

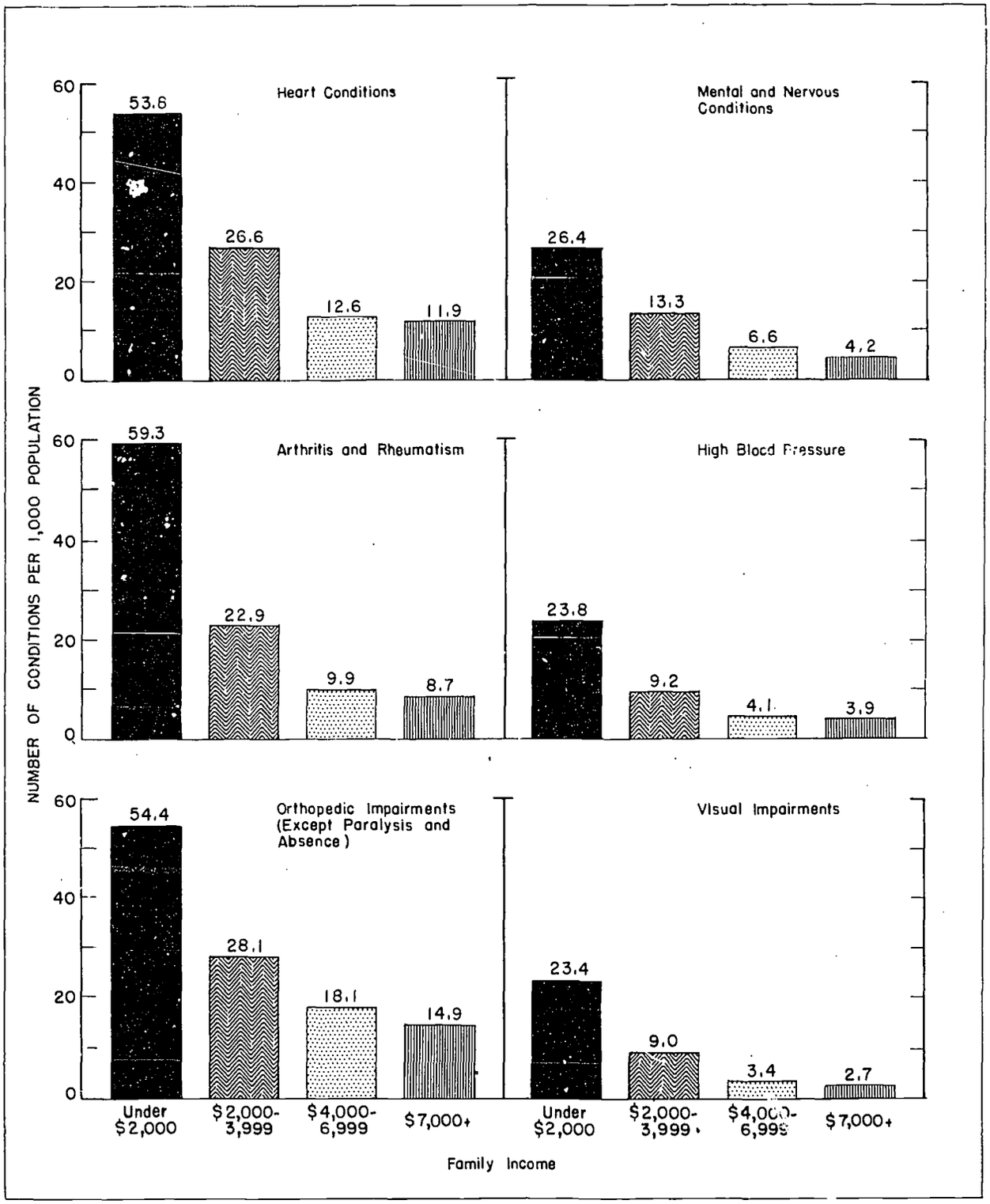


Note: The data refer to disability because of acute and/or chronic conditions. The category "work-loss days" represents currently employed persons.

Source: United States Department of Health, Education, and Welfare, p. 58, 1969 Source Book of Health Insurance Data.

Figure 2

Number of conditions causing activity limitation per 1,000 population, by selected condition categories and family income.

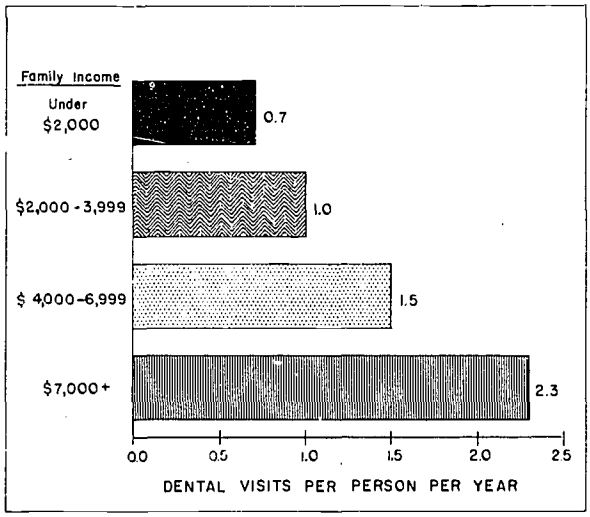


Source: Medical Care, Health Status and Family Income, VHS Series 10, Number 9, May 1964, p. 60, DHEW, PHS, National Center for Health Statistics.

In the category of dental health, studies indicate that 74% of children under fifteen years in low-income families have never received any dental care, as compared to 32% of the same age group in families with annual incomes over $7,000.[1] Thirty-two percent of the dental visits among children under 15 years from low-income families were for extractions, as compared to only 5% among comparable children from families with annual incomes over $7,000.[1]

Figure 3

Number of Dental Visits per Person per Year, by Family Income



Source: National Center for Health Statistics Series 10, Number 9, p. 34.

Figure 3 indicates the extent to which the amount of dental care varies according to family income. The rate of visits for persons with family incomes of $7,000 or more is more than three times the rate for persons with incomes less than $2,000.

Because many people regard dental problems as inconveniences which do not have the life-threatening potential of other chronic conditions, they often postpone visits to the dentist for examination and treatment. This may be particularly true of low income families who, in an attempt to avoid dental expense, often delay going to a dentist until they are in pain or other acute discomfort.

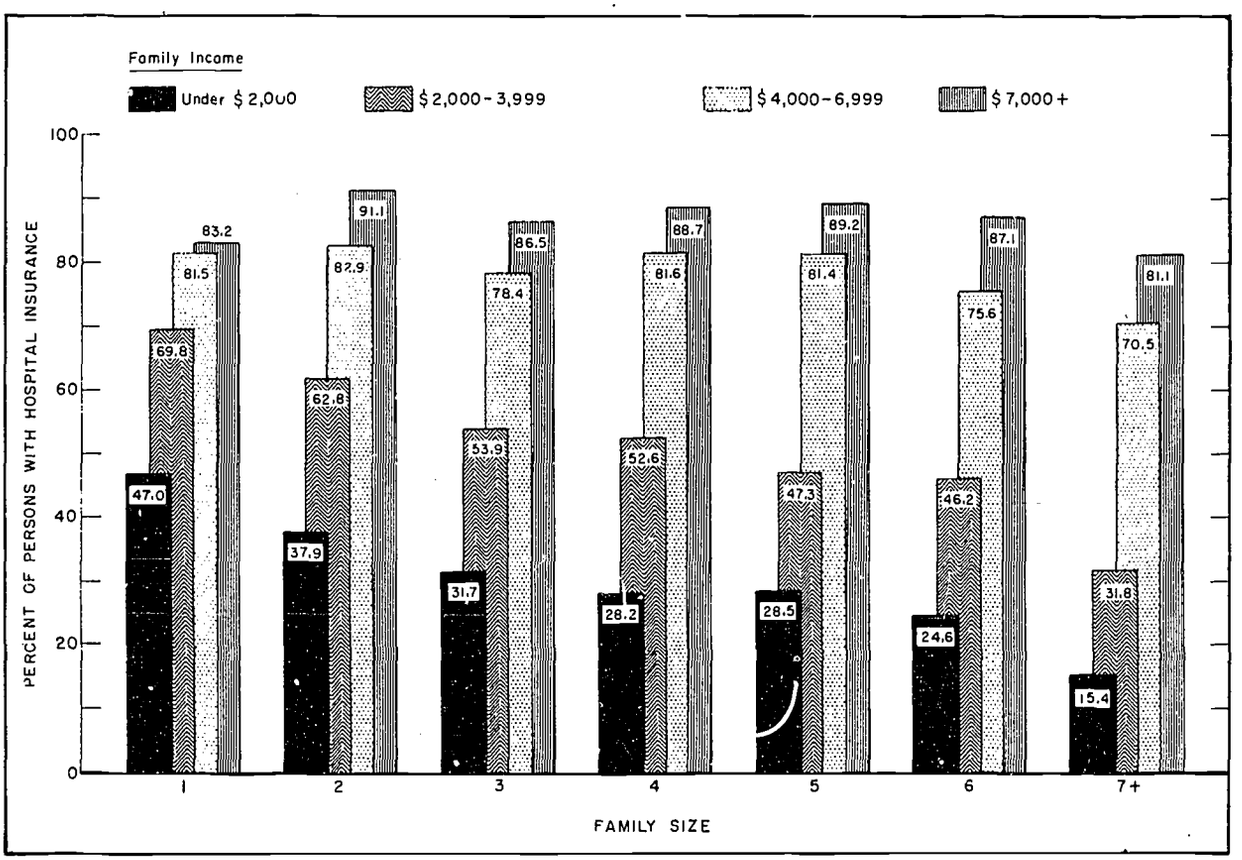
1. National Center for Health Statistics, Series 10, Number 9, pp. 36-37.

In addition to a higher than average incidence of illness and disability, low income families have by far the lowest percentage of hospital insurance coverage (Figure 4). Family size is a significant factor in the low rate of health insurance coverage for persons with family incomes of less than $2,000. Figure 4 indicates that as additional persons must share a limited income, the family resources are spent more on food and shelter than on hospital insurance, even though the risk that someone will require hospitalization becomes greater as the number of persons in the family increases. Coverage is almost negligible (only 15%) where there are seven or more members in a family with income of $2,000 or less and only about 32% in families of $2,000-3,999 income.

In the higher family income groups, hospital insurance protection does not decrease materially with increasing family size. The economic pressures of the large family of moderate or higher income are not sufficient to prevent the purchase of insurance to protect against the financial hazards of ill health.

Figure 4

Percent of Persons with Hospital Insurance Coverage, by Family Income and Size



Source: National Center for Health Statistics, Series 10, Number 9, p. 7.

While the foregoing indicates a higher than average incidence of chronic conditions and disability days among low-income families, there is also evidence that these same families have a significantly lower than average rate of utilization of services. Table 2 summarizes physician visits by family income and family size.

The number of visits was proportionately lower for low-income families as compared to middle-income families.

Table 2

Number of physician visits per family or unrelated individual per year, by family income and family characteristics: United States, July 1963-June 1964

Family Characteristic	Family Income					
	All Incomes[1]	Under $3,000	$3,000-$4,999	$5,000-$6,999	$7,000-$9,999	$10,000 and over
	Physician Visits per Family or Unrelated Individual Per Year					
Total, individuals and families	14.2	9.7	13.8	15.9	17.1	18.7
All individuals	6.0	6.0	5.5	5.6	7.2	6.9
All families	16.2	12.4	15.6	17.0	17.7	19.2
All 2-person families	11.3	10.9	12.4	11.1	11.2	11.1
All 3-person families	15.6	12.4	15.0	17.6	16.8	16.4
All 4-person families	19.1	15.3	18.7	18.6	19.7	22.2
All 5+ person families	21.0	15.0	19.0	20.9	22.3	26.6

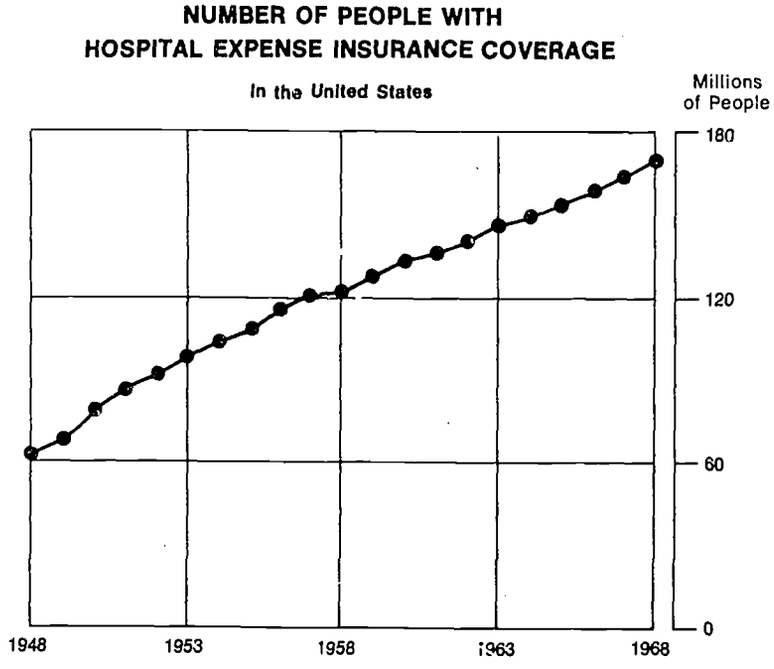
Source: National Center for Health Statistics, Series 10, Number 55, p. 17. (Data based on household interviews of the civilian, non-institutional population.)

1. Includes unknown family income.

Studies in June, 1963, indicate only 34% of persons in families with incomes under $2,000 carried any sort of hospital insurance, compared to 88% of those in families with incomes exceeding $7,000.[1]

While the introduction of Medicaid programs under Title XIX of the Social Security Act have brought increasing numbers of low-income persons under a type of health insurance program, there are still large numbers of individuals for whom no assistance is available. It should be noted that Oregon has not funded the medically needy section of Title XIX (Medicaid), thus providing no financial assistance in paying for needed medical and hospital care, etc. to thousands of Oregonians who have sufficient income to meet their maintenance needs, but lack sufficient income to meet their medical needs. In 1968, approximately 169 million people were protected by one or more forms of private health insurance, representing approximately 85% of the population (Figure 5). The vast majority of the 15% with no private health insurance protection were members of low-income families. The impact of cost for personal health services for low-income families is five times as great as in families with incomes exceeding $7,000.

Figure 5



Source: 1969 Source Book of Health Insurance Data, p. 18.

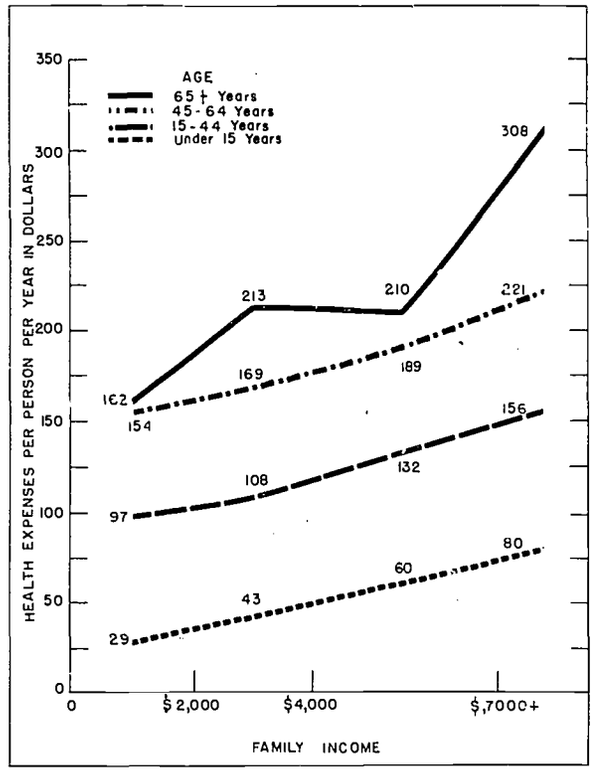
1. National Center for Health Statistics, Series 10, Number 9, p. 6.

While studies indicate a higher than average rate of disability days, there is a consistently lower expenditure for health care among low-income families. Figure 6 indicates the actual levels of health expenditures.

This lower than average level of expenditure, however, represents a significantly higher than average percentage of family income. In the lowest income group, the health expenses represent almost 16% of family income, compared to less than 4% in families with incomes above $7,500, and national average of 5%.

Figure 6

Health Expenses per Person per Year, by Age and Family Income



Source: National Center for Health Statistics, Series 10, Number 9, p. 46)

The foregoing are only examples of the many health problems encountered by low-income individuals and families. Health surveys related to Head Start, Job Corps, and military induction programs continue to substantiate these reports. There is little room to question the significance of the problem or the need to develop more responsive mechanisms for the delivery of health services to the medically needy.

CURRENT PROGRAMS AND ACTIVITIES

The Public Welfare Division's approved 1969-1971 budget for medical, hospital, and nursing home care payments for welfare recipients totaled $48,577,268. This is a closed budget and if funds run out, the Division must request additional funds from the Emergency Board or cut back on services.

During 1970, approximately 118,000 people were receiving some form of welfare assistance in Oregon. Persons on welfare (other than general assistance recipients) receive a medical care card with each support check. This card is valid until receipt of the next welfare check, unless otherwise invalidated.

Procedures for reimbursement of services rendered vary by professional group and type of facility. On the average, payment to physicians is 55.35% of the 75th percentile of physicians' reasonable charges. Dental reimbursements are slightly higher, averaging 58.7% of the 75th percentile of dentists' reasonable charges. Payments for visual examinations average 50% of the prevailing charges. All fees charged by health professionals are based on a fixed fee structure. Skilled nursing home services are reimbursed by a per diem rate for each facility based on operating costs. Reimbursements for inpatient and outpatient hospital services are based on reasonable costs. Reasonable costs are defined as "21 days of hospitalization per person per year." According to the Oregon Association of Hospitals, over $500,000 per year in services are rendered by hospitals and not reimbursed under this payment plan. All of these unreimbursed charges ultimately are paid for by the paying patient. (See Exhibit 1 for more information on the reimbursement procedures for Public Welfare Division.)

Exhibit 2 outlines those services for which the Public Welfare Division currently provides payment in behalf of eligible individuals.

The University of Oregon Medical School Hospitals and Clinics provide a wide range of medical care services. Professional services are provided by the faculty of the Medical School. Charges in all of the hospitals and clinics are based upon the patient's ability to pay, and range from free care to full pay. Determination of the fee schedule is made individually after an admission-eligibility interview. The hospitals and clinics are composed of the following units:

> The Children's Eye Clinic is, in addition to state funds, supported by the Elks Lodges of Oregon. Patients up to the age of 18, with visual handicaps, may be referred to this clinic by a physician, agency, the Elks, or may apply directly to the Outpatient Clinic. Most of the children who come to the clinic have serious eye

disorders and nearly one out of five requires surgery. Children are also examined, treated, fitted with glasses, or other prosthetic devices as their cases may require. Patients must be residents of Oregon without sufficient funds to pay for the full cost of needed medical care.

Crippled Children's Division is a statewide outpatient consultation and treatment service for children up to the age of 21 who have crippling diseases of any type including orthopedic, mental retardation, cerebral palsy, congenital heart disease, etc. Referral is through local physicians and health agencies.

Cystic Fibrosis, Convulsive Disorders, Metabolic Diseases in Children, Rheumatology, Hemodialysis, and Cardiac Evaluation Clinics represent some of the special clinics at the Medical School operated as part of its program of teaching and research. Patients with special problems are eligible for admission and service if referred by their private physician, local health officer, or sponsoring agency.

Doernbecher Memorial Hospital for Children is a 112-bed hospital for the medical and surgical treatment of children up to the age of 14 who are residents of Oregon and who are referred by their physicians or a unit of the Medical School. Doernbecher Hospital is housed on the two top floors of the Medical School Hospital.

General Outpatient Clinic provides all types of medical and surgical care for patients who are ambulatory and are residents of the state, without regard to age or financial need. However, its primary obligation is to provide care to those patients who are without funds such as clients of the Public Welfare Division, or those known to other public or private charitable or health agencies. Patients who have resources to pay for medical care must be referred by their private physicians for consultation or treatment.

Julius L. Meier Clinic is an outpatient service for the diagnosis and follow-up treatment of patients with tuberculosis. The clinic operates in association with the City Bureau of Health and the Medical School's Tuberculosis Hospital.

The Low Vision Aid Clinic is a cooperative program with the Oregon State Blind Commission. Low vision aid appliances are prescribed for patients referred to the clinic by the Blind Commission.

Medical School Hospital is a general hospital with 155 beds for the medical, surgical, and psychiatric care of residents of the state who are referred by their private physicians or units of the Medical School.

Multnomah Hospital is a 295-bed hospital for the medical, surgical, and obstetrical care of medically indigent residents of Multnomah County. It also has a 20-bed psychiatric crisis unit. An emergency department at Multnomah Hospital is open to any ill or injured person. The hospital maintains an intensive coronary care unit and has access to all the specialized services of the Medical School.

Tumor Clinics are conducted in the Departments of General Surgery, Urology, Dermatology, and Otolaryngology. Any patient with a diagnosis of malignancy may be referred by his physician for consultation and treatment. Radiation therapy and chemotherapy are available for use in treatment in addition to surgery.

The University of Oregon Medical School Tuberculosis Hospital has an 80-bed capacity and a large outpatient unit (the Julius Meier Clinic) for patients with tuberculosis. Admission is open to residents of Oregon by referral of a physician.

The University of Oregon Dental School Clinics provide dental treatment to persons of limited means. A moderate fee is charged for these services.

The Portland Center for Hearing and Speech is an affiliated program of the Department of Otolaryngology at the Medical School and a privately-supported agency. It provides specialized hearing and speech programs.

The Maternal and Infant Care Program at Emanuel Hospital in Portland is a special project funded by the State Board of Health. A professional team composed of obstetricians, a pediatrician, public health nurses, dentist, nutritionist, and home economist provides prenatal, obstetrical, postnatal, and infant care to all women living the the Project area. Outpatient service is given at Emanuel Hospital by appointment only. Women are delivered at Emanuel or Multnomah Hospitals. Family planning services are provided to those who wish it by the Planned Parenthood Association.

Shriner's Hospital for Crippled Children is an orthopedic hospital furnishing free treatment and convalescent care to children afflicted with diseases and deformities coming within the scope of orthopedic surgery. Services are available based on ability to pay. Admission for treatment is irrespective of a child's race, creed, or color. Children must be under 15 years of age.

Community Action Programs and 1969 Budgets

Marion - Mid-Willamette Valley Community Action Program - Salem

Emergency Food and Medical Services Program	$54,745
Family Planning Services	64,800

Blue Mountain Economic Development Council - Umatilla, Pendleton

Emergency Food and Medical Services Program	$60,000

Community Action Council, Inc. of Columbia County - Scappoose

Emergency Food and Medical Services Program	$40,000

Eastern Oregon Community Development Council, Inc. - LaGrande

Emergency Food and Medical Services Program	$52,788

Jackson County Community Action Council, Inc. - Medford

Family Planning	$52,343
Emergency Food and Medical Services Program	44,940

Southwestern Oregon Community Action Committee - Coos Bay

Emergency Food and Medical Services Program	$34,175

Portland Metropolitan Steering Committee (PMSC)

Comprehensive Health Care Program	$1,951,765

PMSC has contracted with Kaiser Foundation Health Plan to provide comprehensive health care to 1,800 poor families living in Northeast Portland.

Dental Care Program	$75,671
Alcohol Counseling and Recovery	$93,750
Emergency Food and Medical Services Program	$75,350

County Health Departments vary widely in the number and types of health programs they offer. Some of the larger outreach oriented departments offer well-child clinics, family planning clinics, pre- and postnatal care clinics, and venereal disease clinics scheduled in places and times convenient to the community. The smaller health departments do not have formalized health programs, but provide a limited range of services to those who go to the health department office.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1975, assure all medically indigent persons access to quality health services through a pre-paid medical care plan including prevention, treatment, rehabilitation, and long-term care.

2. By 1972, insure state financial support of county health offices and community mental health clinics.

3. By 1972, develop mechanisms for the coordination of health delivery programs for the medically indigent at the state and local levels.

4. By 1975, expand the role of the local health departments to provide services to the medically indigent through one or more community health care clinics.

5. By 1975, establish multi-service centers including health services in five cities in the state having high concentrations of medically indigent persons.

6. By 1973, assure Medicaid coverage for all medically indigent persons in Oregon.

7. By 1972, assure that no Oregonian will be deprived of needed medical care and consultation because of inability to pay.

RECOMMENDATIONS AND METHODS

1. *DETERMINE THE EXTENT OF NEED FOR SERVICES AMONG THE MEDICALLY INDIGENT AND THE AVAILABLE RESOURCES.*

   Methods

   a. *Areawide comprehensive health planning committees inventory providers of health care services and other resources at the areawide level and assess the expected demand for services.*

   b. *Areawide comprehensive health planning committees develop a working liaison with local community action programs and provide for their representation on areawide comprehensive health planning committees.*

2. *EACH AREAWIDE COMPREHENSIVE HEALTH PLANNING COMMITTEE, IN COOPERATION WITH COMMUNITY ACTION PROGRAMS AND COUNTY MEDICAL SOCIETIES, DEVELOP MECHANISMS FOR REFERRAL OF MEDICALLY INDIGENT PERSONS TO APPROPRIATE PROVIDERS TO ASSURE COORDINATED HEALTH CARE FOR THE MEDICALLY INDIGENT IN THEIR COMMUNITY.*

3. *EXPAND ENROLLMENT OF SCHOOLS OF MEDICINE AND ALLIED HEALTH AND RECRUIT A HIGHER PERCENTAGE OF STUDENTS FROM LOW-INCOME FAMILIES.*

   Method

   All colleges, universities, and professional schools publicize scholarship and other financial assistance information among low-income and minority groups, through schools serving low-income areas and special representative organizations.

4. *DEVELOP COST ESTIMATES AND METHODS OF FINANCING THE DELIVERY OF HEALTH CARE SERVICES TO THE MEDICALLY INDIGENT OF THE STATE.*

Method

Governor's Health Planning Committee, cooperatively with the Welfare Department's Title XIX Advisory Committee and the Governor's Assistants on Human Resources and Economic Development and Consumer Services, appoint a task force to develop a plan with several alternative methods of financing for the consideration of the Chief Executive prior to his preparation of the budget for the 1973-75 biennium.

5. *OREGON MEDICAL ASSOCIATION ENCOURAGE PHYSICIANS TO ORGANIZE GROUP PRACTICES AND HEALTH MAINTENANCE ORGANIZATIONS.*[1]

6. *INCREASE STATE SUPPORT TO COUNTY HEALTH DEPARTMENTS AND COMMUNITY MENTAL HEALTH CLINICS TO EXPAND THEIR SERVICES TO THE MEDICALLY INDIGENT.*

Methods

a. *Legislature approve the legislation submitted by the Committee on the Structure for Delivery of Public Health Services at the Local Level, increasing state support to local health departments.*

b. *Legislature approve the Mental Health Division's request for state financial support of the community mental health clinics.*

7. *OFFICE OF ECONOMIC OPPORTUNITY AND/OR COMPREHENSIVE HEALTH PLANNING PROVIDE FUNDING FOR NEIGHBORHOOD HEALTH CENTERS, OFFERING A COMPLETE RANGE OF PREVENTIVE, DIAGNOSTIC, THERAPEUTIC, AND OUTREACH SERVICES TO BE OPERATED BY ANY OF THE FOLLOWING: UNIVERSITY OF OREGON MEDICAL SCHOOL, LOCAL HEALTH DEPARTMENT, HOSPITAL, OR GROUP PRACTICE.*

Method

Oregon State Board of Health revise Oregon Administrative Rules (Rules, Regulations, and Standards for Hospitals 23-124) to include the licensing of neighborhood health clinics.

8. *AS AN INTERIM MEASURE, UNTIL THE ADOPTION AND IMPLEMENTATION OF SOME FORM OF PREPAID HEALTH CARE COVERAGE, STATE OF OREGON EXPAND TITLE XIX MEDICAID TO PROVIDE MEDICAL CARE ASSISTANCE TO COVER THOSE PERSONS OR FAMILIES WHO ARE CAPABLE OF PROVIDING FOR THEIR OWN MAINTENANCE NEEDS, BUT CANNOT COPE FINANCIALLY WITH THE ADDITIONAL DEMANDS OF THEIR MEDICAL CARE NEEDS.*

---

1. *Health Maintenance Organizations (HMO) is a system for the consolidation of various providers of health care into one organization (non-profit corporation) delivering comprehensive health service to be reimbursed on the basis of aggregate fixed sum or per capita payment, as opposed to fee for service.*

9. *FACILITATE ENTRY OF MEDICALLY INDIGENT PERSONS INTO THE MEDICAL CARE DELIVERY SYSTEM AND ELIMINATE BARRIERS EXISTING BECAUSE OF IGNORANCE, DISCRIMINATION, FINANCES, OR HANDICAPPING ADMINISTRATIVE PROCEDURES.*

Methods

a. *Oregon Medical Association insure that no Oregonian will be deprived of needed medical care and consultation because of inability to pay.*

b. *University of Oregon Medical School, Oregon State Board of Health, Oregon Medical Association, and Oregon Association of Hospitals develop plans for establishing and staffing neighborhood health clinics in strategic high density areas throughout Oregon to increase accessibility to health services for the indigent and provide a primary point of entry to the medical care delivery system.*

c. *County health departments, in cooperation with Oregon State Board of Health, expand outreach efforts by taking health services to the poor, such as using mobile health clinics.*

d. *Local comprehensive health planning committees establish a Medical Care Ombudsman Committee to hear grievance cases of the medically indigent.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALJATION CRITERIA

To be determined.

PRIORITY

To be determined.

EXHIBIT 1

MEDICAL SERVICES COVERED BY PUBLIC WELFARE DIVISION

1. Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases), paid on a reasonable cost basis (subject to limit of twenty-one days per fiscal year and payment of physicians' charges);

2. Outpatient hospital services; (elective and rehabilitative procedures are subject to prior authorization);

3. Other laboratory and x-ray services;

4. Skilled nursing home services (other than services in an institution for tuberculosis or mental diseases); (maximum on cost reimbursement);

5. Physicians' services, (M.D.'s and D.O.'s) whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere; (elective and rehabilitative procedures subject to prior authorization);

6. Medical care, or any other type of remedial care recognized by state law, furnished by licensed practitioners within the scope of their practice as defined by state law; (subject to prior authorization);

7. Private duty nursing services; (subject to prior authorization);

8. Clinic services; (elective and rehabilitative procedures subject to prior authorization);

9. Dental Services; (subject to prior authorization);

10. Physical therapy (subject to prior authorization);

11. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the individual may select; drugs - formulary authorized, eyeglasses - prior authorized;

12. Other diagnostic, screening, preventive, and rehabilitative services;

13. Inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

14. Any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary and includes:

a. Transportation including expense for transportation and other related travel expenses necessary to secure medical examinations and/or treatment when determined by agency to be necessary in the individual case. "Travel expenses" are defined to include the cost of transportation for the individual by ambulance, taxi cab, common carrier, or other appropriate means; the cost of outside meals and lodging in route to, while receiving medical care, and returning from a medical resource; and the cost of an attendant to accompany him if medically or otherwise necessary. The cost of an attendant may include transportation, meals, lodging, and salary of the attendant, except that no salary may be paid a member of the patient's family.

b. Family Planning Services -- drug supplies, and devices, when such services are under the supervision of a physician.

c. Whole Blood -- including items and services required in collection, storage, and administration, when it has been recommended by a physician and when it is not available to the patient from other sources.

d. Care and services provided in Christian Science Sanatoria operated by, or listed and certified by, the First Church of Christ Scientist, Boston, Massachusetts.

f. Emergency hospital services, which are necessary to prevent the death or serious impairment of health of the individual and which, because of threat to the life or health of the individual necessitates the use of the most accessible hospital available which is equipped to furnish such services even though the hospital does not currently meet the conditions for participation under Title XVIII of the Social Security Act, or definition of inpatient or outpatient hospital services in D-5141, Items 1 and 2.

g. Nursing care in recipient's home prescribed by a physician and rendered by an individual, not a member of the family, certified by a physician who is qualified to perform such services.

15. First three pints of blood in a spell of illness under Title XVIII.

16. Necessary pints of whole blood.

17. Early and periodic screening and diagnosis, and treatment of conditions found, when and as prescribed by the Secretary, for individuals under 21 years of age.

Lacking to meet the Federal definition of "comprehensive" care are the following:

Home Health Agency Services
Audiometrist Services
Occupational Therapist Services
Speech Therapist Services

Source: Public Welfare Division, October, 1970.

EXHIBIT 2

OREGON PUBLIC WELFARE DIVISION
BASIS FOR REIMBURSEMENT FOR MEDICAL AND INSTITUTIONAL CARE

1. Inpatient hospital services: reasonable cost, as specified in Federal Regulation 250.30 (b) (1), Par. 21,730. (Interim rate percentage with adjustment at the end of year)

2. Outpatient hospital services, including emergency services: reasonable cost, as specified in Federal Regulation 250.30 (b) (3) (ii), Par. 21,730. (Interim rate percentage with adjustment at the end of year)

3. Physicians' services, including laboratory and X-ray services: fixed fee structure.

4. Prescribed drugs: the upper limit for payment is the wholesale cost, plus 50% of the wholesale cost, plus 85¢ dispensing fee.

5. Skilled nursing home services: per diem rate for each facility based on operating costs but not to exceed the statewide ceiling rate established by the Division.

6. Dental services: same as 3., above.*

7. Eye care: visual service fee structure for medical doctors and optometrists.

8. Transportation: charges to the general public as certified to and filed with the Division.*

9. Private-duty registered nurse services: same as 3., above.*

10. Physical therapy services: same as 3., above.*

11. Services of podiatrists, chiropractors, and naturopaths: same as 3., above.*

12. Home health services: nursing and physical therapy services--paid at those rates certified to and filed by the home health agency with the Division.*

13. Ophthalmic materials: same as 3., above.*

14. Medical supplies and equipment, prosthetic devices, and special appliances: these items are reimbursed at the best price available in the community.*

15. First three pints of whole blood: this deductible under Title XVIII paid at the going rate in the community.

* Prior authorization by the County Public Welfare Office or the Medical Assistance Section in the Division's State Office.

Source: Public Welfare Division, October, 1970.

MIGRANTS

GCAL PROVIDE A HEALTHY LIVING AND WORKING ENVIRONMENT FOR THE SEASONAL AND MIGRANT FARM WORKER AND HIS FAMILY AND MAKE AVAILABLE NEEDED MEDICAL AND DENTAL SERVICES.

CONDITION

It is estimated that between 31,000[1] and 44,000[2] inter-state workers and families migrate to Oregon each year. These seasonal farm workers concentrate in 19 counties. Their stay varies from approximately three weeks in Wasco County to seven months in Malheur County. The work force swells as approximately 68,000 intra-state farm workers, most of whom are local residents, join the inter-state workers in planting, cultivating, and harvesting the crops.[3]

There are approximately 870 farm labor camps within the state; the largest number of these are "on-the-farm camps" provided by growers to house their agricultural work force. Cooperatively sponsored camps and housing authority administered camps comprise the remainder of the housing provided for these workers and their families.

In February 1970, the State Board of Health revised the farm labor camp and field health standards to make them more stringent. In the beginning of the 1970 season, there were 863 farm labor camps reported by the Oregon State Board of Health.[4] Upon inspection prior to occupancy, 506 were found to be in compliance with state statutes and the newly revised Oregon State Board of Health standards. There were 315 that did not comply at the time of initial inspection. Subsequently, 86 camps were brought into compliance. There were 64 that either did not open or were closed because they could not meet standards. An additional 164 did not meet standards, but were allowed to operate.

1. Occupational Health Section, Oregon State Board of Health, 1969 estimate.
2. 1969 Report of the Senate Committee on Migratory Labor.
3. Employment Division, Figure represents the peak number of intra-state farm workers recorded during the 1970 crop season recorded by the Division. The Division surveys on the 15th of the month from May to October.
4. Preliminary data on farm labor inspection activities obtained from the Oregon State Board of Health.

These camps were put on notice that they would not be allowed to operate the following season, unless they met standards. Eighteen camps were closed because they fell below standards during the season. In addition, 42 camps operated during the 1970 season, but were never inspected.

It should be noted that there is no state requirement for the provision and maintenance of drinking water and hand washing facilities at places of employment. This problem involves not only migrant or seasonal farm workers, but women and children from the metropolitan and rural areas of the state who work the fields. Of the 116 water supplies checked in 1969 for potability, 37% were contaminated. Only 16% of these were corrected.

During the 1960's, the Oregon State Board of Health randomly surveyed migrant camp conditions throughout the state. Table 1 illustrates that improvements are made at a very slow rate. Among the problems listed, only toilet construction showed significant improvement. In the initial survey, 56% were improperly constructed; however, in the second survey only 25% were identified as problems (an improvement of 31%). Improper garbage disposal showed virtually no improvement (0.7%).

It should be noted that the health problems among migrants are many and significant; morbidity rates are considerably higher than among the general population. In 1969, 29% of the 18,500 migrant workers and their families screened by public health nurses needed medical care, and approximately 3% required hospitalization.

The administration of the Farm Labor Camp Statute and enforcement of regulations has been delegated to local health officers. However, the State Bureau of Labor and the State Division of Employment have concurrent jurisdiction to inspect and close facilities within a camp. Only a health officer can close an entire camp. The health officer has the authority to rescind closure orders posted by any other agency within 24 hours of issuance, if the order was erroneously issued or the facility was brought into compliance with the health code.

Responsibility for the statewide administration of the Migrant Health Services Program is assigned to the State Board of Health. In Linn and Polk Counties, the Oregon State Board of Health performs the migrant health services.

The questions to which this specific program must address itself are numerous. Some examples are:

1. How best can the medical needs of this group of workers and their families be met?

Table 1

COMPARISON OF THE MOST SIGNIFICANT SANITATION PROBLEMS ENCOUNTERED IN THE FARM LABOR CAMPS SURVEYED BETWEEN 1964-1967[1] and 1968-1969

Item	1964-1967 First Survey Total Camps-161 No. of Camps	% of Camps	1968-1969 Second Survey Total Camps-234 No. of Camps	% of Camps	Improvements In Percent
Unapproved Water Source	24	14.9	19	8.1	+ 6.8
Improper Sewage And Liquid Waste Disposal	33	20.5	27	11.5	+ 9.0
Poor Toilet Repair And Maintenance	82	50.9	65	27.8	+ 23.1
Improper Toilet Construction	90	55.9	58	24.8	+ 31.1
Improper Garbage Storage	87	54.0	74	31.6	+ 22.4
Improper Garbage Collection	24	14.9	16	6.8	+ 8.1
Improper Garbage Disposal	18	11.4	25	10.7	+ .7
Poor Camp Maintenance	71	44.2	76	32.5	+ 11.7

Source:
Oregon State Board of Health, Oregon Migrant Health Project - 1969 Annual Report.

Only those camps that were resurveyed are compared.

2. To what extent shall the state regulate the quality of living conditions in temporary seasonal housing beyond the point of strict communicable disease control?

3. Should the administration of this program be limited to the local health departments and the State Board of Health, or should it remain as it presently is, with concurrent jurisdiction shared among the health agencies, the Oregon State Bureau of Labor, and the Oregon State Employment Service?

4. To what degree should the local and state health departments continue to rely on federal support to provide necessary health services to this target population?

CURRENT PROGRAMS AND ACTIVITIES

Oregon State Board of Health is responsible for the administration of the Migrant Health Service Project. Annual funding for the program is $584,514 (including $77,799 of "in kind" matching). Of this amount, $132,168 (including $26,631 of "in kind" matching) is allocated to the State Board of Health for the administration of the program and for providing direct services to Linn and Polk Counties. The remainder of the funds ($488,795) is allocated to 12 counties to support: public health nurses, who conduct health screening, health counseling, referral and follow-up; sanitarians, who are responsible for the quality of the living and working environment; and community health aides, who work directly with migrants in the areas of health education. The project also provides for fee-for-service payment to physicians for outpatient medical care in clinics; payment for necessary drugs and biologicals; and payment for special diagnostic, laboratory and x-ray services.

The responsibility for the maintenance of housing, sanitary facilities and water supplies is shared by the Oregon State Board of Health, local health departments, State Bureau of Labor, and the State Employment Division.

State Bureau of Labor enforces wage and hour legislation including unfair employment practices, as well as labor contractor licensing. They are responsible for enforcing state farm labor standards. The Bureau reported that it made 380 inspections of farm labor camps in 1969. The Civil Rights Division is concerned with cases of discrimination in the seasonal work force.

Public Welfare Division provides temporary financial assistance to workers through Title IV, Part A, Emergency Assistance under the Aid to Families with Dependent Children whose residency has been established in Oregon. For those who are eligible and have residency

established in other states, the state's Title XIX should cover health services while they are out of their home state. Oregon has not funded the medically needy program of Title XIX, so that persons financially ineligible for welfare are also ineligible for health care services under Title XIX.

Department of Motor Vehicles establishes and enforces standards relating to the safety of trucks and buses transporting labor within the state.

State Department of Education administers the summer migrant schools through grants from the U.S. Department of Education.

The Oregon State University - Cooperative Extension Service has assisted in coordinating the activities of the various agencies. Home demonstration agents conduct various homemaker programs for women in farm labor camps.

Governor's Chicano Affairs Advisory Committee makes recommendations to the Governor on matters effecting the Chicanos.

Valley Migrant League, funded primarily through the Office of Economic Opportunity, provides direct assistance to those migrants desiring to settle permanently in Oregon. The League provides assistance in housing, job finding, loans to assist in the establishment of small businesses, day care, and language and literacy classes.

Oregon Council of Churches provides direct help in the camps.

State Division of Employment recruits agricultural labor from local, intra- and inter-state sources.

AUTHORITIES

ORS 446.510 - 990
OAR Chapter 333, Section 22-120 - 22140

OBJECTIVES

1. Improve living and working conditions on farm labor camps.

2. Make needed health care services available to all migrants by 1973.

RECOMMENDATIONS AND METHODS

1. *CORRECT EXISTING DEFICIENCIES IN LIVING AND WORKING CONDITIONS ON FARM LABOR CAMPS SO THAT BY 1971, 100% OF THE CAMPS COMPLY WITH OREGON LAW.*

Methods

a. *Oregon State Board of Health and local health departments improve camp and field inspection procedures.*

b. *Camps be inspected prior to initial occupation for the season and be approved for human habitation, upon compliance with Oregon laws.*

c. *Camps and fields be inspected at least monthly during the harvest season to assure continued compliance with Oregon laws.*

d. *Inspections be made in response to complaints that conditions in the camps are violating state laws.*

e. *Camps violating the Oregon laws be closed, in accordance with ORS 446.620.*

2. *ENCOURAGE APPROPRIATE ORGANIZATION (OREGON FARM BUREAU, GRANGE, ETC.) TO SUBMIT LEGISLATION PROVIDING FOR A TAX INCENTIVE FOR FARMERS TO IMPROVE THEIR MIGRANT CAMP HOUSING AND FACILITIES.*

3. *OREGON STATE BOARD OF HEALTH TO SUBMIT LEGISLATION TO:*

   A. *REQUIRE HAND WASHING FACILITIES IN THE FIELD NEAR TOILETS.*

   B. *REQUIRE POTABLE DRINKING WATER IN PLACES OF EMPLOYMENT.*

   C. *REQUIRE A MINIMUM OF 60 SQUARE FEET PER PERSON FOR THE LIVING, EATING, AND SLEEPING UNITS.*

   D. *REQUIRE ELECTRIC LIGHTING IN THE COOKING, SLEEPING, BATHING, AND TOILET AREAS OF THE CAMP.*

   E. *REQUIRE MECHANICAL REFRIGERATION FOR FOOD STORAGE.*

   F. *REQUIRE THAT HOUSING USED FOR FAMILIES WITH ONE OR MORE CHILDREN OVER 6 YEARS OF AGE HAVE A SEPARATE SLEEPING AREA FOR HUSBAND AND WIFE. THE PARTITION TO BE OF RIGID MATERIAL AND INSTALLED SO AS TO PROVIDE REASONABLE PRIVACY.*

4. *ESTABLISH, BY EXECUTIVE ORDER, AN INTERAGENCY COORDINATING COUNCIL CONSISTING OF REPRESENTATIVES FROM THE OREGON STATE BOARD OF HEALTH, BUREAU OF LABOR, EMPLOYMENT DIVISION, LOCAL HEALTH DEPARTMENTS, AND THE VALLEY MIGRANT LEAGUE TO DESIGN COORDINATED INSPECTION PROGRAMS OF FARM LABOR CAMPS TO AVOID DUPLICATION OF SERVICES AND ASSURE THAT STATE AND FEDERAL REGULATIONS ARE MET.*

5. *CONGRESSIONAL DELEGATION OBTAIN THE RESTORATION OF THE HOSPITAL BENEFITS OF THE MIGRANT HEALTH PROJECT RECENTLY DISCONTINUED BY THE PUBLIC HEALTH SERVICE.*

6. *IN THOSE AREAS WHERE THE SEASONAL MIGRANT POPULATION TAXES THE AVAILABLE MEDICAL AND DENTAL RESOURCES, UNIVERSITY OF OREGON MEDICAL SCHOOL AND UNIVERSITY OF OREGON DENTAL SCHOOL SUPPORT THE ESTABLISHMENT OF SPECIAL MEDICAL AND DENTAL CLINICS UTILIZING STUDENTS TO PROVIDE PREVENTIVE AND NEEDED CARE UNDER THE SUPERVISION OF A LICENSED PROFESSIONAL.*

   Method

   Conference of Local Health Officers, in cooperation with Oregon Dental Association, submit legislation permitting full-time students of dentistry to practice off the school premises while under the supervision of a licensed dentist.

7. *COLLEGE OF OPTOMETRY AT PACIFIC UNIVERSITY EXPAND OUTREACH EFFORTS AND INFORM POTENTIAL USERS THROUGH THE VALLEY MIGRANT LEAGUE AND LOCAL HEALTH DEPARTMENTS OF THE SERVICES OFFERED AT THE COLLEGE VISION CARE CLINIC.*

8. *LOCAL HEALTH DEPARTMENTS RECEIVING FUNDS FROM THE MIGRANT HEALTH SERVICE PROJECT EXPAND OUTREACH EFFORTS AND HEALTH SERVICES TO THE MIGRANTS.*

   Methods

   a. *Public health nurses and nurses aides conduct casefinding, referral, and follow-up in the migrant labor camps.*

   b. *County health departments provide diagnostic and treatment services including laboratory, x-ray and drug services and such preventive services as immunizations, family planning, pre- and postnatal care, and well-child supervision.*

   c. *All county health departments serving migrants utilize the Family Record Form and instruct families and individuals to retain this medical record and present it upon receipt of medical care to maximize continuity of health care.*

   d. *Extend present medical and dental services to include provision of glasses, dentures, and orthopedic devices.*

OPERATIONAL PROBLEMS

1. It is difficult to preserve continuity of medical care as the workers and their families travel from state to state or county to county.

2. Because of the seasonal nature of this project, staffing on a part-time basis has been and continues to be a problem, especially in the area of sanitation.

3. Because of a recent Supreme Court decision, farmers and camp operators are within their rights to refuse entry to farm labor camps by county sanitarians for the purposes of inspection. There are no provisions in Oregon laws to issue warrants to property for the purposes of inspection.

4. This program is almost solely supported by federal dollars; the state contribution is minimal.

EVALUATION CRITERIA

The responsibility for determining the progress toward the achievement of the objectives is within the Occupational Health Section of the State Board of Health.

PRIORITY

To be determined.

EXHIBIT 1

A COMPARISON OF LABOR CAMP REGULATIONS

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Camp Location and Maintenance			
Grounds sanitary, free from putresible material. Sites graded, ditched to prevent standing water.	Well drained, located and maintained to prevent health and safety hazards. Sanitary, dust-free; roads and walks graded, gravel or hard surfaced.	Grounds free from depressions. Water within 200 ft. of camp drained or filled or treated with larvicide or oil.	Site well drained, free from depressions in which water can stand and located so as to prevent health and safety hazards. Water within 200 ft. drained or treated with larvicide.
(None)	200 ft. from occupied feed lot, dairy or poultry operation.	At least 75 ft. from pens of livestock or poultry. Domestic animals and poultry not permitted to run at large.	Site at least 200 ft. from livestock or poultry quarters and from all establishments processing or distributing commercial food products.
(None)	Recreation area related to size of facility and type of occupancy.	(None)	Adequate service building to be erected on every site except where lavatory, laundry, bath, and toilet facilities are provided with each dwelling unit.
Dwelling Unit Construction and Maintenance			
Sleeping places structurally sound. Protects from elements.	Dwelling units structurally sound, good repair, sanitary condition and protect against elements.	Comply with CAC Title 8, Cap. 9, Act 8, Sec. 17000.	Shelters structurally sound. sanitary and protect from elements.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Dwelling units - continued			
(None)	Finished inside walls unless health officer permits otherwise. Such permission is subject to annual review. Painted walls and ceilings minimum requirement.	CAC Title 8, Chap. 9, Act 8, Sec. 17000.	(None)
Floors			
Rigid and durable material, smooth and cleanable finish.	Wood, concrete, tile or other impervious material. If elevated, no storage underneath.	CAC Title 8, Chap. 9, Act 8, Sec. 17000.	Wood, concrete, asphalt, or comparable material. If wooden, must be elevated not less than 12 in. from ground level, screened, and not used for storage. If concrete or asphalt, elevated at least 6 in. from ground level.
(None)	At least ½ of floor area must have 7 ft. ceiling. Finished ceilings mandatory if pitch of roof exceeds 3½ ft. Ceiling cleanable and light colored.	Average ceiling height 7 ft. 6 inches.	Ceiling height 7 ft.
Construction and Maintenance			
(None)	Separate sleeping room for husband and wife if any children over 6 yrs.	CAC Title 8, Chap. 9, Act 8, Sec. 17000.	Separate sleeping room for husband and wife if one or more children over 10 yrs. in housing hereafter constructed.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Construction and Maintenance (continued)			
(None)	70 sq. ft./1st occupant, 50 sq. ft./each additional occupant. If ceiling less than 5 ft., floor space not counted.	CAC Title 8, Chap. 9, Act 8, Sec. 17000.	For all housing units hereafter constructed: 70 sq. ft. floor space/ 1st occupant; 50 sq. ft./ each additional occupant. Floor space not counted if ceiling height is less than 7 ft.
Water			
Approved by Board 1 mo. prior to occupancy. Meets Board's standards.	Approved by Health Officer Meets State standards.	Potable, meets local department's standards. Samples to be tested prior to opening of camp.	Meets State Health Dept. standards.
Ample supply, 35 gal./ person/day.	Adequate supply, 35 gal./ person/day. 15 psi. at the tap.	35 gal./person/day. Pressure: normal operating pressure. Rate: 2½ times hourly demand.	Adequate supply, 35 gal./ person/day. Pressure: normal operating pressure to all fixtures. Rate 2½ times average hourly demand.
No common cups. If fountains must be jet type.	No common cups.	No common cups.	(None)
Adequate hot and cold water available at all farm labor camps. Facilities for heating water sufficient if camp open 2 weeks or less, or if less than 50 people are housed.	Hot and cold running water for central bathing, handwashing and laundry facilities 24 hours.	Hot and cold water for maximum number of people to be housed. Continuous supply.	Where delivered under pressure, adequate hot water for bathing, laundering, and dishwashing purposes at all times of occupancy. Water under pressure supplied to all habitable buildings in sites hereafter constructed.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Water (continued)			
(None)	Cold under pressure, plumbed and trapped sink for each family unit.	Hot and cold with approved sink for every kitchen.	(None)
Available from convenient outlets.	Cold, under pressure within 100 ft. of living unit without water.	Suitable and conveniently placed. Drainage must be provided.	Cold under pressure within 100 ft. of living units. Drainage facilities must be provided.
Sewage and Liquid Waste			
Disposal conforms to law and rules of Board. Where public sewers available, shall be connected to it.	Disposal approved by Health Officer. Public sewer used if available. If not, approved sewage disposal system required.	Approved disposal system for all fixtures. Comply with CAC.	Disposal approved by State Board of Health. Public sewers used if available; if not, approved sewage disposal system required.
Plumbing			
Comply with ORS 447.010 and Rules of Board.	Conform to WAC 248.94.	Comply with CAC. Title 8, Chap. 9, Act 8, Section 17000.	Must meet State requirements.
Refuse Disposal			
Water tight containers exclude flies and rodents, clean and good repair. Cover cans, garbage area clean, free of flies and rodents. All refuse and trash removed from farm labor camp at least 1/wk. and disposed so as not to endanger health.	Managed to prevent rodent, insect and health hazards. Clean, water tight, rodent-proof containers adjacent to dwelling units, at least 50 ft. from outdoor water faucets.	Garbage, waste, etc. in suitable covered containers, emptied daily or oftener, contents disposed of in sanitary manner.	Fly-tight containers adjacent to each shelter, 1/family. Collected 1/wk. or when full. Containers thoroughly cleaned. Garbage removed from mess hall and rooming house containers daily.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Rodent and Insect Control			
Living quarters shall be free from rodents, insects, and animal parasites before occupancy. Measures shall be taken to prevent or control breeding of mosquitoes, flies and rodents.	Appropriate measures to control rodents and insects.	All labor camps maintained free from vermin, insects and rodents. All openable windows screened. Doors screened with self-closing devices.	Effective measures to control rodents and insects. All outside openings protected with fly screening of not less than 16 mesh. Self closing devices.
Lavatory, Toilet, Shower and Laundry Facilities			
1/15 employees, adjacent either to toilet facilities or to living facilities.	1/12 persons. If camp has central facility, must be separate for sexes and located within 200 ft. of dwelling units.	1/30 occupants, continuous supply of hot and cold water, adjacent to toilet facilities.	1/20 persons in facilities hereafter constructed. 1/30 in existing facilities.
1 toilet or equivalent/15 of each sex; where 7 or less of both sexes, only one required. In facilities hereafter constructed, toilets not more than 200 ft. from living quarters.	1 toilet/15 persons or major fraction thereof. Water flush toilets or approved method. Toilet paper furnished for central facilities. Urinals: 1/30 males or major fraction thereof.	1/15 persons of each sex. Toilets not more than 400 ft. from sleeping quarters. Urinals may be substituted for 1/3 required toilets.	(None)
(None)	(None)	Windows of 3 sq. ft./ shower or toilet.	4 ft. sq. window opening or adequate mechanical ventilation.
Shower heads: 1/15 employees or major fraction thereof.	Shower heads: 1/15 or major portion thereof. 9 sq. ft. for shower space in new construction. Trapped floor drainage.	Shower heads: 1/15 or major fraction. Sloped floors to drain.	Shower heads: 1/20 persons. Properly trapped floor drains.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Lavorities, etc. (continued)			
(None)	Laundry and drying facilities within 200 ft. of dwelling units. Laundry tray and wash machine/50 or major fraction.	(None)	Double laundry tubs: one set per 25 families. Facilities clean and sanitary. Hot and cold water supplied.
Ventilation			
(None)	All habitable rooms at least one window or skylight. Window area=10% of usable floor area. Openable area 45% of minimum window area. Mechanical or other approved methods may be adequate if they provide comparable ventilation.	Habitable room-window 12½% of floor area or 12 sq. ft., whichever is greater. Opening for vent=1/16 of floor area.	Habitable rooms-window 10% of floor area. At least one window or skylight direct to outside. Opening for skylight= 15% of total floor area.
(None)	(None)	340 cu. ft./person or 300 cu. ft./person and additional ventilation.	400 cu. ft./person.
Heating			
(None)	Dwelling units heated to 68° F. in cold weather.	Habitable rooms 60°.	Habitable rooms 70°.
(None)	Proper venting, safe location, to prevent fire hazards or fume concentration.	Gas burning appliances of approved type and requirements of CAC Title 8, Chap. 9, Act 8, Sec. 17000.	Stoves, other sources installed so as to avoid fire hazards. Concrete slab provided where solid fuel is to be used.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Lighting			
(None)	20 ft. candles on work surfaces in dwelling units, toilet, shower, laundry rooms.	10 ft. candles at floor level within toilet and bath buildings.	At least 1 electric light and outlet within 300 ft. of each habitable room.
(None)	All labor camps shall be provided with electric source.	(None)	(None)
(None)	Dwelling units, toilet, bath and laundry rooms shall be provided with one ceiling fixture.	All lights in toilet and bath buildings shall be wall switched.	Hallways, toilets, bath, laundry rooms shall contain at least one ceiling or wall-type fixture.
Food Handling Facilities			
Central facilities: ORS 624 governs.	Comply with State rules and regulations.	Ranges provided with ventilating hoods.	Separated from sleeping quarters. Equipment in good repair and clean.
Dwelling unit kitchen: None.	Cook stove, or hot plate with 2 burners, storage shelves, refrigerator provided in each unit. Walls cleanable, fire resistant, nonabsorbent.	Sink provided, continuous supply of hot and cold water.	Separated from sleeping quarters. Equipped with cook stove, adequate shelves, refrigeration, and storage area, sink where water under pressure is supplied.
Beds and Bedding			
If provided, mattresses shall be cleaned.	Beds, bunks or cots shall be provided for each occupant, also clean mattresses and covers.	Suitable, separate beds of steel, canvas, or other sanitary material shall be provided. Mattress at request at reasonable charge.	Beds, bunks, cots with springs, and clean mattresses provided.

OREGON	WASHINGTON	CALIFORNIA	IDAHO
Beds and Bedding (continued)			
(None)	12" clearance from floor, beds 36" lateral clearance, bunks 48" lateral clearance, bunks 36" clearance top, bottom to top bunk clearance 36".	10" clearance from floor. Clear space from one bed to adjacent bed must be 30".	12" clearance from floor, beds 36" laterally or end to end, bunks 48" lat. or 36" end to end, bunks 36" clear above mattress to ceiling, bunks 27" between upper and lower bunk.
Fire and Safety			
(None)	Local rules and regulations. No storage of hazardous material.	No hazardous materials on premises.	Local regulations.
Additional exits for sleeping areas.	2 means of escape (window). First aid facilities and kit. Extinguishing equipment=to 2½ gal. water extinguisher, 100 ft. from dwelling units.	Comprehensive code for buildings indicating access, first aid, and electrical requirements.	Sleeping and eating quarters have two outside exits. Enclosed stairways and self closing doors from upper stories. First aid facilities and kit. Extinguishing equipment=to 2½ gal. water foam, or soda and acid. One unit for each 1,000 sq. ft., 100 ft. from each dwelling unit.
Communicable Disease			
Report to Health Officer.	Report to Health Officer.	Area shall be kept clean and free from vermin.	Area shall be kept clean from insects and rodents.

NEWBORNS, INFANTS, AND PRESCHOOL CHILDREN

GOAL IMPROVE THE HEALTH OF NEWBORNS, INFANTS, AND PRESCHOOL CHILDREN.

CONDITION

Newborns

The infant death rate is universally accepted as the indicator of effectiveness of the total health effort from environmental health to skilled care. In 1969 there were 33,843 live births in Oregon; however, 592 of these infants died before reaching their first birthday (Table 1).

Oregon's infant death rate of 17.5 per 1,000 live births, although lower than the United States rate of 22.4 per 1,000 live births, causes Oregon to be ranked 17th among the other states with regard to infant mortality. Of the 100 pregnancies reaching viability each day in Oregon, 1 will die before birth, 2 will die before reaching one year of age and 6-7 will have a serious problem, too often the result of prematurity or asphyxia and injury at the time of birth.

Premature births have increased in Oregon to a rate of 69.9 per 1,000 births (Table 1). These babies need skilled intensive care, especially during the first days of life. The positive correlations between prematurity and mental retardation and between prematurity and low socio-economic status have been well established. For example, in that area of Portland served by Emanuel Hospital (the location of the federally funded Maternal and Infant Care Project), 60% of the residents are receiving public assistance. Women living in this area had a 1968 prematurity rate of 75 per 1,000 live births as compared to a statewide rate of 66 per 1,000 live births.

Reported congenital malformations are increasing in Oregon (Table 2). Twelve out of every 1,000 children in Oregon are born with a congenital anomaly; this is an increase of 45% since 1957.

There are 76 hospitals in the state having maternity services, but only 40 have the equipment and trained professional personnel to provide life-saving resuscitation and supportive care to the newborn infant during his critical first 24 hours of life.

The rising illegitimacy rate is adding to the risk of medical problems among newborns. Illegitimate babies are more likely to be unhealthy because of the lack of medical care the mother generally gets during pregnancy. Also, an increasing number of young women who are abusing drugs are giving birth. The newborn is at high risk at birth and

Table 1

TOTAL BIRTHS, INFANT DEATHS AND NEONATAL DEATHS
OREGON, 1956-1969

	Total Births	Under 2500 gm.	Ratio*	Infant Deaths	Ratio*	Neonatal Deaths	Ratio*
1956	38423	2356	61.3	887	24.1	645	16.8
1957	37828	2170	57.4	828	21.9	587	15.5
1958	36245	2191	60.1	844	23.3	597	16.1
1959	36634	2349	64.1	927	25.3	664	18.1
1960	38347	2437	63.6	891	23.2	635	16.6
1961	37475	2328	62.1	861	23.0	604	16.1
1962	36983	2267	61.3	811	21.9	554	15.0
1963	34863	2276	65.3	747	21.4	551	15.8
1964	32500	2171	66.8	754	22.5	532	15.9
1965	32955	2146	65.1	696	21.1	477	14.5
1966	32446	2064	63.6	697	21.5	506	15.6
1967	31446	2036	64.7	616	19.6	436	13.9
1968	32136	2123	66.1	637	19.8	460	14.3
1969	33843	2195	69.9	592	17.5	409	12.0

*per 1000 births.

TABLE 2

NUMBER OF CONGENITAL MALFORMATIONS WITH RATIOS

OREGON, 1957-1969

YEAR	NUMBER	RATIO*
1957	303	8.0
1958	291	8.0
1959	293	8.0
1960	313	8.2
1961	303	8.1
1962	318	8.6
1963	292	8.4
1964	330	9.9
1965	353	10.7
1966	318	9.8
1967	334	10.6
1968	321	10.0
1969	392	11.6

*ratio per 1000 live births.

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can die without proper withdrawal treatment. Many of these mothers are having their babies at home and consequently the medical care needed by the newborn is unavailable.

The chances of survival for even the healthy newborn are affected by the fact that only about 10% of the newborn bassinets are in hospital nurseries that meet the minimum standards of care for newborns as outlined by The Academy of Pediatrics and the Oregon State Board of Health rules and regulations for hospitals in Oregon.

Infants

The health problems of infants after the neonatal period consist principally of the manifestation of birth defects including mental retardation. Certain hereditary conditions involving errors in metabolism may lead to severe handicaps and mental retardation if not identified within the newborn period. An average of six such cases in Oregon per year can be expected. Other problems facing infants during their first year of life include sudden and unexpected deaths, failure to thrive due to lack of nurturing and morbidity from acute infections. Proper and routine health care can serve to eliminate many of these problems.

Preschool Children

Accidents are the most frequent cause of mortality among preschool children in Oregon. About 44% of the deaths of children under the age of five years in Oregon during 1969 were caused by accidents.

Areas which require medical care among preschool children are morbidity from acute infections and manifestations of chronic diseases including vision, hearing, and dental problems. Such undetected and uncorrected problems often lead to under-achievement and frequently progress to permanent impairment. For example, screening for amblyopia, an eye disorder causing the child to see sharply with one eye and poorly with the other, should be diagnosed before the age of five if the condition is to be corrected before it leads to blindness. About 2% of Oregon children suffer from amblyopia. In addition, about 8% of the preschool children are identified as having decreased hearing sensitivity. Many children with such handicapping conditions go undetected until the child enrolls in school, since the majority of Oregon communities have poorly planned and implemented health programs for the preschool child. Environmental factors such as poor housing conditions, poor sanitation, and poor nutrition can permanently affect the health of the child.

CURRENT PROGRAMS AND ACTIVITIES

The Maternal and Child Health Section of the Oregon State Board of Health provides consultation services to maternity and infant care sections

of hospitals to insure healthful environments and maintenance of standards and to local health departments for services to mothers and newborns including nutrition, medical and health education, classes in child care for new parents, and well child conferences.

In addition, the Maternal and Child Health Section conducts in-service training for hospital personnel in order to upgrade knowledge and techniques of quality care; and coordinates referral for community health care of the sick, handicapped and high risk infants from the University of Oregon Medical School.

The PKU screening program is directed toward the prevention of mental retardation caused by inborn errors of metabolism. All infants born in Oregon are tested at birth and retested at four to six weeks of age. For those cases identified, the Oregon State Board of Health provides medical and nutritional consultation and assistance to the families.

The University of Oregon Medical School conducts an intensive care unit for newborns in the teaching hospital. The unit has 18 incubators and is staffed by six doctors and 15 to 20 nurses. The staff includes public health nurses and a social worker who assists in community referral for continuation of care after discharge.

Local health departments provide medical services to infants and children through their well child clinics and postnatal care clinics. These services include immunizations; special screening programs with emphasis on dental, vision, and hearing problems; nutrition counseling; and public health nurse follow-up of high-risk children. Local health departments also conduct educational programs in the care of infants and children and present programs to interested community groups. The extent of the above activities varies considerably among counties depending upon the staff and funds available.

The Maternal and Infant Care Project designed to reduce the number of premature births and provide comprehensive medical care to high-risk women during and immediately following pregnancy, is conducted at Emanuel Hospital in Portland. The project utilizes a team approach to provide medical, dental, nutritional, and emotional counseling and services to women in the Albina section.

Child development clinics are affiliated with the Health Departments in Washington, Clackamas, Polk, and Yamhill counties. These clinics provide thorough diagnosis and evaluation of children who evidence significant delay in development. Multi-discipline services are provided to the child and include medical and nursing consultation, direct nutrition, speech and hearing services, psychological counseling, and physical therapy. An important facet of the programs is community

follow-up. The clinics are continually informed as to the progress of the child by that agency which eventually handles the case.

The Teen Mothers Program, sponsored by the Salem Young Women's Christian Association (YWCA), in conjunction with several other community organizations, provides medical care to infants through well baby clinics conducted by the public health nurse. In addition to medical services, the program is designed to teach new mothers nutrition and the proper care of the infant.

AUTHORITIES

To be researched.

OBJECTIVES

1. Reduce the infant mortality rate in Oregon 20% by 1973 (from 19 to 15 per 1,000 live births).

2. Reduce the prematurity rate in low socio-economic areas of Oregon 25% by 1975.

3. Reduce incidence of congenital abnormalities 15% by 1975.

4. Improve the hospital services to newborns so that by 1975 all newborn wards in general hospitals meet the minimum standards of equipment and personnel as outlined by the American Academy of Pediatrics.

5. Increase casefinding of handicapping conditions, including mental retardation, among preschool children so that by 1975, 75% of the children with such conditions are identified and are receiving care to insure their reaching maximum potential.

RECOMMENDATIONS AND METHODS

1. *EXPAND PUBLIC EDUCATION PROGRAMS EMPHASIZING THE NEED FOR ADEQUATE HEALTH CARE FOR THE MOTHER AND HER BABY TO REDUCE PREGNANCY COMPLICATIONS AND CONGENITAL ANOMALIES.*

   Methods

   a. *Oregon State Board of Health and local health departments develop an educational program stressing the need for and benefits of prenatal care, utilizing all mass media to disseminate the information.*

   b. *All local health departments and clinics conduct and publicize classes in child care for expectant and new parents.*

c. *Local school districts include topics on infant and preschool child care and general child health in the high school health curriculum. Courses should be open to both sexes.*

2. *DESIGNATE STRATEGICALLY LOCATED REGIONAL HOSPITALS TO PROVIDE INTENSIVE CARE FOR HIGH-RISK NEWBORNS.*

Methods

a. *Oregon State Board of Health, in conjunction with the Oregon Association of Hospitals, the Oregon Medical Association, and the University of Oregon Medical School identify those hospitals capable of expanding their services to include intensive care for high-risk newborns.*

b. *Oregon State Board of Health, University of Oregon Medical School, and Oregon State Police develop a plan for emergency medical transportation services, providing ground and air transportation equipped for rapid transfer of prematurely born infants to designated intensive care centers.*

c. *University of Oregon Medical School, in cooperation with the Oregon State Board of Health, provide specialized maternal and child health professional consultation to designated regional hospitals.*

3. *DEVELOP CONTROLLED STUDIES TO IDENTIFY THOSE FACTORS CONTRIBUTING TO CONGENITAL MALFORMATIONS, PREMATURITY, AND INFANT DEATHS.*

Method

University of Oregon Medical School and other educational institutions prepare proposals and seek funding from the National Institute of Child Health and Human Development and other organizations for research projects.

4. *EXPAND THE TRAINING OF MEDICAL AND PARAMEDICAL PERSONNEL IN THE TECHNIQUES OF PROVIDING QUALITY CARE TO THE NEWBORN.*

Methods

a. *University of Oregon Medical School, in cooperation with the Maternal and Child Health Section of the Oregon State Board of Health, establish in-hospital training programs for maternity and newborn nursing staffs at designated regional hospitals with high-risk nurseries.*

b. *University of Oregon Medical School and Oregon State Board of Health to conduct periodic demonstration courses and workshop sessions on infant care for all health professionals.*

5. *REQUIRE HOSPITALS WITH NEWBORN WARDS TO MEET MINIMUM STANDARDS AS DEFINED BY THE AMERICAN ACADEMY OF PEDIATRICS.*

Methods

a. *Oregon State Board of Health Licensing Section and Oregon Association of Hospitals encourage each hospital medical staff to appoint a physician to be responsible for the quality of newborn care.*

b. *Oregon Association of Hospitals develop procedures to monitor and insure that hospital newborn ward standards remain high.*

6. *INCREASE EARLY DETECTION OF CHILDREN WITH DEVELOPMENTAL PROBLEMS THROUGH THE ESTABLISHMENT OF AT LEAST THREE MORE CHILD DEVELOPMENT CLINICS IN OREGON.*

Methods

a. *Areawide comprehensive health planning agencies assess the prevalence of children with developmental problems and the need for services.*

b. *Oregon State Board of Health and Mental Health Division assist local health departments in areas with high-risk populations to obtain federal funding for the establishment of child development clinics.*

c. *Oregon State Board of Health and Crippled Children's Division provide consultation in nutrition, vision and hearing, and public health nursing to the child development clinics.*

7. *ESTABLISH A STATEWIDE REFERRAL SYSTEM FOR COMMUNITY FOLLOW-UP OF SICK AND HANDICAPPED INFANTS AND CHILDREN.*

Methods

a. *Oregon State Board of Health provide a public health nurse to assist in the coordination of referrals of sick and handicapped children from the high-risk neonatal nursery of Doernbecher Hospital and the Pediatrics Department of the University of Oregon Medical School to appropriate medical care in the community.*

b. *Oregon State Board of Health assist local health departments and other community agencies in the establishment of a public education program outlining and defining the scope of the services available for children in the community.*

c. *Maternal and Child Health Section of the Oregon State Board of Health develop a Directory of Services for Children and distribute it to all agencies responsible for child services in Oregon. Such a directory would help to coordinate the services.*

d. *Oregon State Board of Health, in conjunction with local health departments, establish community follow-up of all children identified on birth certificates as having congenital abnormalities to insure they are receiving adequate medical care.*

8. *EXPAND PREVENTIVE HEALTH SERVICES FOR CHILDREN AT LOCAL HEALTH DEPARTMENTS.*

Method

Local health departments, with assistance from the Oregon State Board of Health, establish or expand the following services: a) well child clinics; b) classes for new parents in the fundamentals of parenthood and childrearing; c) community immunization programs; d) vision and hearing screening for children; and e) public educational programs on accident prevention among children.

9. *REQUIRE THAT ALL CHILDREN HAVE A PHYSICAL EXAMINATION, INCLUDING A VISION AND HEARING TEST, PRIOR TO ENTRY INTO THE FIRST GRADE.*

Methods

a. *Oregon State Board of Health submit legislation requiring physical examinations of children prior to entry into the school system.*

b. *Local health departments with vision and hearing specialists from the Oregon State Board of Health conduct physical examinations of preschool children in special clinic sessions to be held in August. For those able to pay for the examination, a sliding scale fee would be applied. Parents may choose to have their children examined by their private physician in lieu of the clinic.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual contraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Successful evaluation of the services to insure good health among newborns, infants, and children of preschool age car. be measured by the Oregon State Board of Health through:

1. Reduction in the incidence of morbidity/mortality, prematurity and congenital abnormalities among newborns as reported on by the birth certificate.

2. Increase in referrals of newborns for proper medical care.

3. Increase in number of well child conferences and other preventive medical services.

4. Increase in level of immunization in Oregon.

5. Decrease in the number of admissions of mental retardates to Fairview Hospital.

6. Increase in the number of hospitals meeting minimum standards in the maternity and newborn nurseries.

PRIORITY

To be determined.

SCHOOL-AGE CHILDREN

GOAL IMPROVE THE HEALTH OF SCHOOL AGE CHILDREN TO AID THEIR GROWTH AND DEVELOPMENT.

CONDITION

School age children comprise approximately one-fourth of Oregon's population (about 500,000). Serious health damage can often be averted if health problems are detected at early ages. Vision, hearing, and dental problems that are undetected and uncorrected often lead to under-achievement and frequently progress to permanent impairment. For example, amblyopia, an eye disorder that occurs in approximately 2% of the children, may lead to blindness if not diagnosed early and preferably before the age of five. It is estimated that 20 to 30% of all school age children suffer from visual defects that require professional care. In Oregon, approximately 4% of all school age children are found to have decreased hearing sensitivity. Among preschool children the percentage is even higher (approximately 8% of the children ages 3, 4, and 5 years). About 70% of children age 4-16 are in need of dental care. The actual percentage varies among communities according to the availability of fluoridated water supplies. Accidents, a leading cause of deaths for persons aged 1-24, represent another serious health problem for school children. Due to the extent and relative seriousness of the health problems experienced by this young population, the school health programs of screening, immunization, and education have proven to be a most satisfactory method of detection and prevention of health problems in children.

CURRENT PROGRAMS AND ACTIVITIES

The Interagency Committee on the Health of the School Age Child comprised of representatives of the Oregon State Board of Health, Board of Education, Board of Higher Education, and the Mental Health Division is responsible for developing and recommending interagency policy, and planning and coordinating agency programs in health services and education.

Oregon State Board of Health School Health Program provides medical, dental, public health nursing, nutrition, and health education consultation on the maintenance of child health to local health departments, schools, professional groups, hospitals, institutions, and community groups. The program also provides for hearing tests in grades K, 1, 3, 5, and 7; the fitting of a limited number of hearing aides; vision consultation and inservice training of volunteers and teachers to conduct vision screening.

Local health departments provide immunizations, public health nursing services, and consultation to schools on all matters pertaining to health, including health curricula; issue health certificates to school employees; check plumbing and water supplies in schools; conduct child abuse investigations; conduct communicable disease control centers; provide periodic evaluation of student dental needs; and refer children in need of care to physicians and dentists.

School Districts

There is no coordinated statewide school health program at the local level, since each school district is relatively autonomous. Some school districts hire full-time nurses, others contract with local health departments to provide nursing services to the schools.

The public health nurse assists families, physicians and school personnel under direction of the county health officer. She promotes and arranges for group immunization and testing, and helps school personnel become more adept at recognizing health anomalies. She follows up on children screened for defects of vision, hearing, teeth, growth, and development. The public health nurse works with parents and teachers to prevent illness through health education. This failing, she visits with the family with orders from their physician to assist them in regaining their children's health. This, then, results in a family-centered program focusing on their total health rather than just the health of the individual child.

Districts may require physical examinations at any designated grade level and/or before children may enter school. Schools may budget funds to pay local physicians and dentists for examinations or contribute directly to public health unit budgets for this purpose. A State Board of Education health guideline recommends that all pupils should be examined: 1) prior to entering school for the first time; 2) when referred as a result of teacher-nurse screening; 3) upon entering the seventh and tenth grades in systems having junior and senior high school or upon entering the ninth grade in systems having an elementary/high school transition. In addition, the State Board of Education requires that students participating in interscholastic athletic contests be examined each year prior to participation.

The State Board of Education requires that primary and secondary schools provide instruction in the areas of health as outlined below. At the primary level, these subjects are integrated into the existing curriculum. At the secondary level, the instruction becomes more formalized, requiring at least 45 class periods of health instruction.

Personal Health

1. Personal hygiene

2. Nutrition

3. Wholesome activity and rest

4. Choice and use of health services and practices

Community Health

1. Prevention and control of disease

2. Community health services

Mental Health

1. Personality and character development

2. Individual adjustment and family living

3. Alcohol, drugs, and tobacco

Safe Living

1. Home safety

2. School safety

3. Community safety

Many of the larger school systems in Oregon operate special programs of education for handicapped children. These programs include home instruction for crippled or chronically ill children who are unable to attend school, special classes or schools, special instruction by remedial teachers, and consultant services for special types of disabilities.

The State Board of Education has no full-time specialist in the area of health education. Health has been assigned to the physical education specialist. In fact, most schools combine physical education and health education, and hence the quality of the health education may be seriously jeopardized.

The Special Programs section of the State Department of Education maintains a staff of consultants who are available to any school distrct in the state to assist in providing for the educational needs of handicapped children. These consultants are available for vision, hearing, speech handicaps, mental retardation, and the special needs of children with physical disabilities or psychological problems. The consultants assist local schools in selecting children for special service, diagnosing their learning problems, recommending educational adjustments and assisting with the in-service education of teachers.

The Division of Vocational Rehabilitation provides service to all physically handicapped persons who have completed high school or are over 16 years of age.

The State School for the Blind provides education for those children having a vision problem of such severity as to make attendance in the public schools unprofitable. Referrals may be made through the consultant for the education of the visually handicapped child in the State Department of Education, through the public health nurse, or by direct referral to the State School for the Blind at Salem.

The State School for the Deaf provides education for deaf children and, in some cases, for those with such severe hearing loss that their needs cannot be met locally. Referrals may be made through the consultant for the education of the hard of hearing child, in the State Department of Education, through the public health nurse, or by direct referral to the State School for the Deaf.

Fairview Hospital and Training Center is a state institution providing residential care and training for mentally retarded children who cannot benefit from public education. Admission is provided only on a commitment basis.

AUTHORITIES

1. State Board of Education regulations pertaining to health and physical education programs in Oregon schools are as follows:

> "Section A: Health instruction and physical education required. District school boards shall provide in their respective schools, programs of health instruction and physical education for the development of health and physical fitness for all elementary school pupils in such schools and for the high school students as provided in paragraphs (1 and 2) of Section (Aa) of these regulations in order to promote, develop, and maintain among pupils at all age levels optimum physical growth, health and physical fitness.
>
> "Section B: State direction of program. The health instruction and physical education programs shall be under the general direction of the Superintendent of Public Instruction. He shall:
>
> A. Prescribe for, with the advice of the State Board of Health, a program of health examinations of pupils in the elementary and secondary schools necessary to achieve the purposes of Section A.
>
> "Section C: Responsibility of county and city school superintendents under health and physical education program. County

school superintendents and city school superintendents shall carry out rules and regulations laid down by the Superintendent of Public Instruction for the implementation of this program...."

2. ORS 342.600 requires each school employee to have a health certificate issued by a duly licensed physician-surgeon showing that the teacher is free from communicable tuberculosis.

3. ORS 433.255, 433.260, 433.265, 433.270 pertain to communicable disease control.

4. ORS 433.265 gives the State Board of Health authority to prohibit the attendance of unvaccinated children in schools.

5. ORS 433.260 states pupils suspected of having communicable diseases are to be excluded from school, reported to the local health department, and parents notified.

6. ORS 433.260. After having a communicable disease, a pupil is required to present a certificate from a legally qualified physician stating that he is not a carrier of any communicable disease.

7. Internal medication should be given only by or on order of a physician. The giving of aspirin or any other drug internally at school is not approved, as this is the responsibility of the parent or the physician. Pupils who must depend upon medication in order to stay in school should have a written order from a physician giving specific directions for taking medication. Directions should also be clearly marked on the bottle together with the pupil's name and the name of the physician. Medication should be stored in a safe place. Children in the first and second grades may need some assistance in taking medication, but generally older children need only to be reminded when to take medication.

8. All pupils taking part in interscholastic contests are to be examined before participation in the sports program each school year. A physician's certificate of the pupil's fitness to engage in interscholastic sports must be on record in the school and a suitable record made on the Oregon Health Record Card. Any limitation of activity is to be stated, showing clearly duration of restriction. This statement is a regulation adopted by the State Board of Education.

OBJECTIVES

1. By 1973, develop and implement a coordinated and comprehensive health education program in all Oregon schools.

2. By 1975, provide a coordinated array of health services to children in all Oregon schools.

3. By 1973, develop and enforce structural and environmental standards for all Oregon schools which will be conducive to the health and well-being of the child.

RECOMMENDATIONS AND METHODS

(Objective #1)

1. *UPGRADE THE SCOPE AND DEPTH OF THE HEALTH CURRICULA IN OREGON SCHOOLS TO MAKE COURSES MORE RELEVANT TO THE NEEDS OF THE SCHOOL AGE CHILD.*

   Methods

   a. *Interagency Committee on the Health of the School Age Child survey all schools districts to determine the scope of the health curricula and the level of health knowledge among teachers and students.*

   b. *Interagency Committee on the Health of the School Age Child, in cooperation with the Oregon Medical Association, review existing health curricula and prepare recommendations to expand the health education programs in Oregon school districts.*

   c. *Board of Education encourage all local school districts to include courses in sex education and responsible adult living in their health curriculum.*

2. *SEPARATE THE HEALTH EDUCATION FROM PHYSICAL EDUCATION IN ALL SCHOOLS.*

   Methods

   a. *Board of Education appoint a properly qualified health education consultant solely responsible for the coordination of health education programs in the schools.*

   b. *Boards of Education and Higher Education, the Oregon State Board of Health, and the Interagency Committee on the Health of the School Age Child establish and implement more appropriate standards for health educators in all Oregon schools.*

   c. *Local health departments employ qualified health educators with knowledge of school health education and community organization to coordinate health programs in the schools within the region.*

   d. *Board of Education encourage local school districts to provide separate and distinct classes in health instead of combining them with physical education.*

e. *Board of Education encourage local school districts to employ or contract for qualified health educators from the local health department to teach the health curriculum.*

(Objective #2)

3. *IMPROVE SCHOOL HEALTH SCREENING PROGRAMS AND REFERRALS FOR POTENTIAL OR EXISTING HEALTH PROBLEMS NEEDING MEDICAL ATTENTION OR INHIBITING LEARNING.*

Methods

a. *Interagency Committee on the Health of the School Age Child, in cooperation with the University of Oregon Medical School and the Oregon Medical Association, study the feasibility of establishing a partially self-administered multiphasic screening program with parent participation in all school systems in the state. Such a system will reduce the time spent by professionals in school health services and create parental involvement in the health problems of the child.*

b. *School nurses review the results of the screening program, refer all children with identified problems to appropriate medical attention and maintain contact with the parents to insure that the child receives medical care for his emotional or physical problems.*

4. *STANDARDIZE THE FORMS AND PROCEDURES FOR COLLECTING MEDICAL HISTORIES, PHYSICAL EXAMINATIONS, SCREENING PROGRAMS, AND OTHER HEALTH DATA ON SCHOOL CHILDREN.*

Methods

a. *Board of Education require that all schools use and maintain the Oregon Pupil Medical Record and Medical Examination cards to standardize the health information of all school age children in the state for purposes of programming and evaluation.*

b. *Board of Education require all schools to forward health records when a child transfers to another school.*

5. *ESTABLISH SPECIFIC PREVENTIVE MEDICAL AND DENTAL CARE PROGRAMS AND POLICIES TO INSURE CONTINUED GOOD HEALTH FOR ALL OREGON SCHOOL CHILDREN.*

Methods

a. *Oregon State Board of Health, in cooperation with Oregon Medical Association, define levels and types of immunizations to be required at particular ages for all school children.*

b. *Oregon State Board of Health and Board of Education work cooperatively to secure necessary legislation prohibiting children who do not meet minimum immunization standards from attending school when immunization is not contraindicated by medical or religious reasons.*

c. *University of Oregon Dental School, Board of Dental Examiners, and Oregon Dental Association, together with the Educational Coordinating Council, explore possibilities of expanding the scope of existing dental assistant and dental hygienist programs to qualify dentists' assistants to teach home care methods in the schools.*

6. *PROVIDE A DENTAL INSPECTION (TYPE 3) TO ALL CHILDREN IN GRADES 1, 5, AND 10.*

Methods

a. *Local school districts contract with University of Oregon Dental School and Oregon State Board of Health to provide dental health screening by dental students under the supervision of a dentist. (The dental students to receive credit for field experience in local schools.)*

b. *Oregon State Board of Health expand the use of mobile dental equipment for dental inspection in the schools.*

7. *FINANCE NEEDED MEDICAL AND DENTAL CARE FOR SCHOOL CHILDREN FROM MEDICALLY INDIGENT FAMILIES.*

Methods

a. *Interagency Committee on the Health of the School Age Child, in cooperation with Oregon State Board of Health, local health departments, and Public Welfare Division, explore existing and propose alternate means of financing medical and dental care to children in need.*

b. *Areawide comprehensive health planning agencies identify and marshal community resources to provide needed medical and dental care.*

c. *School nurses refer children and their families to local health departments and arrange for medical care when parents are unable to pay for medical care and appliances through their private physician.*

8. *STANDARDIZE THE DUTIES, RESPONSIBILITIES, AND QUALIFICATIONS OF THE SCHOOL NURSE IN ALL SCHOOL DISTRICTS.*

Methods

a. *Interagency Committee on the Health of the School Age Child, in cooperation with the Oregon State Board of Health, Board of Education, and the Oregon Nurses Association, develop and implement clearly defined duties and responsibilities of the school nurse.*

b. *Local school districts require all school nurses to be under the administrative jurisdiction of the local health department so that they will work under medical supervision and within the framework of a coordinated family-centered program.*

c. *In areas without a health officer, school nurses will be responsible to the Oregon State Board of Health or to a local physician identified by the school district.*

9. *INSURE AN ADEQUATE PROGRAM FOR FIRST AID EMERGENCY CARE IN ALL SCHOOLS.*

Methods

a. *Local school districts require school personnel to be skilled in first aid. At least two persons who have completed the standard first aid course should be available on the school premises at all times children are in the building or on the playground.*

b. *Oregon State Board of Health, in cooperation with Oregon Medical Association, and the American Red Cross, provide circuit courses in first aid and emergency care for school personnel in areas not convenient to a community college.*

c. *School nurses maintain a well-equipped first aid kit in all schools as recommended by the Board of Education.*

(Objective #3)

10. *DEVELOP STANDARDS AND INITIATE PERIODIC INSPECTIONS OF ALL SCHOOLS TO INSURE THE HEALTH, SAFETY, AND WELL-BEING OF ALL CHILDREN.*

Methods

a. *Interagency Committee on the Health of the School Age Child, in cooperation with the Accident Prevention Section of the Oregon State Board of Health and the State Fire Marshal, develop standards for accident prevention, adequate lighting and heating, and proper sanitary facilities in all schools.*

b. *Oregon State Board of Health or local health departments inspect all schools for safety and adequacy of facilities and make recommendations for improvement.*

11. *IMPROVE THE DESIGN OF SCHOOL BUILDINGS TO INSURE ADEQUATE PURIFICATION OF AIR TO REDUCE THE INCIDENCE OF RESPIRATORY INFECTION AMONG SCHOOL CHILDREN.*

Methods

a. *Construction Consultant of Board of Education develop standards requiring all new school construction to provide for an effective air purification system.*

b. *Board of Education, in cooperation with Oregon State Board of Health and local health departments, inspect the air systems of all existing schools and make recommendations for improvement.*

c. *Board of Education encourage all school districts to install air purification devices in the ventilating systems of school buses.*

12. *FLUORIDATE THE WATER SUPPLIES OF PUBLIC SCHOOLS OUTSIDE FLUORIDATED AREAS TO REDUCE THE INCIDENCE OF DENTAL PROBLEMS AMONG CHILDREN.*

Method

Local school districts outside fluoridated areas, in cooperation with Oregon State Board of Health, fluoridate their school water supplies.

OPERATIONAL PROBLEMS

1. Lack of motivation, financial resources, and education on the part of parents in certain areas of the state contribute to the lack of care received by children with health problems.

2. Lack of health educators adept at community organization to work at the local level to motivate professionals and others in the community to institute on-going multiphasic screening programs, mass immunization programs, and coordinated health education programs in the schools.

3. Lack of adequate teacher interest or training in the field of health.

4. Citizen opposition to health programs such as fluoridation of the water and human sexuality classes in the schools.

5. Lack of resources for health care for the medically indigent throughout the state.

EVALUATION CRITERIA

1. Increase in the number of children whose handicapping conditions are identified and treated or corrected before or shortly after entering school.

2. Decrease in accidental death rate among school children.

3. Decrease in the number of children with health problems that impede learning.

4. Reduction in communicable diseases.

PRIORITY

To be determined.

PERSONAL HEALTH PROBLEMS
Mental Health

MENTAL HEALTH

GOAL PROMOTE MENTAL HEALTH AND REDUCE THE NEGATIVE CONSEQUENCES OF MENTAL ILLNESS.

CONDITION

Mental Health can be defined as the ability to function adequately in interpersonal relationships and provide for one's material needs. Precise figures on the incidence of mental illness in Oregon are not available. However, the Mental Health Division has estimated that 225,250 Oregonians are mentally ill. Of this figure, about 2,000 are in hospitals. An additional 58,500 persons suffer from alcoholism, and 35,775 (18,370 adults and 17,405 children) suffer from mental retardation. Approximately 3,000 of the mentally retarded are hospitalized. The total number of persons addicted to drugs is unknown, although the usage is growing.

Of the 777,000 children under age 19 in Oregon, about 50,000 are in need of mental health services (38,000 school age children and 12,000 pre-school children). Approximately 10,000 children are now receiving direct mental health services. There are 5,000 others--including 4,000 in foster care--who are receiving indirect mental health services. The total of 15,000 who receive some kind of service, however, is only 30% of those under the age of 19 who are estimated to be in need of care. Therefore, 60-70% of the children remain untreated.

The impact of mental illness on the individual and his family results in untold misery and loss of productivity. Significant causative factors have been identified only for a small portion of the mentally ill, mentally retarded and alcoholic; for the majority of the mentally ill, the significant causative factors are not well understood, indicating the vast time gap between research and implementation. Based on figures provided by the State Revenue Department, the direct and indirect cost to Oregonians for mental illness during 1969-70 are $34,800,000 and $26,657,000 respectively.

The unwarranted fear of the mentally ill has been reduced. One indication of the greater acceptance of the problems of mental illness is the increased incidence of treatment voluntarily sought. Nevertheless, there is still considerable discrimination in employment, insurability, general hospital admissions, and in some instances, in terms of social acceptance.

CURRENT PROGRAMS AND ACTIVITIES

- The Veterans' Administration operates a clinic in Portland and a hospital in Roseburg for the treatment of the psychiatric patient.

The Mental Health Division has primary responsibility for mental health services and programs in the state. During fiscal year 1969-70, a total of $3,323,426 was budgeted for mental health services--50% of these funds were provided by the local areas and 50% by state and federal funds. The county per capita expenditure for mental health in Oregon ranged from $0.83 to $3.94.

The Mental Health Division administers three hospitals for the mentally ill in Oregon: Oregon State Hospital, Salem; Dammasch State Hospital, Wilsonville; and the Eastern Oregon Hospital and Training Center, Pendleton. In June, 1970, the average daily population in these state hospitals was 1,873--a drop of 140 from the previous year. The decline may be the result of the continued emphasis on placing patients in local community facilities. Expansion of hospitals' programs and services to the mentally ill during 1970 included the reopening of two wards at Dammasch State Hospital and the establishment of adolescent treatment programs at the Oregon State Hospital and Dammasch Hospital.

The Alcohol and Drug Section of the Mental Health Division has the responsibility for public education and treatment programs for alcoholics and drug addicts. (A detailed description of the programs and activities of the Section are discussed in the Drug and Alcohol Section of the Plan.)

The Mental Health Division, through subcontracts with private agencies, provides assistance for:

1. Five halfway houses for alcoholics.
2. Two halfway houses for mentally retarded (Portland).
3. One halfway house for mentally ill (Portland).
4. One center for mentally retarded (Eugene).
5. Three family service clinics.
6. One community mental health center (Eugene).
7. One epilepsy and learning problems clinic (Good Samaritan Hospital, Portland).
8. One children's residential center (Portland).
9. One child guidance clinic (Multnomah).
10. One treatment clinic for transient young people (Outside-In, Portland).

The Mental Health Division has also initiated a pilot program for emotionally disturbed children. Care is provided through a community consultation team and through selected after care contract agencies.

The Mental Health Division administers two federally funded programs having a direct bearing on mental health services in Oregon:

1. Mental health centers contruction and staffing grants; and

2. Comprehensive Health Planning 314(d) grants.

The Public Welfare Division administers several federal programs having an indirect effect on the mental health field including: (1) Welfare Medical Assistance; (2) Welfare Assistance Programs; and (3) Welfare Assistance to Dependent Children.

The State Board of Health administers Medicare (Title XVIII), a program enforcing federal standards applicable to care facilities getting federal reimbursement for services to Medicare patients.

The Division of Vocational Rehabilitation administers the statewide vocational rehabilitation program funded by the federal government.

County efforts in mental health are centered in the community mental health clinics which are operated by the counties with the costs shared by the state and local jurisdictions. There are 26 community clinics serving all Oregon counties except Gilliam, Grant, Lake, Wallowa, and Wheeler.

The clinics are staffed by psychologists and social workers supported by psychiatric consultation and provide a complete range of counseling services to the communities.

The University of Oregon Medical School Hospital operates a psychiatric department with a 26-bed psychiatric ward and provides extensive outpatient services for the mentally ill.

There are three specialized hospitals providing psychiatric services in Oregon: Holladay Park Hospital in Portland; St. Vincent Hospital in Portland; and Sacred Heart General Hospital in Eugene. Regular hospital beds are sometimes utilized for psychiatric patients in almost every area of the state where private psychiatric service is available.

A crisis intervention unit at the Multnomah County Hospital is provided for patients who appear to be dangerous to themselves and/or others. Lane County provides a similar service in the Johnson Unit which is a component of the Lane County Mental Health Center located at Sacred Heart Hospital in Eugene. Unit III at Oregon State Hospital serves as a crisis center for Marion and Polk Counties and operates as a short-term, intensive care facility.

A large volume of patients receive mental health services from the private sector. In Oregon, there are 60 psychiatrists and 30 psychologists in private practice. No data are available as to the number

of patients receiving services through the private sector. Three general hospitals in Oregon--Holladay Park Hospital in Portland; St. Vincent Hospital in Portland; and Sacred Heart Hospital in Eugene--provide separate and discrete psychiatric services. The Rogue Valley Memorial Hospital in Medford is building a psychiatric ward.

In addition, there are a large number of voluntary associations and agencies and self-help groups providing direct and indirect services to the mentally ill.

AUTHORITIES

The primary authority for treating the severely mentally ill or psychotic person in Oregon is the Mental Health Division. Its functions are defined by ORS 430.010 to 430.041. In addition, all district courts and circuit courts have the power to determine competency and to commit to the Mental Health Division upon proper examination and testimony.

OBJECTIVES

1. Reduce the incidence and negative consequences of mental illness, mental retardation, alcoholism, and drug abuse and create a climate which promotes individual fulfillment of potential.

2. Expand preventive efforts directed at mental illness through research and development aimed at identifying causative factors for which effective intervention programs can be implemented.

3. Expand inpatient and outpatient treatment facilities and services, both in the public and private sector, to provide essential care for those requiring treatment.

4. Assure early placement in appropriate programs or environments for those with acute problems to increase the number of persons who can be returned to independent community living.

5. Materially reduce the number of persons requiring prolonged institutional care and upgrade the care standards for those unable to return to community living.

RECOMMENDATIONS AND METHODS

1. *MENTAL HEALTH DIVISION, IN COOPERATION WITH INSTITUTIONS OF HIGHER LEARNING, DEVELOP AN OPERATIONAL DEFINITION OF MENTAL HEALTH.*

2. *EXPAND RESEARCH EFFORTS INTO THE FACTORS CONTRIBUTING TO MENTAL ILLNESS AND ESTABLISH A DATA BASE FOR PLANNING AND EVALUATING MENTAL HEALTH SERVICES.*

Methods

a. *Mental Health Division and institutions of higher learning establish a coordinated research program to study factors contributing to mental illness and improve treatment of the mentally ill.*

b. *Mental Health Division design and implement a statewide data collection system for mental health. The system would include medical, demographic, and social information about persons seen at the state hospitals, mental health clinics and private agencies, and organizations and personnel serving the mentally ill, and be coordinated with the statewide health information system. The Mental Health Division to tabulate and analyze the information and distribute estimates of the prevalence of mental disorders in the state through published reports.*

3. *DEVELOP AN EFFECTIVE STATEWIDE EDUCATIONAL PROGRAM DESIGNED TO CREATE AN UNDERSTANDING OF MENTAL ILLNESS AND RELATED DISABILITY WHICH WILL PERMIT THE MENTALLY ILL AND MENTALLY RETARDED TO FUNCTION IN THE COMMUNITY.*

Methods

a. *Mental Health Division, in cooperation with the University of Oregon Medical School and the Mental Health Association, prepare and implement a statewide campaign to educate the public about mental illness and the services available.*

b. *Mental Health Division, in cooperation with the University of Oregon Medical School and the Mental Health Association, conduct seminars for the professional training of clergymen, physicians, dentists, lawyers, educators, law enforcement, and correctional personnel to delineate their relationship to community mental health. (The seminars to also emphasize preventive measures and early detection of mental illness.)*

c. *Regional directors of the Mental Health Division, representatives of local mental health clinics, the State Board of Education, and local school districts develop in-service training programs for all teachers focusing on the identification of children's emotional needs and constructive methods of handling problem children, including an appropriate referral mechanism.*

d. *Regional directors of the Mental Health Division and local mental health associations establish community programs to inform*

the public of the services available to them; to refer persons seeking help to the appropriate service; and to provide support services to the mentally ill and their families.

4. *ESTABLISH EARLY DIAGNOSTIC AND TREATMENT SERVICES FOR ALL MENTALLY ILL AND MENTALLY RETARDED CHILDREN TO MAXIMIZE THEIR POTENTIAL FOR DEVELOPMENT.*

Methods

a. *Mental Health Division coordinate the activities of the child service agencies such as mental health clinics, schools, public health agencies, welfare, the courts, and physicians to provide a full array of mental health services to children.*

b. *Mental Health Division, Oregon Association for Retarded Children, and local Mental Health Associations encourage the public schools to develop special classes for children who are unable to profit from regular classroom instruction.*

c. *Mental Health Division, Oregon Association for Retarded Children, mental health clinics, and local Mental Health Associations, utilize local community groups to establish homebound instruction and counseling services for children with emotional or mental problems and their families.*

d. *Mental Health Division develop strategically located residential treatment centers for children with mental or emotional problems.*

5. *ASSURE GREATER COORDINATION OF THE TOTAL RANGE OF MENTAL HEALTH SERVICES IN LOCAL COMMUNITIES.*

Methods

a. *Regional directors of the Mental Health Division and local mental health associations survey and identify all agencies and persons providing mental health services in the community.*

b. *Local mental health personnel, with the assistance of the Mental Health Division, design a plan to coordinate the community mental health services in order to provide a full range of services and avoid duplication.*

6. *ESTABLISH TREATMENT, REHABILITATION, AND AFTER-CARE SERVICES IN COMMUNITIES SO THAT PERSONS WITH MENTAL OR EMOTIONAL PROBLEMS CAN BE RESTORED TO THEIR FULLEST PHYSICAL, MENTAL, SOCIAL, AND VOCATIONAL USEFULNESS WHILE REMAINING IN THEIR LOCAL COMMUNITIES.*

Methods

a. *Mental Health Division implement district-based diagnostic and treatment centers in at least ten Mental Health Service Areas*

to provide appropriate and immediate treatment for all who have acute mental disorders (as outlined in Exhibit 1).

b. *Mental Health Division, Oregon Association of Hospitals, and the Oregon Medical Association designate general hospitals in selected areas of the state which include or can expand their services to include psychiatric care.*

c. *Mental Health Division and local mental health associations assist communities to establish: (1) foster home care and halfway houses for long-term patients who do not need mental hospital services; and (2) short-term detention facilities for mentally ill persons in local hospitals instead of jails.*

d. *Mental Health Division and local mental health associations evaluate the present programs for caring for mentally ill aged in the community and where warranted, establish suitable community facilities or programs as an alternative to mental hospital care.*

e. *Mental health clinics and local mental health associations coordinate the existing social services to families of the mentally ill.*

f. *Local mental health clinics expand staff to include community mental health workers to assist psychotic patients at point of emergence and provide support services to the families of the mentally ill. These sub-professional aides to be recruited from the local community and trained by the Mental Health Division.*

g. *Mental Health Division and Department of Employment develop and supervise programs for on-the-job training of workers with mental health problems.*

7. *MENTAL HEALTH DIVISION ENCOURAGE HEALTH INSURANCE CARRIERS TO INCLUDE COVERAGE FOR MENTAL ILLNESS IN BASIC HEALTH PLANS.*

8. *PROVIDE QUALITY HOSPITAL CARE FOR THE MENTALLY ILL WHO, BECAUSE OF PHYSICAL OR MENTAL DETERIORATION, NEED CONTINUOUS INSTITUTIONAL CARE.*

Methods

a. *Mental Health Division evaluate systematically the programs at the state hospitals for the mentally ill to assure quality care and treatment to mental patients.*

b. *Mental Health Division improve professional education and in-service training programs, recruitment practices and career programs, and develop competitive salary scales for personnel in mental hospitals to insure effective programs of quality care.*

OPERATIONAL PROBLEMS

1. Lack of good baseline data to determine community needs with respect to mental illness.

2. Lack of adequate care facilities for holding mentally disturbed or psychiatric individuals after they have come to the attention of public officials.

3. Limited training in the handling of severely disturbed mental patients among law enforcement officers who are often first on the scene.

EVALUATION CRITERIA

Mental Health Division evaluate mental health services through:

1. Examination of patient movement.

2. Auditing of the treatment process--was the treatment prescribed carried out?

3. Accounting for needed services which were not available.

4. Measurement of the satisfaction of: (a) direct recipient; (b) indirect recipient; and (c) staff of treatment center.

5. Measurement of the recurrence of deviant behavior of patients after discharge.

6. Measurement of behavior change and reduced dependency.

PRIORITY

To be determined.

EXHIBIT 1

PROPOSAL FOR DISTRICT COMMUNITY MENTAL HEALTH PROGRAM

The Mental Health Division proposes that the State of Oregon assume direct responsibility for the operation of local mental health services. This includes full funding of all direct services and specified contract services. Other contract services are to be provided under joint state and local funding.

The proposal will replace grant-in-aid to local, county-based clinics with state-operated mental health clinics based in all of the Governor's 14 administrative districts. Satellite clinics will be provided in county units and in communities with sufficient population.

The clinics and the state mental hospitals will be operated as a single system of care; although clinics, hospitals, day-care centers, etc., will be discrete modules providing comprehensive and integrated services.

Clinic programs will be developed into comprehensive services, ensuring continuity of care and community-based, lower-cost alternatives to state hospital care.

Short-term, crisis-type hospital care will be purchased in the local general hospital. Backup day-care and aftercare clinics will be provided.

A range of special services for emotionally disturbed children is to be provided in the community. These services will include diagnostic-evaluative services, day-care programs, small therapeutic group homes, consultation to school systems, etc.

State mental hospitals will be further reduced in size and refashioned to provide special treatment programs, psychiatric security care, and other special services.

Treatment services for alcoholics and drug abusers will be provided in district clinics.

The district clinics will serve as the prime points by which services will be found for the mentally retarded.

Broad-based district councils will be formed to ensure community participation in planning and coordinating services.

District clinic directors will be responsible for planning, coordinating, and integrating services with all other Human Resource district agencies to provide continuity of care and to minimize duplication and overlapping of services.

Present community mental health personnel will become Mental Health Division employes and will provide the initial skeleton of staffing for the district satellite clinics.

Increased costs of the improved program will be partially offset through (a) savings accrued through reduced mental hospital populations, (b) improved utilization of Federal funds, and (c) increased revenues from those patients able to pay.

STRUCTURE OF DISTRICT MENTAL HEALTH SYSTEM

District Clinics

The district clinic will provide the necessary clinical, planning, coordinating, and integrating services to a region bounded by one (or in Eastern Oregon, one or more) of the 14 administrative districts. These districts are often multi-county.

The district clinic will be staffed by working mental health professionals (social workers, psychologists, nurses, physicians, psychiatrists). The staff will include experts in children's problems and alcohol and drug problems. A specialist in mental retardation will serve the unique needs of the mentally retarded.

In addition to providing direct mental health services, the staff will guide and supervise the work of satellite clinics and will plan, develop, and administer the prevention, treatment, and restoration program in the district. A citizens' advisory council will aid in assessing district needs, planning services, and ensuring community support and cooperation.

The district clinics will develop, consult with, and supervise district-based backup or specialized services, including halfway houses, day-care programs, aftercare special clinics, and eventually special services for children.

Contracts will be drawn with selected general hospitals to provide short-term (three- to seven-day) emergency psychiatric hospitalization in the community. Hospital and physician costs will be paid, except when private insurance, Medicare, Medicaid, etc., can make payment.

All referrals to backup services will be made through the district clinics. Care will be exercised to provide that the patient moves rapidly from one service to the next to minimize "dropouts" from treatment.

The district clinics will develop special services to alcoholics and drug addicts, public education, halfway houses, court services, and detoxification centers where necessary.

The line of authority will be from the Mental Health Division to the district clinic.

The district clinics will coordinate activities with all other district Human Resource agencies.

Satellite Clinics

Present county-based community mental health clinics will be maintained as direct service clinics. They will be under the supervision of the district clinics.

Satellite clinics ideally would be based in smaller communities or even neighborhoods of larger cities. Personnel will generally reside in or near the community or neighborhood. To maximize this effect, it is planned to select, recruit, and train neighborhood personnel as nonprofessional staff members. These nonprofessional staff members will provide services under the supervision of the professional staff.

Volunteer services will be recruited and supervised by the satellite clinic staff. Social activity, companionship, transportation, crisis contact, public involvement, and community activities are to be encouraged through volunteer and nonprofessional staffs.

Satellite clinics should be housed in high-risk areas readily accessible by public transportation and open for service at appropriate hours. Multi-service centers are likely areas for placement.

Satellite clinics must develop the capacity to respond flexibly to crisis situations in the community and to provide service as near the point of emergence as possible.

Backup Services

A variety of backup or special services will be necessary. The number, extent, and types in each district will vary with the population and size of the district. Any backup service will be available to patients from any other district by arrangement through the district clinic staffs.

Some backup services, such as aftercare clinics and day-care programs, will be state operated. Other backup services, such as hospital crisis care, detoxification centers, etc., will be contracted at full cost.

Still other backup services, such as halfway houses, family counseling services, etc., are to be funded jointly by the state and the local agency in keeping with preference and tradition.

Those backup services which provide residential care--hospital care, residential treatment centers for children, halfway houses, detoxification centers, etc.,--must be provided under contract; since the Oregon Constitution prohibits the state from operating such services outside Marion County unless authorized by referendum at a general election. A constitutional revision will be required to allow state operation of such facilities.

Central State Services

The state will continue to provide mental hospital services at existing locations. Hospital populations will be reduced over time. Psychiatric security will be available at Oregon State Hospital. The state mental hospital staffs will be made available for appointment to district and satellite clinics or backup services as the accelerated decline in mental hospital populations will allow.

Specific specialty clinics will be maintained when education and training are special missions of such clinics, including alcoholism and drug addiction clinics in Portland.

Administrative and Support Services

As much as possible, administrative and support services will be operated by the Mental Health Division central office. This will free the district staffs to put their major efforts in clinical services, planning, community liaison, and organization.

District offices should be located with other Human Resource district offices whenever possible. Satellite clinics should be housed in rented space in high-risk areas, which are also accessible by public transportation.

District clinics will order supplies from regional warehouses at the three state hospitals.

Personnel services, payroll, bookkeeping, and accounting services will be maintained by the State Mental Health Division Administrative Services staff.

Patient charges will be computed on a unit cost of service. Charges will be communicated to regional centers at state hospitals, then reported centrally by automated equipment. Total patient charges will be computed centrally, and a patient billing system will be provided. This will be operated by the appropriate department of state government (now the Executive Department). That department will also have the responsibility for collection of those charges.

A standard method of computing the patient's liability for cost of care must be developed. The district or satellite clinic should be able to compute the patient's liability for payment for him. It is suggested that a sliding percentage scale of fees based on income be established. Unit costs of service will be standardized.

Drugs for treatment will not normally be dispensed by clinic staffs because of the rigid requirements of control by either a pharmacist or a physician. Prescriptions will be filled under contract with a local pharmacy. As an alternative, a mail-out prescription service could be established at the three state mental hospitals.

Patient records will be standardized at all clinics and state mental hospitals. A standard patient identification system based on the Social Security system seems most feasible.

To provide standard accounting procedures and standard patient charges throughout the clinics and hospitals, it is proposed that the present Executive Department Institutional Accounting System be upgraded. The Shared Hospital Accounting System (SHAS) appears to have the capability to provide the accounting data and to generate patient billings and the accounts receivable file. This system is adaptable within the state's IBM Systems 360 computer capabilities.

Personnel services will be provided centrally. It is desirable that a new mental health personnel series be developed to specify a graded series of community mental health specialists ranging from nonprofessional clinical associates to several steps of mental health professionals. Such a personnel series is now available for Mental Health Division central staff. Development of a community staff series is entirely possible. Over a period of time, this personnel series should evolve into a career ladder for persons of varying background.

Manpower Development

The proposed system will require an extensive manpower development program. Division, hospital, and district staffs will require advanced management training. Professional personnel will require additional training in such areas as working with nonprofessional personnel, community organization and resources, crisis intervention, and systems theory.

Research and Program Evaluation

Program evaluation services will be provided centrally. It is essential that a sound Management Information System capturing costs in a systematic way be established. This can be done through SHAS. Program effectiveness is a more difficult task because of the need to develop more precise outcome indicators than are available today.

It is proposed that a Research and Program Evaluation Section be established in the Mental Health Division through transfer of the existing research staff of the Executive Department to the Mental Health Division. This staff would be responsible for two major measurement functions.

The first is comparable to market analysis and consists of the development of community indices of mental health. The second is the development of performance evlauation indices, including treatment effectiveness indicators and systems effectiveness indicators.

Eventually, the existing WICHE, TRACK, Biometrics, and SCOPE data programs will be absorbed into either the Management Information System or the Research and Program Evaluation Section.

PHASING IN OF DISTRICT MENTAL HEALTH PROGRAM

New programs must be developed with planned and phased-in additions. The development of a comprehensive program will probably require about six years. A precise timetable can evolve only with the establishment of an adequate data base evolved through analysis of community indices, manpower needs, and administrative support requirements.

During the period of development, an initial investment in new district-based services will be required. State mental hospital programs will need to remain intact. Beginning with the second year (July 1972), an accelerated decline in mental hospital populations should begin and should last for several years. The decline in hospital population will free monetary and manpower resources for the development of the district programs.

The following timetable is suggested.

	Completion Dates
1. Develop basic planning	
a. Implement SHAS	July 1970 to July 1971
b. Prepare necessary legislative recommendations	
c. Develop 1971-73 budget estimate	
d. Outline and implement manpower development program	
2. Designate district mental health directors and assign following tasks and completion dates:	July 1, 1971
a. Establish district mental health councils	October 1, 1971
b. Continue existing community mental health programs plus normal expansion	Immediate
c. Complete short-term planning for 1972-73 fiscal year	January 1, 1972
d. Deploy existing program components in district and satellite clinics in accordance with this plan	July 1, 1972
e. Develop comprehensive long-range plan and priorities	January 1, 1973

3.	Implement first phase-in of expanded district programs in accordance with short-term plans as approved by Mental Health Division (request funds be reserved for this purpose)	July 1, 1972
4.	Continue expansion of district clinic programs in annual increments	July 1, 1973
5.	Implement system integration plan at all levels	Immediate and ongoing

ADVANTAGES OF DISTRICT MENTAL HEALTH PROGRAM

Program

1. The present community mental health system is the framework of the district program. The increase in numbers and diversity of personnel and the implementation of backup services will "flesh out" the program and provide comprehensiveness and diversity.
2. Care will be placed closer and be more accessible to the patient.
3. Undesirable dislocation of patients and families will be reduced.
4. Continuity of care will be enhanced.
5. High-cost patient care problems will be met more effectively and with more emphasis upon lower-cost alternatives to hospitalization.
6. Services and cooperation among Human Resource agencies will be promoted.
7. The ability to shift resources to high-risk or high-demand areas will be enhanced.

Costs

1. Lower-cost alternatives to hospitalization will be provided.
2. Local governments will receive relief from high-cost mental health services--property tax relief.
3. Reimbursement will be increased through improved billings to, and collections from, health insurance, Medicare, Medicaid, and patients able to pay.
4. Unity of the system will allow greater utilization of Federal funds, e.g., through consolidation of services within districts to form mental health centers.
5. Local indirect administrative costs will be eliminated.

Efficiency

1. The present multiple levels and routes of administration will be reduced to one unified system.

2. A single unified personnel system will be implemented.

3. Centralized administrative services will reduce administrative responsibilities at the community level, freeing staffs for patient care.

Accountability

1. Standard patient records and identification system will allow tracking and an analysis of utilization of services by patients.

2. Standard unit costs will be established.

3. Standard expenditure reports will be available.

4. Output or effectiveness indicators will be developed.

5. Cost-benefit studies will become available.

ALCOHOLISM AND DRUG ABUSE

GOAL REDUCE THE INCIDENCE AND NEGATIVE CONSEQUENCES OF ALCOHOLISM AND DRUG ABUSE.

CONDITION

While caution must be used in this approach, alcoholism and other types of drug abuse are best treated as a single problem entity. Dependence on alcohol and other drugs must be considered, not only in terms of the agents involved, but in terms of the host and environment as well. There are a number of pharmacological differences, legal complications, and differences in social usage and acceptance which make the combining of alcohol and other drug abuse problems somewhat controversial. These differences, however, are outweighed by similarities of causation and similarities in the measures required for prevention, treatment, and control, compounded by the interchangeability of agent with respect to maintenance of dependence.

Alcoholism

The World Health Organization defines alcoholism as "a chronic behavioral disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary and social uses of the community and to an extent that it interferes with the drinker's health or his social or economic function."

It is difficult to obtain statistics reflecting the actual extent of alcoholism. It is evident, however, from analysis of data available through both public and private agencies, that alcohol is the most significant malefactor of the drug-dependency problems in terms of prevalence, law enforcement expense, loss of human life, illness, social and family problems, and work disability.

In 1969, the Federal Bureau of Investigation reported 1,420,161 arrests for public drunkeness by 4,759 agencies covering a population of 143,815,000. This figure accounted for over 25% of the total arrests for all offenses. If alcohol-related offenses (driving under the influence of alcohol, disorderly conduct, and vagrancy) were added to this percentage, it would constitute 42% of all reported arrests in 1969. Recidivism is extremely high among the chronic alcoholic offenders. For example, in Portland in 1963, 2,000 individuals accounted for 11,000 reported law violations involving drunkeness or the effects of drinking.

The total picture of police involvement with the alcoholic is not depicted by the number of arrests because of varying police procedures for handling alcoholics. Some cities use the "disorderly" statutes while others use the "vagrancy" statutes for arresting an alcoholic. In addition, in suburban communities intoxicated individuals may be escorted home by the police or the police may have friends escort them home or telephone a taxicab to do such. Another method is to detain the individual until sober and release without charge. Such is the case in Detroit, Michigan, where the police released 5,865 such persons and prosecuted 8,665.

In 1967, the national cost for housing the alcoholic was conservatively estimated at $100 million. This does not include costs for treatment or rehabilitation programs.

Based upon use of the Jellinek Formula (a widely accepted method for estimating number of alcoholics within population groups, which utilizes reported deaths from cirrhosis of the liver), Oregon has an estimated 55,000 alcoholics.[1]

The ten counties with the highest estimated rates of alcoholism (all exceeding the state ratio of 44.8) are indicated below:

COUNTY	ESTIMATED NO. ALCOHOLICS	RATE/1000 POPULATION 20 YEARS OF AGE AND OLDER
Klamath	3,721	94.4
Clatsop	1,476	81.5
Multnomah	28,221	78.4
Curry	553	75.0
Tillamook	600	64.?
Harney	230	53.5
Jefferson	277	49.5
Lake	184	49.3
Wheeler	46	45.5
Coos	1,3[illegible]	45.1

A significant issue in any discussion of problems related to abuse of alcohol is the effect of alcoholism on traffic accidents. Twice as many persons died in auto wrecks involving alcohol as were murdered in the United States in 1969. The value of property destroyed in these accidents was six times the value of property stolen in all the robberies, larcenies, and burglaries in the country. There is a popular misconception that it is the average "social" drinker driving home from a cocktail party rather than the chronic "problem drinker" who causes this annual highway calamity. National estimates

1. Estimated Number of Alcoholics and Rate Per 1,000 Population Aged 20 Years and Over by County Residence, 1967, Mental Health Division, 1969.

of the percentage of accidents involving the chronic drinker range from 20% to 50%, with a preponderance of estimates in the upper portion of this range.

Based upon an Oregon medical examiner's study of 337 driver accident deaths,[1] it was found that 42% of those examined had blood alcohol readings above the state's legal intoxication level of 0.15. Over 50% of all traffic accidents in Oregon are caused by a mere 4% of the population - the chronic alcoholic. This 4% target group of alcoholics consists of individuals with known alcohol dependency, and does not include the social or occasional drinking driver. It should be noted that although a blood alcohol percentage of 0.10 (the federally established standard for legal intoxication - National Highway Safety Bureau) will cause nausea, vomiting, sleep, etc., for the occasional drinker, the average blood alcohol percentage at the time of apprehension in this target group of alcoholic drivers was 0.23.[2] In addition, these offenders generally had repeated drunk driving arrests, lengthy records of accidents, and frequent citations for leaving the scene of an accident.

Special mention must be made of the drunk driving arrest repeaters convicted of drunk driving while on a suspended license from earlier convictions. Oregon law provides for a mandatory minimum jail sentence of two days to a maximum of one year for individuals convicted of driving a motor vehicle with a suspended license, as well as for the mandatory impounding of his car for a minimum of 30 days. These laws are designed to remove persons who should not be driving from the public streets and highways, at least for a short period of time. Unfortunately, these laws, for all practical purposes, are being ignored by Oregon's courts. Less than 10% of those individuals convicted of drunk driving with suspended licenses were given the "mandatory" jail sentence, and there was not one car impounded from January 1965 to November 1969 for this offense.

Recognizing that there remains considerable differences of opinion on this matter in that metabolic disorders causing alcoholism have not been identified, alcoholism is generally regarded as a disease by both the health and legal professions. Nonetheless, there are approximately two million arrests and jailings annually in this country (primarily skid-row indigents) for public intoxication. Although having some utility as a control mechanism, arrest and imprisonment are of questionable value as far as contributing to the treatment and rehabilitation of these individuals.

1. Oregon Department of Motor Vehicles, May 8, 1969.
2. Oregon Study of Drinking Drivers, 1969; U.S. Department of Transportation, Motor Vehicles Division.

The incarceration of skid-row offenders who pose a much smaller threat to public health and welfare than does the drunk driver, serves to point up the ambivalence of our official and unofficial attitudes toward alcoholism. As earlier indicated, an amazingly large percentage of traffic accidents and deaths are caused by alcoholics who are not imprisoned (and often allowed to continue to drive) in the belief that alcoholism is an illness not ameliorated by jail. It is apparent that if alcoholism is to be regarded as a disease, and therefore a medical-social problem, alternate methods of dealing with this problem must be adopted to replace the criminal law provisions now being sporadically applied in a discriminatory fashion. Whether alcoholism is a disease or a symptom, it is apparent that its treatment should be socio-medical rather than punitive.

Drug Abuse

While the number of people abusing drugs other than alcohol is relatively small in comparison with the alcoholism problem, there is a seriously rising trend of abuse of these drugs. Drug abuse is growing at a phenomenal rate in Oregon, but there is inadequate data to accurately determine either the incidence or the rate of increase. Statistics available through law enforcement and state mental health programs, however, serve to point up the growth of this problem area. The following information should be treated cautiously because it represents only those persons who are officially brought to the attention of these two fields (i.e., those who are arrested or who seek state medical help.)[1]

LAW ENFORCEMENT STATISTICS

Adult Arrests

Adult arrests for narcotic law violations reported to the Oregon State Police rose from 395 in 1967 to 1,181 in 1969, representing a 200% increase. Comparable data for all arrests reported to the Oregon State Police in this same time period reflected a 19% increase, indicating that narcotic arrests are rising at a much more significant rate than total arrests. To further emphasize the drug problem, the 200% increase corresponds to a 4% increase in general population.

Within the state, there are some wide geographic variations in narcotic arrests from 1967 to 1969. Four Districts (7 and 8 in Southwestern Oregon; 11 in South Central Oregon; and 14 in Southeastern Oregon) experienced increases in excess of 500%. It is significant that the greatest change occurred in the rural districts. This data should be treated carefully because of the small numerical amounts. The following table shows arrest data.

1. This information was reported in a study by the Governor's Law Enforcement Council staff (November 27, 1970).

Table 1

Narcotic Violation Adult Arrests, 1967-1969
for Administrative Districts

District-Group	Arrests 1967	1968	1969	1967-1969 % Increase
500% and Over				
District 7	2	15	34	1600%
District 11	2	7	22	1000%
District 14	1	10	9	800%
District 8	15	60	100	567%
200-499%				
District 12	7	26	35	400%
District 13	2	10	9	350%
District 3	19	77	85	347%
District 1	8	29	27	238%
100-199%				
District 2	209	383	551	164%
District 4	43	44	112	161%
District 5	55	64	129	135%
District 6	25	57	57	128%
Less than 100%				
District 10	4	8	7	75%
District 9	3	4	4	33%
All Districts/State	395	794	1,181	199%

It must also be noted that increases in narcotic violation arrests are more pronounced in the younger adult age groups. The average age at arrest decreased from 25.1 years in 1967 to 23.1 years in 1969. Table 2 reflects the arrest data by age group.[1]

Table 2

Narcotic Violation Adult Arrests, 1967-1969
for Age Groups

Age Groups In Years	Calendar Years 1967	1968	1969	1967-1969 % Increase
18-20 Years	140	329	558	299%
21-25 "	137	285	406	196%
26-30 "	49	88	109	122%
31-35 "	27	26	37	37%
36-40 "	19	26	20	5%
41-50	14	22	35	150%
51-60 "	4	8	8	100%
61 and Over	4	3	4	0
Unknown Age	1	7	4	300%
All Ages	395	794	1,181	199%

1. See Exhibit 1, Chart A.

Juvenile Court Referrals

Not only is there an upward trend in the younger adult age groups for narcotic arrests, but the juvenile courts are also feeling the impact of the problem. A study of nineteen of the state's thirty-six courts (including those having the largest caseloads: Multnomah, Clackamas, Washington, Marion, and Lane) reflected an increase of 392% from 1967 to 1969 in cases referred for narcotic law violations (from 95 to 467 cases). It must be emphasized that the data do not represent all of the juveniles using drugs because only those directly referred for drugs are reflected in the case counts. It does not include those who are referred for other reasons but are also drug users, nor those who have successfully avoided detection.[1]

Type of Drug

Another aspect which should be examined is the type of drugs used. Data available from the Portland Police Department reflected the following:

Table 3

Narcotic Arrests, 1967-69 by Drug Class[2]
Portland Police Department

Class	Arrests 1967	1968	1969	1967-1969 % Increase
I	43	84	138	221%
II	133	285	508	282%
III	13	66	132	915%
All 3 Classes	189	435	778	312%

Other Categories

Additional statistics in law enforcement substantiating the drug problem may be found in the addict statistics which are voluntarily reported to the U.S. Bureau of Narcotics and Dangerous Drugs, and in the number of tests and examinations of narcotics and dangerous drugs conducted by the Oregon State Police Crime Laboratory. The number of Oregon narcotic addicts reported to the Bureau of Narcotic and Dangerous Drugs increased 161%

1. See table in Exhibit 1, which gives detailed information for each district, and Chart C, which gives a summary of adult arrests and juvenile referrals.
2. Classification of Drugs:

Class	Type
I	Opium, Opium Derivatives, Heroin, Morphine, etc.
II	Marijuana
III	Dangerous Drugs, Glue Sniffing, etc.

(from 31 to 81) from 1967-1969, while the actual number of active narcotic cases increased 46% (from 154 to 225) from December 31, 1968 to December 31, 1969.

The Oregon State Police Crime Laboratory, combining chemical and technical examination, conducted 5,387 examinations during 1967-68, and 7,035 during 1968-69, for a 31% increase. In these tests, marijuana went from 3,035 tests performed in 1967-68 to 4,575 in 1968-69 for a 51% increase; while the "all other" category went from 2,352 to 2,460 for a 5% increase.

MENTAL HEALTH STATISTICS

Psychiatric Hospitals

Three hospitals, operated by the Mental Health Division, serve different areas of the state. Dammasch State Hospital serving the metropolitan area of Clackamas, Multnomah, and Washington Counties, received 491 drug contacts during the time period of July 1969 through September 1970. Of these, 34% used Class I or hard drugs, 14% marijuana, and 67% Class III or dangerous drugs. In the same time period (July 1969 through September 1970) Oregon State Hospital, which serves all other counties except those in eastern Oregon, processed 356 contacts. In contrast to Dammasch, only 19% used Class I, 33% Class II, and 88% Class III. Eastern Oregon Hospital and Training Center, which serves the eastern part of the state, had 54 contacts for the 15-month period. Of these, 33% used Class I, 43% Class II, and 70% Class III.

The state total for all three hospitals shows 901 contacts from July 1969 through September 1970. Of these 28% used Class I drugs, 23% Class II, and 76% dangerous drugs. Examination of age groups for all classes shows that 63% were under 25 years of age.

Table 4

Oregon Psychiatric Hospitals
Drug Contacts (7/69-9/70)
By Age Groups and Drug Class

Drug Class	Age Group in Years 12-19	20-24	25-34	35-84	All Ages
I	29	45	53	40	167
II	15	21	6	2	44
III	128	168	90	97	483
I and II	5	1	1	1	8
I and III	13	10	14	7	44
II and III	45	58	19	1	123
I, II, and III	16	12	4	0	32
All Classes	251	315	187	148	901
Percent	28%	35%	21%	16%	100%

Table 5

Oregon Psychiatric Hospitals
Drug Contacts (7/69-9/70)
By Age Groups and Drug Class

Drug Class	Age Group in Years 12-19	20-24	25-34	35-84	All Ages
All I	63 7%	68 8%	72 8%	48 5%	251 28%
All II	81 9%	92 10%	30 3%	4 *	207 23%
All III	202 22%	248 28%	127 14%	105 12%	682 76%

*Less than .5 of 1%.

Alcohol and Drug Section of the Mental Health Division

In a five-month survey conducted August through December, 1969, 371 persons sought assistance for treatment from the Alcohol and Drug Section of the Mental Health Division. Of these, 229 were males (62%) and 137 were females (37%). (Sex was not reported for 5 (1%)) Over 50% were under age 24, while only 12% were over 35. (See Table 6 for age detail)

Table 6

Alcohol and Drug Section
Drug Contacts by Age Group
August - December, 1969

Age Group	Number	Percent
13-19	111	30%
20-24	82	22%
25-34	90	24%
35+	44	12%
Unreported Age	44	12%
All Ages	371	100%

Mental Health Clinics

Another segment of the state's mental health programs is the community mental health clinics. The 26 clinics throughout the state reported 410 drug contacts in the same five-month survey conducted by the Alcohol and Drug Section. In contrast to the disproportionate percentages of the Alcohol and Drug Section's male and female contacts, the clinics had 207 males (50%) and 201 females (49%). (Sex was not reported on 5 (1%)) In the clinics, 84% were under 19 years of age. Table 7, which follows, gives the age detail for the out-patient clinics.

Table 7

Mental Mental Health Clinics Drug Contacts
by Age Group[1]
August through December, 1969

Age Group In Years	Number	Percent
9-19	235	57%
20-24	109	27%
25-34	42	10%
35+	20	5%
Unreported Age	4	1%
All Ages	410	100%

While the above data admittedly does not provide the necessary information to determine actual usage and dependency rates, nor identify the prevalence of the various types of drug usage, it does indicate a sharp rise in the use of all types of these drugs, with the greatest increases taking place in the younger age group.

Relationship of Drug and Alcohol Abuse to Behavior Disorders

Whether as the cause, a contributing effect, or a result, there is a pronounced relationship between drug abuse problems and behavior disorders. In a recent study[2] by the Vocational Rehabilitation Division, counselors working with youths with behavior disorders in juvenile homes reported that approximately 40% of these youths had drug or alcohol problems. Counselors in the corrections program reported up to 85% of their clients had a history of difficulty with alcohol or drugs, and 60% of a client sample in Salem's correctional program had a history of alcohol or drug abuse.

In addition to the abvious health and public safety considerations, unemployment, family problems, divorce, child abuse and neglect, crime, and other manifest behavior disorders help to identify the nature and complexity of the alcohol and drug abuse problem.

Prevention and Treatment

It has become evident that the number of alcoholics and other drug abusers in need of outpatient services is increasing at a somewhat greater rate than the population increase. There is also a significant number who have residual defects requiring prolonged inpatient care. Drug dependency is usually associated with a vast array of physical, mental, and social problems, which appear to reinforce one another rather than present clear cases of cause and effect.

1. Exhibit 1, Chart B, provides a composite picture of the Mental Health Division drug contact programs.
2. Report of Alcohol and Drug Abuse in Oregon Vocational Rehabilitation, Vocational Rehabilitation Division.

Treatment and rehabilitation of drug-dependent persons is a lengthly and expensive process, usually heavily subsidized by society. Taking cognizance of the fact that alcohol and drug abuse are not restricted to any one age group, sex, occupation, economic, or social strata, the size and characteristics of the population at risk help to identify prevention, rather than treatment, as the area for primary emphasis if we are to make the most efficient use of available resources.

The significant causative factors for alcohol and drug abuse problems are not well understood, which serves to emphasize the vital need for research in this area if effective intervention programs are to be established.

Control

In addition to the basic health problems of prevention, treatment and rehabilitation, there is the problem of control of chronic and periodic abusers. Programs of control are for the protection of society as well as for protection of the individual abuser; often these programs are not primarily curative in nature. For such problem areas as drunk driving, we must concentrate our efforts toward the protection of the public through legal rather than medical means, until such time as prevention and treatment can effectively cope with the drug abuse problem.

Target Populations

Although alcoholism and drug abuse are not restricted to any one age group or social strata, there are particular target populations with a higher prevalence of abuse problems. Alcoholism, with a wide range of drug-dependency problems, appears to be concentrated in the middle-age and older population. The use of opiate-type drugs (heroin) is concentrated in a small number of addicts in metropolitan areas. Recreational or experimental drug usage involving marijuana and a host of other hallucinogens seems to be concentrated in the "under thirty" age group and there has been a surge of dangerous drug usage of this type in "middle class" youth. It is generally accepted that no drug personality profile would fit the entire population of these "recreational" drug users. In spite of the recent increase in other types of drug usage, it should be noted that alcohol appears to remain the most frequently used drug in the younger as well as older group.

Cultural Attitudes

Alcoholism and other forms of drug abuse involve both problems of complete dependency and problems of occasional or recreational use of drugs with potential ill effects. Effective treatment is largely dependent upon the drug abuser's willingness to be helped. The use of marijuana is commonly compared by today's youth to society's accepted use of alcohol, and professional opinion as to possible harmful effects is divided.

Any comprehensive attack on the problem must take into consideration the relatively frequent misuse of prescribed drugs in addition to the use of drugs without legal or medical sanction. Problems of both physical and psychological dependency often go undiagnosed and untreated until some traumatic experience demonstrates the individual's need for help. It is clear that societal attitudes are not consistent nor well defined, and that prevention will involve more than increased legal vigilence and enforcement of existing drug abuse laws. Affecting a change in the public attitude to embrace either abstinence, more restrictive medically approved usage, or well-defined moderation as generally accepted personal behavior standards will be no easy task.

The direct and indirect costs of alcoholism and drug abuse in Oregon, as well as the non-quantifiable human suffering involved, serve to point out that significant efforts must be made immediately to come to grips with the entire spectrum of alcohol and drug abuse problems. These multiple problems extend beyond the competence of any single profession or group, and demand a multi-disciplinary approach encompassing legal, cultural, economic, social, and health considerations.

CURRENT PROGRAMS AND ACTIVITIES

Federal Services

The Roseburg Veterans' Administration Hospital serves veterans from Oregon, Northern California, Western Idaho, and Nevada. A group of 14 acknowledged alcoholics are admitted into its Alcohol Rehabilitation Program every 90 days. Treatment includes medical, educational, and group therapy; selected patients are encouraged to use Antibuse. In addition, an alcohol and drug education program is conducted on one of the hospital wards. The Portland Veterans' Administration Hospital has neither an established program for alcoholism nor drug abuse. Patients with these conditions are referred to the other Veterans' Administration hospitals or to some other local facility for treatment. Camp White, in Southern Oregon, has the largest number of resident alcoholics of the federal facilities in Oregon.

State Services

The Mental Health Division has the major responsibility for providing services in Oregon for alcoholism and drug abuse. Primary responsibility is centered in the Alcohol and Drug Section. The Division is also responsible for the care and treatment of alcoholics in the state hospitals for the mentally ill and provides coordination and state matching funds to community mental health clinic programs in 31 counties.

Alcohol and Drug Section

The central offices of the Alcohol and Drug Section are located in Portland. This facility houses the Alcoholism Treatment and Training Center which provides direct medical, psychological, and social

services to alcoholics primarily from Metropolitan Portland. The Center recently expanded its services to assist selected young drug abusers. In addition, there are field offices in Eugene, Salem, Grants Pass, and Ontario; each staffed with one director. They provide consultant services and educational materials to other agencies with alcoholism case problems, as well as a program of public education and information about drug abuse. This includes an educational program especially directed toward youth and the schools. Their activities include conferences, lectures, seminars, etc., with teachers, law enforcement personnel, and health personnel. The Alcohol and Drug Section conducts an annual conference on drug studies on the campus of Portland State University (Western Institute of Drug Problems Summer School). In conjunction with the Board of Education, the Section has also helped to develop a drug education handbook (teacher's manual and curriculum guide).

The Alcohol and Drug Section of the Mental Health Division also conducts a Narcotic Addict Aftercare Program to provide services to Oregon drug addicts who are committed from U.S. courts. The federally funded program provided services to 54 persons in 1969-70; and is divided into three areas: (1) diagnostic and evaluation services prior to inpatient care; (2) inpatient treatment up to 36 months; and (3) aftercare treatment in outpatient clinics. Services are contracted out to those facilities able to provide such care.

In addition, the Alcohol and Drug Section established a Synthetic Narcotic (methadone) Program for drug addicts in Oregon in 1969, to provide substitution of a medically and legally controlled drug (methadone) for the illegal and uncontrolled use of narcotics such as heroin. All persons who have been residents of Oregon for one year or more are eligible for the program. Most of the clients voluntarily seek help; however, some patients are referred to the program by parole and probation officers and the courts. At present, there are about 312 persons in the program. While the program does not achieve full rehabilitation of the addict, it has clearly achieved a measure of control, supervision, and partial rehabilitation never before available. At present, there are three approved drug stores for furnishing methadone in Portland and eight others distributed throughout the state. A satellite clinic is being proposed for the Eugene area and would be incorporated into the Lane County Mental Health Clinic. Occassionally, the program refers patients to Dammasch State Hospital or the Oregon State Hospital for further treatment.

The total expenditure for the Alcohol and Drug Section for 1969 was $246,074, of which 68% went into alcohol programs.

Hospitals for the Mentally Ill

In Oregon there are three state hospitals for the mentally ill located in Wilsonville, Salem, and Pendleton. None of the institutions operate special treatment programs for narcotic users nor do they have programs for alcoholism distinguishable from the total hospital program. In 1969, approximately 20% of admissions (933 patients) were admitted to the state hospitals as alcoholics.

Community Mental Health Clinics

There are 26 clinic programs run by the counties with funding support and guidance from the Mental Health Division, providing a wide range of mental health services in 31 counties. Four of these clinics have contracted with a total of 15 private, non-profit organizations to supplement their programs in various areas, including five halfway houses for treatment of alcoholism, two programs for transient young people, and one crisis referral center. The local clinics are staffed by psychiatric social workers, psychiatrists, and psychologists. In most cases, the psychiatric services are available on a part-time basis. Twelve of the community mental health clinics offer some direct programs for alcoholics. Approximately 8% of the people seeking help in the clinics during 1968-1969 (about 680 persons) had alcoholism problems and about 3% were reported to have drug problems. Many of these people seeking help are not diagnosed as drug abusers, but use drugs to cope with other problems. Treatment may include individual, group, or family therapy. In cases of severe drug problems, clients are referred to other drug programs, including the state mental hospitals.

Projects and Proposed Services

1. The Multnomah County Mental Health Clinic proposes to establish a detoxification center in Portland to be set up in Multnomah County Hospital. To date, the center is in a formative state.

2. The Citizen's Advisory Committee on Alcoholism recommended the establishment of a detoxification center in the skid-row area of Portland. This is also in a formative stage.

3. A demonstration project on the rehabilitation of problem drinkers who drive, jointly prepared by the Oregon Traffic Safety Commission and the Drug and Alcohol Section of the Mental Health Division, has been approved and funded. The project will be conducted in Portland and Eugene and will be financed through a federal grant of $2,149,898. It has two major elements: (a) community organization and education, and (b) diagnostic referral and treatment under the courts. Federal funds are not

available for treatment; therefore, proposed treatment and rehabilitation caseload (about 300 cases over the three-year project period) "is to be absorbed by various participating community agencies, such as Alcoholics Anonymous, Community Mental Health Clinics, etc."

4. Drug Treatment Project. The program is made available through a grant to the Alcohol and Drug Section of the Mental Health Division from the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare. The first-year grant is for $194,095 and is matched by $21,566 of state community mental health funds. Renewal of the grants for the second and third years of the project is expected, thus making the program available through May 31, 1973.

   The focus of the project is upon research and comparison between different methods of treatment of the drug abuser. The patient group to be selected will be older adolescents or young adults who use drugs such as amphetamines, barbiturates, and other non-narcotic drugs.

   Federal research and demonstration requirements will limit service to patients selected by the project staff. A three-year research study will compare different treatment methods. In about half the patients, parental or family participation will be studied as a part of the treatment program.

   In addition to receiving treatment, patients will receive rehabilitation services from the State Vocational Rehabilitation Division. A training program for community workers who deal with drug abusers will also be conducted by the project.

5. Rogue Valley Council of Governments. The Law Enforcement Council has approved a grant of $10,200 to create a detoxification center affiliated with the local mental health clinic to treat alcoholics and drug abusers in Jackson and perhaps Josephine Counties.

The Division of Vocational Rehabilitation has $55,497 budgeted for alcohol and drug programs for 1970. Approximately 63% ($35,000) of this sum will fund two vocational rehabilitation positions in the Portland offices of the Alcohol and Drug Section of the Mental Health Division; one Alcoholism Consultant and one Vocational Rehabilitation Counselor. The remaining $20,000 will be used for case services to people with alcohol and drug problems. Clients served by the Division of Vocational Rehabilitation have a physical or mental handicap which limits their employability.

Although the Division of Public Welfare has no identifiable program for alcoholism or drug abuse, a study of welfare cases conducted in November, 1967, indicated that approximately 350 mothers and 230 fathers in homes receiving Aid to Dependent Children have an alcoholic problem.

The Oregon State Police, in cooperation with the Implied Consent Program of the Oregon State Board of Health, are expanding training in the use of the Breathalyzer. A $24,870 grant provides equipment to enable minimum numbers of state, county, and city police officers in Oregon to be trained, certified, and re-examined (at least biennially) as alcohol breath test operators. The objectives of the program during the twelve-month test period are to: (1) train 450 new officers; and (2) retrain 720 officers. Increased use of the Breathalyzer may result in increased alcohol convictions, necessitating an expansion of alcohol treatment centers in the state.

During the past year, the entire membership of the Department of State Police, consisting of 634 officers, has received a minimum of 17 hours training in narcotic and drug identification and investigative functions.

In addition, the Department maintains a cross-reference file on all reported narcotics cases including arrest reports; however, reporting has not been uniform to date. The number of persons arrested or convicted for drug use is only a proportion of the total users since it is difficult to apprehend an individual in the process of using a drug. The State Police Crime Laboratory also identifies drug users.

The State Police have established a specialized enforcement unit within the State Police Department to detect, enforce, investigate, and prevent narcotic and drug abuse, and to aid and assist other law enforcement agencies engaged in similar activities. Personnel assigned to this unit also are available to initiate and participate in drug abuse prevention programs and training of law enforcement officers from all agencies in the state.

The State Police have also established additional crime detection laboratories at Ashland and Pendleton, which, together with the one located in Portland, serve all law enforcement agencies in the state in the analysis of chemical and physical evidence; a major function is narcotic and drug identification. A proposal to establish a similar laboratory in the Eugene area is now under consideration for funding by the Law Enforcement Council.

Oregon Board of Education

State law requires all public schools to include alcohol and drug education in the curriculum. A teacher manual, "Alcohol Education in Oregon Schools," was developed by the Board of Education for use by Oregon teachers.

In addition, the Board of Education has received a $40,000 federal grant and has established training sessions in drug education for educational personnel at the local school district level. This Drug Education Program

for Oregon Teachers (DEPOT) includes concepts, objectives, and skills necessary to deal with the drug problem; in addition, DEPOT involves parents, youth, and community resources in the planning, implementation, and evaluation of the drug education program. Regional workshops and training sessions are now underway and ultimately, fourteen training programs will be conducted in the administrative districts in the state by a multi-disciplinary training team.

The following institutions and agencies are actively participating in the program: Oregon State Board of Education, Mental Health Division, Oregon Board of Health, Law Enforcement agencies, Intermediate Education Districts, and local school districts.

If adequate funds are available, it is anticipated that the evaluation of the program will be contracted to a private agency and that two types of evaluation will be provided: (1) formative or process evaluation concerning how the program is functioning, and (2) summation or product evaluation concerning the value of the program.

Department of Justice

The Attorney General has proposed that the Governor establish, by Executive Order, a special Narcotic Investigative Task Force in the Department of Justice. The first nine months of operation would be devoted to training personnel, developing intelligence data, and initiating undercover penetration.

This initial phase would be financed out of existing budgets for the Department of Justice and State Police. Eventually, approximately $75,000 would be required to pay for the cost of special detection equipment, purchase money, and information fees. It is expected that this would be financed by a combination of legislative action and federal law enforcement funds.

It is expected in the future that the Task Force would consist primarily of officers from the State Police and local law enforcement agencies assigned on a temporary basis. The unit's primary responsibility would be to develop investigations against high level sources of supply of illicit drugs and narcotics in the state of Oregon. The unit would also be available to assist local agencies by assigning undercover agents to these agencies on a loan basis. However, the unit would only indirectly concern itself with "street level" enforcement.

The Columbia Regional Association of Governments and the Law Enforcement Council proposed an association of local police agencies and District Attorneys for better apprehension and detection of drug abusers. A narcotics squad, responsible to the Association, would be formed. This proposal has been approved by the Law Enforcement Council and a grant of $138,563 has been awarded.

Voluntary Services

There are seven Alcoholic Rehabilitation Centers in Oregon. Four are located in Portland (two for men and two for women) and one each in Grants Pass, Pendleton, and Eugene. The total capacity for all centers in the state is approximately 150, with the Portland centers accounting for about two-thirds of the total.

Alcoholics are referred to the rehabilitation centers by the state hospitals, corrections programs, and other community services. The centers provide supportive community home care and counseling services available through the Alcoholism Treatment and Training Center of the Mental Health Division and the Multnomah County Mental Health Clinic. Counseling includes group therapy sessions, psychological testing, and individual counseling. The counseling service at the Eugene Center is provided through the Lane County Mental Health Clinic.

Although the rehabilitation centers are operated by local councils on alcoholism, they receive about $62,000 in annual state funding through the Mental Health Division. Collectively, they also receive county funds of $57,600, voluntary funds of $950, city funds of $6,200, and fees of $43,300, for a total annual budget of approximately $170,000.

Private Inpatient Facilities

The Raleigh Hills Hospital is a private, nonprofit organization devoted to alcoholic rehabilitation. The hospital utilizes systematic conditioning techniques to assist addicted alcoholism patients. The Raleigh Hills program consists of 11 treatment sessions within a one-year span. The first session requires two weeks in the hospital, followed by ten one-day and one-night supportive treatments spaced throughout the year. The hospital employs six physicians, one psychiatrist, three psychologists, five counselors, and sixteen registered nurses. Most of the professional staff is part-time, serving a maximum of fifteen patients at any one time.

The Blanchet Farm in Yamhill County is an inpatient rehabilitation program for alcoholics. Blanchet Farm, which has a capacity of 35, has recently entered into a cooperative plan with the City of Portland to accept offending drinkers from the municipal court to be "dried out" and receive therapy.

Information-Referral Centers

There are six alcoholism referral centers located in Baker, Josephine, Lane, Malheur, Umatilla, and Union Counties. They are managed by voluntary organizations, providing the public with information about the problems of alcoholism and referring people with alcoholism problems to service

agencies. Each center receives approximately $2,000 from the state through the Mental Health Division. The funds are spent primarily on educational materials made available to various community groups and agencies. The centers utilize both paid and voluntary help to serve as a community point of referral for alcoholism services.

There are 54 separate Alcoholics Anonymous groups in Portland and 70 Alcoholics Anonymous groups distributed throughout the rest of the state. There are no Alcoholics Anonymous organizations in Gilliam, Sherman, Wheeler, and Wallowa Counties. These groups are also organized in some communities to assist the families of alcoholics to better understand the problems of alcoholism.

The Social Service Clubs have been organized by ex-alcoholics and provide a recreational facility for people with a past alcoholism problem. There are eight such clubs in the state; six are in Portland.

The Oregon Alcoholism and Health Association coordinates the activities of community alcoholism councils organized to provide educational information at the local level as well as service programs in some cases. The Association has a small office in Portland.

A voluntary organization developed a facility in Portland named "Outside-In"; a comprehensive health care program for youth with problems located in a low economic area. Its primary service is medical care and counseling to youthful drug users. This program receives some grant assistance from the Mental Health Division, but depends heavily upon voluntary medical help.

The White Bird Socio-Medical Aid Station, Inc. is a non-profit clinic recently established in Eugene to provide a comprehensive health care program for alienated youth with drug problems.

Other Voluntary Agencies

The Salvation Army has several autonomous organizations in the larger population centers of the state. They provide food, housing, and counseling to skid-row alcoholics.

The Oregon Council on Alcohol Problems, located in Portland, is an information and referral agency for persons with alcohol problems. Through its Speakers Bureau, the Council provides educational programs on alcoholism to any group requesting their assistance. In addition, the Council refers alcoholics to existing community services.

The Women's Christian Temperance Union emphasizes both abstinence from alcohol and a dependency upon religion to conquer alcoholism.

It should be noted that a significant number of alcohol and drug abusing patients are treated by private practitioners in offices, emergency rooms, and hospitals throughout Oregon.

AUTHORITIES

ORS 430.080, .090, .100, .103, .107, 475.645, and 475.715 respectively, place responsibility on the Mental Health Division for: (1) developing a public education program relating to the harmful effects of alcohol and other drugs; (2) operating a rehabilitation clinic for alcohol-dependent persons; (3) appointing an Oregon Alcohol and Drug Education Committee; (4) establishing a committee of ex-drug addicts to conduct services in junior and senior high schools; (5) appointing a Drug Addiction Advisory Committee; (6) providing facilities for drug withdrawal of persons convicted of narcotics use; and (7) establishing a synthetic narcotic drug (methadone) treatment program for persons dependent on narcotic drugs.

ORS 426.10 provides for admission of drug addicts to state hospitals for the mentally ill.

ORS 430.630 establishes Alcohol Education and Rehabilitation as one of the elective programs in community mental health clinics.

ORS 430.630 allows special funds and personnel designated for enforcement of liquor laws to be utilized for enforcement of laws regulating or prohibiting the sale and use of narcotic drugs.

ORS 475.685 and .705 provide for appointment of physicians by the State Health Officer to assist city and county health officers in administration of tests for drug addiction and use, and for funding of the program by the state.

OBJECTIVES

1. Reduce the incidence of alcoholism.

2. Reduce the incidence of drug dependence (drugs other than alcohol).

3. Reduce the incidence of drug abuse and misuse in the non-dependency category.

4. Increase the inpatient and outpatient treatment capabilities and outreach efforts of state and local community resources for alcohol and drug-related problems and behavior disorders 25% by 1973.

5. Reduce the Driving Under the Influence of Liquor (DUIL) traffic accident rate 25% by 1973.

RECOMMENDATIONS AND METHODS

1. *IMPROVE PROGRAM COORDINATION AND UTILIZATION OF EXISTING PUBLIC AND PRIVATE RESOURCES.*

   Methods

   a. *Governor's Assistant for Human Resources clarify and restate role and relationships of the Mental Health Division to both public and private agencies, fixing full responsibility on the Division and giving it the necessary authority to coordinate all state and local drug and alcohol programs to include reveiw and recommendations as to funding priorities for all agency programs relating to this problem area.*

   b. *Mental Health Division establish requisite baseline data for identification, quantification, and analysis of drug and alcohol abuse and their adverse direct and indirect effects. Establish an effective statewide reporting system to provide necessary input to implement evaluation mechanisms by 1973.*

   c. *Regional field representatives of the Alcohol and Drug Section agressively seek community leaders to organize complete community prevention, treatment, and rehabilitation programs designed to provide for a more productive, independent life for people with alcohol and drug abuse problems. The development of comprehensive community drug abuse programs will require mobilization of top-level community and professional leadership if it is to succeed.*

   d. *Field representatives of the Alcohol and Drug Section contact areawide comprehensive health planning committees and request participation in developing specific plans for attacking drug and alcohol problems.*

   e. *Field representatives of the Alcohol and Drug Section encourage local mental health associations to provide organizational leadership for a wide range of programs aimed at soliciting community participation and increasing local knowledge of drug problems.*

2. *EXPAND COMMUNITY LEVEL EFFORTS AIMED AT EARLY IDENTIFICATION AND ENTRY INTO THE TREATMENT AND REHABILITATION SYSTEM OF INDIVIDUALS WITH ALCOHOL AND DRUG PROBLEMS.*

   Methods

   a. *Mental Health Division initiate a pilot program involving use of community centers offering a diversified program encompassing the full range of alcohol and drug abuse problems. These centers should be designed for easy public access for individuals*

with alcohol and drug problems and receive substantial local publicity. The primary focus of these community centers will be on individuals with behavioral problems who do not acknowledge a drug problem and are not confirmed alcoholics or drug-dependents. This program could easily be coordinated with the concept of the outreach mental health worker, as proposed in the Mental Health Division's Plan for Community Services.

b. Increase outreach efforts of the local mental health clinics for drug and alcohol-related problems through community involvement, committees, and services.

3. EXPAND TREATMENT AND REHABILITATION SERVICES FOR DRUG AND ALCOHOL ABUSERS SEEKING ASSISTANCE.

Methods

a. Provide for expansion of the methadone treatment program as caseload requires, eliminating the one-year state residency requirement for program eligibility.

b. Department of Justice encourage utilization of ORS 475.645 allowing commitment of persons convicted of narcotic use to state mental hospitals for up to six months treatment in lieu of imprisonment.

c. The Mental Health Division phase in treatment and halfway house programs throughout the state, based on community resources and need, as a component of basic district mental health programs. These detoxification programs could be housed in separate facilities or joined with other services, such as community hospitals or nursing homes, and either be directly administered by the Mental Health Division or contracted for with a public or private agency. The program should consist of both a treatment center and a holding facility, providing room and board, recreation, counseling, and drug therapy following detoxification.

d. The Veterans' Administration Hospital in Portland establish a special program for the treatment of alcoholic veterans.

4. ESTABLISH AND FUND AN INTENSIVE PUBLIC EDUCATION AND INFORMATION PROGRAM ATTACKING DRUG AND ALCOHOL ABUSE IN THE STATE.

Methods

a. The Mental Health Division design an intensive program, utilizing every available form of mass media, aimed at securing a rational approach and public understanding of drug and alcohol abuse problems. In addition to focusing on the potential physiological and psychological consequences, a reasonable attempt should be

made to influence public attitude toward acceptance of either abstinence or moderate use of legally approved drugs as a desirable personal behavior standard.

1) The Mental Health Division bring together professionals from industry, medicine, education, and elsewhere, with expertise in behavior modification, to fully explore existing knowledge of why individuals use drugs, and determine how to best effect a change in behavior.

2) The Governor's Commission on Youth call upon local youth groups to develop recommendations for the positive, constructive role of youth in combating drug and alcohol problems. These suggestions should be used by the Mental Health Division in planning strategies for developing a program of public acceptance of abstinence or moderation practices.

b. The Mental Health Division, in cooperation with the State Board of Health and Board of Education, develop and implement a program designed to increase community understanding and involvement of the new public school curriculum aimed at preventing experimental or recurring illegal drug use in school-age children.

1) Visiting teams of professional medical personnel and ex-abusers, coordinated and evaluated by the Mental Health Division, may be organized to visit junior and senior high schools throughout Oregon as a part of special consultant services in the State Board of Education. These teams should remain in school districts for a week at a time and hold numerous informal talk sessions with youths, parent groups, and local professional people. The visiting team should be prepared to evaluate the community reaction to the new drug education curriculum and make recommendations for its use.

2) Each community organization with an involvement in drug problems should have representation on an advisory committee established jointly by the school system and the field representative of the Alcohol and Drug Section. This advisory committee would provide continuing input into the program for implementing the drug abuse curriculum.

5. ESTABLISH A SPECIAL DANGEROUS DRUGS INVESTIGATIVE TASK FORCE AT THE STATE LEVEL.

Method

Implement the Attorney General's proposal to establish this task force in the Department of Justice (see "Department of Justice"; Current Programs and Activities). Primary focus would be investi-

gating high-level sources of supply of illicit drugs and narcotics in the state.

6. *INCREASE EMPHASIS AND CONTROL OVER MISUSE OF PRESCRIBED DRUGS.*

Method

State Board of Medical Examiners and the State Board of Pharmacy, in cooperation with appropriate licensing boards, establish more stringent guidelines for ethical medical practice in relation to the use of potentially hazardous and dependence-producing drugs

7. *IMPROVE INFORMATION BASE ON THE DISTRIBUTION AND EXTENT OF ALCOHOL-CAUSED TRAFFIC ACCIDENTS AND EFFECTIVENESS OF EXISTING CONTROL PROCEDURES.*

Methods

a. *Oregon Traffic Safety Commission prepare legislation requiring the administration of blood alcohol tests for all persons over 15 years of age killed in traffic accidents, when such tests can be administered within four hours of the accident; and require surviving drivers of fatality-causing accidents to submit to an appropriate alcohol level test. Traffic Safety Commission establish procedures for forwarding data to the Motor Vehicle Division for correlation with traffic accident statistics.*

b. *Motor Vehicle Division develop a case history file of drivers convicted of Driving Under the Influence of Liquor (DUIL), to include summaries of medical history, state and local police records, recent employment records, and other data which might serve to point up relative risk considerations. Non-driving public intoxication convictions, as well as Driving Under the Influence of Liquor violations, should be considered in making license restrictions.*

c. *Motor Vehicle Division expand research and evaluation of drinking driver problems to include:*

   1) *Correlation between DUIL fatal and personal injury accidents and DUIL arrests on a geographic basis ;*

   2) *Effectiveness of various punitive or control measures (to include court probationary actions and probationary licensing procedures, fines, and jail sentences) ;*

   3) *Effectiveness of state and community sponsored alcohol rehabilitation programs and public information activities ;*

   4) *Frequency and significance of DUIL repeaters ;*

5) *Comparison of the involvement of the confirmed alcoholic with the average social drinker in traffic accidents/ fatalities in Oregon.*

8. *IMPROVE OR EXPAND PRESENT PROGRAMS TO COPE WITH THE DRINKING DRIVER PROBLEM.*

Methods

a. *Alcohol and Drug Advisory Committee of the Mental Health Division, together with the Director of the Traffic Safety Commission, prepare legislation and solicit legislative support to:*

1) *Reduce the legal intoxication level from 0.15 to 0.10;*

2) *Require an open-ended drivers license revocation for persons convicted of two or more drunk driving violations within a five-year period. Make reinstatement dependent on recommendation by State Health Officer that such persons have undergone successful treatment for their alcohol problems.*

b. *State law enforcement agencies re-emphasize their road block check program for drinking drivers during peak traffic accident periods.*

c. *Motor Vehicle Division develop a predictability scale based on a study of driving records to assist in early identification of drivers with alcohol problems.*

d. *State law enforcement agencies institute procedures requiring the administration of the Michigan Alcohol Screening Test (MAST) or an equivalent to all Driving Under the Influence of Liquor first offenders, as well as to drivers whose records indicate high-risk patterns of driving behavior. The test should be given at the driver improvement interview conducted by the Motor Vehicle Division. A program for referral to nearby treatment facilities should be established.*

e. *The Mental Health Division, working through local mental health and other health agencies, expand specialized treatment facilities throughout the state for problem-drinking drivers, emphasizing rehabilitation and follow-up procedures. The Traffic Safety Commission/Mental Health Division demonstration project on rehabilitation of problem drinkers who drive (Portland and Eugene) should provide substantial direction for continued efforts in this area of concern.*

f. *Mental Health Division encourage an increase in the use of antabuse in the treatment of alcoholic drivers.*

g. *Oregon State Police expand training programs to provide specialized training for law enforcement officers in the detection and handling of persons driving under the influence of alcohol, as well as in the use of the Breathalyzer. Increase training programs in all phases of drug identification, symptomatology, use, dependency, etc., for state and local law enforcement officers.*

9. *REVIEW EXISTING ALCOHOL AND DRUG LEGISLATION FOR ADEQUACY.*

Method

The Alcohol and Drug Advisory Committee of the Mental Health Division review model legislation prepared for the National Institute of Mental Health by John M. Kenochan of Columbia University (Alcoholism and Intoxication Treatment Act) to ensure that Oregon has adequate legislation on which to build effective treatment and control programs.

OPERATIONAL PROBLEMS

1. Lack of adequate evaluation criteria for identification, classification, and reporting, as well as inadequate existing statistical data on incidence or effects of drug or alcohol abuse. Difficulty in measuring success or accomplishment of preventive programs.

2. Size and complexity of the problem in view of limited existing resources and capabilities.

3. Relative dearth of knowledge as to causative factors and extensive time lag between research and utilization, as well as the multiplicity of disciplinary interrelationships involved.

4. Public ambivalence and attitudes toward alcohol and drug usage (alcohol vs drugs; prescribed vs non-prescribed; disease vs criminal act; addicting vs non-addicting; psychological vs physiological addiction; etc.) which militates against an acceptable, rational, uniform approach toward prevention, treatment, and rehabilitation.

5. Historically, attempts to effectively legislate morality or to prevent people from engaging in self-defeating behavior have been unsuccessful. This is compounded by acknowledged difficulties in affecting a change in public attitude to embrace abstinence and/or moderation as desirable personal behavior standards.

6. Fragmented and unevenly distributed drug and alcohol services throughout the state and difficulties in coordinating a comprehensive, multidisciplinary prevention and treatment program. Need for better

communications between agencies with responsibilities for different phases of drug and alcohol problem related programs.

7. Delayed entry of drug and alcohol abusers into medical channels, usually only when problems become acute, and difficulty of early identification and effective outreach efforts because problems are not recognized.

8. Problems of physician/patient "privileged information" with reference to comprehensive reporting and recording systems and case history file assembly for drug and alcohol abusers, operating to disallow early identification of potential driving hazards or behavioral disorders.

EVALUATION CRITERIA

1. To be established by the Mental Health Division for current assessment, progress indicators, and objective attainment for Objectives 1-4 (see Recommendation 1, Method b).

   a. The Cooperative Extension Service, Oregon State University, could develop key local agency reporting resources to determine local estimates of drug use - both initial drug use and regular drug abuse. Counties are staffed with local Cooperative Extension Service agents who work with local study committees.

   b. A number of local agencies could be enlisted by Cooperative Extension agents to collect data about the extent of use, regular abuse, or dependency. Possible agencies include: key people in public schools, mental health clinics, local health department nursing programs, county welfare social workers, police departments, community action agencies, hospitals, and clinics. Community colleges and universities should be enlisted as reporting agencies especially in identifying drug abuse other than alcohol. Routine physical examinations required in colleges and universities should include testing for identifiable drug usage.

   c. Some counties are now collecting data based upon CHIPS (Comprehensive Health Information Planning System) developed by the State Board of Health. Alcohol and drug data should be added in these counties and the CHIPS program expanded throughout the state.

2. The evaluation of Objective 5 will be conducted by the National Highway Safety Bureau in accordance with established standards.

PRIORITY

To be determined.

EXHIBIT 1

Table 1

Juvenile Narcotic Law Violations, 1967-1969
for Administrative Districts

District*	1967	1968	1969	1967-1969 % Increase
District 1 Clatsop, Tillamook	0	8	21	--**
District 2 Clackamas, Multnomah, Washington	72	199	224	211%
District 3 Marion, Polk	8	14	26	225%
District 4 Lincoln	1	15	2	100%
District 5 Lane	12	26	80	567%
District 6 Douglas	0	9	23	--**
District 7 Curry	0	3	1	--**
District 8 Jackson, Josephine	1	27	56	5500%
District 9 Hood River, Sherman, Wasco	1	6	2	100%
District 11 Klamath	0	6	8	--**
District 12 Umatilla	0	12	21	--**
District 13 Union	0	2	3	--**
All Districts (19 courts)	95	327	467	392%

* Counties which reported for all three years 1967-69, listed under districts.
** Undefined.

EXHIBIT 1
CHART A
OREGON NARCOTIC VIOLATIONS ADULT ARRESTS
1967-69 Percentage Increases for Age Groups

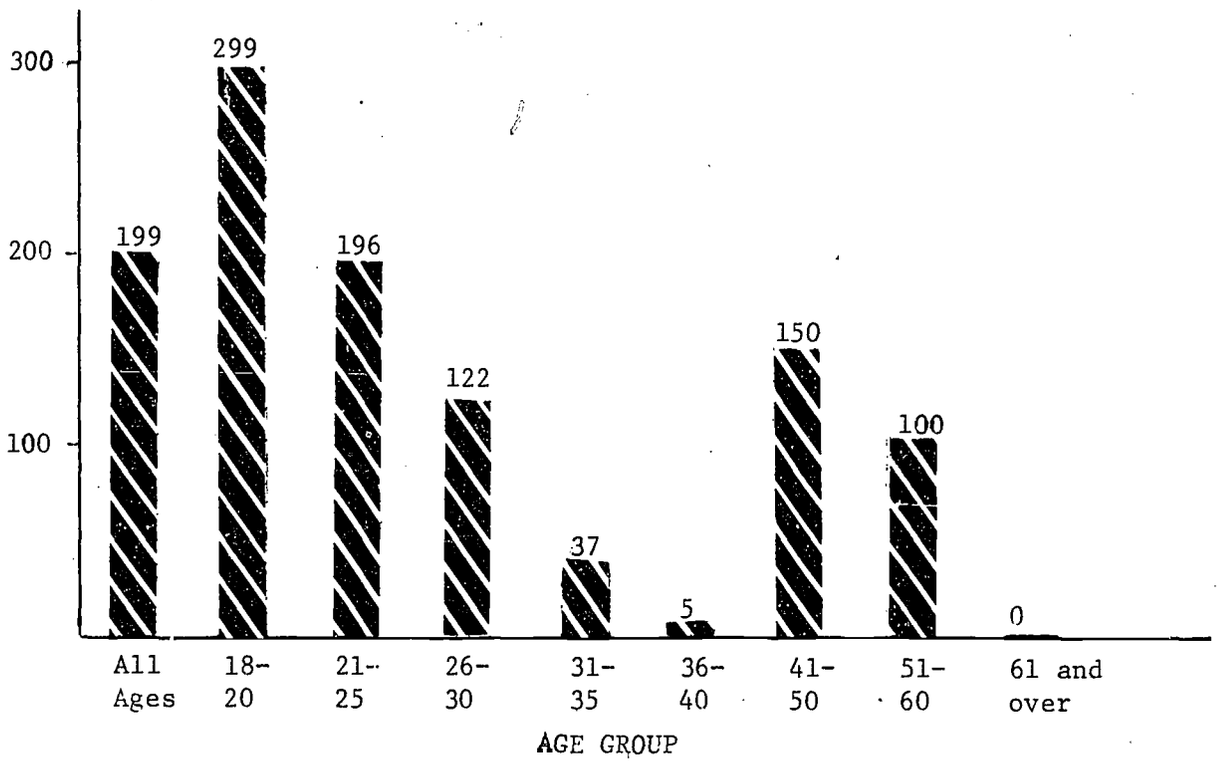


CHART B
OREGON MENTAL HEALTH PROGRAMS 1969 DRUG CONTACTS

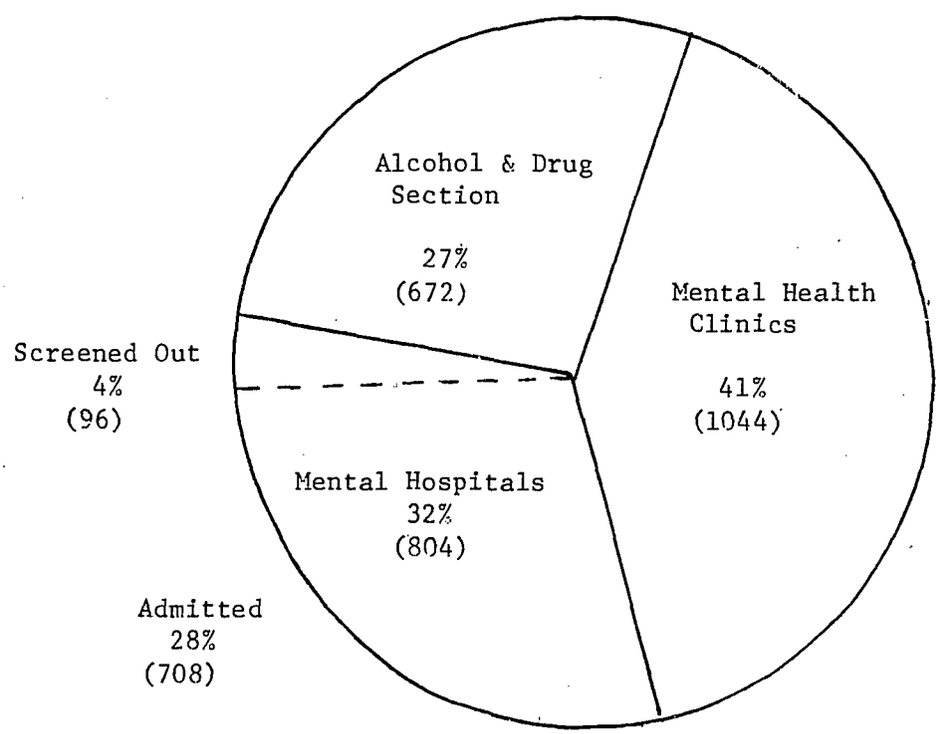
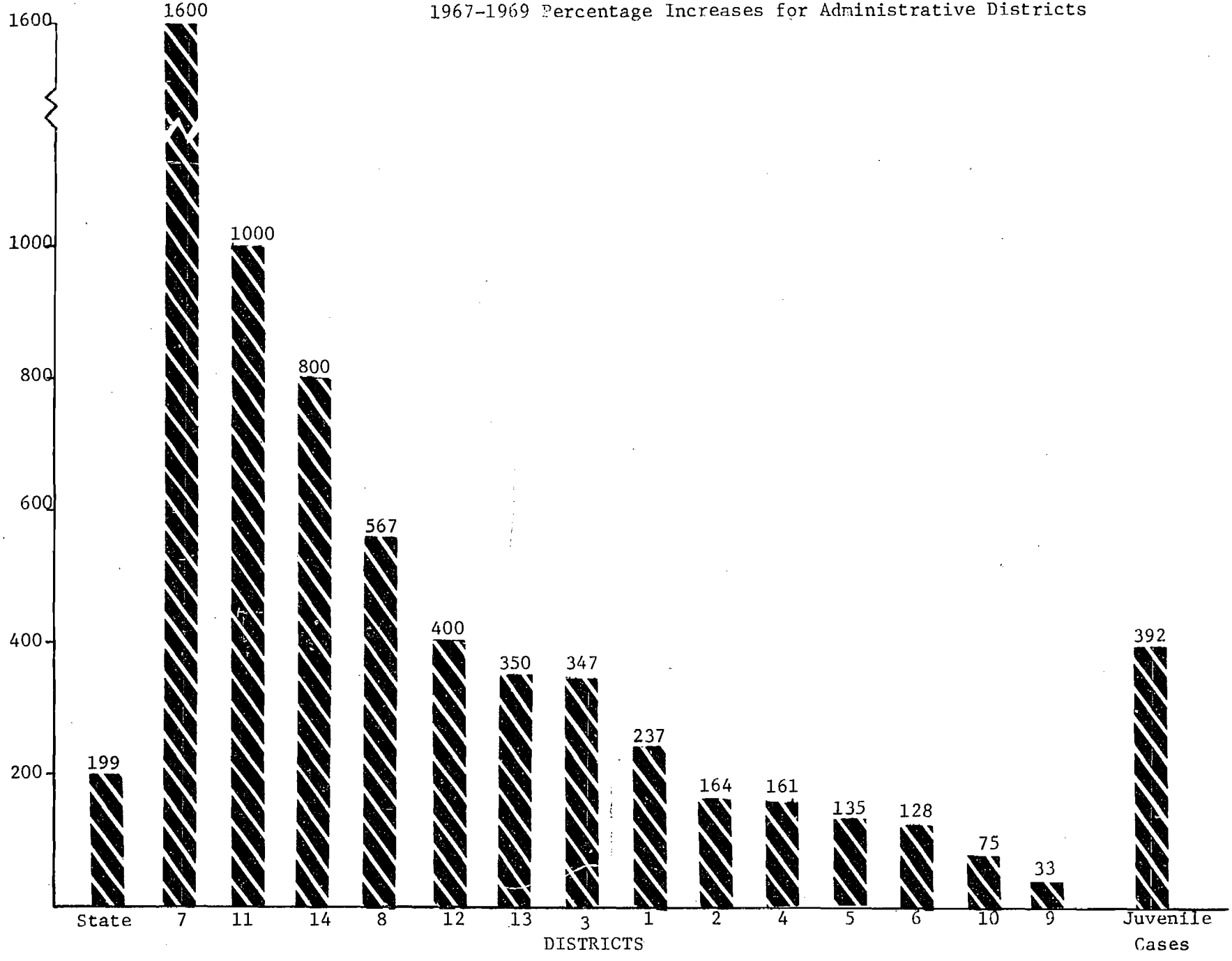


EXHIBIT 1

CHART C

OREGON NARCOTIC VIOLATIONS ARRESTS

1967-1969 Percentage Increases for Administrative Districts



MENTAL RETARDATION

NOTE: Mental Retardation is "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior." (American Association for Mental Deficiency definition)

There are three rather divergent facets to dealing with the problems of mental retardation. The first is prevention. Women exposed to certain diseases, drugs, or other toxic hazardous influences during pregnancy and prior to pregnancy, or as a result of hereditary influences give birth to infants with a variety of congenital anomalies that may result in mental retardation. Mental retardation may result from some types of poisoning, as well as secondary complications from an illness or disease. Prevention involves such services as genetic counseling, immunization against rubella (German measles) and rubeola (measles), and screening for metabolic disorders (PKU). Other preventive measures include special programs or projects, such as Head Start, that attempt to ameliorate those socio-cultural conditions contributing to mental retardation.

The second is habilitation, involving the social service and education programs that provide training, education, and habilitative social services necessary for the retardate to fully develop his potential.

The third is health care, providing such services as medical and dental care and corrective physical restoration. The great susceptibility of the mentally retarded to various adverse medical and dental conditions requires that treatment be readily available. It is not uncommon that parents are unable to find medical and dental assistance for their retarded child in their communities.

GOALS

REDUCE THE INCIDENCE OF MENTAL RETARDATION.

TRAIN, EDUCATE, AND HABILITATE THE MENTALLY RETARDED TO A DEGREE CONSISTENT WITH THEIR CAPACITIES IN ORDER THAT THEY MAY ACHIEVE MAXIMUM SELF-SUFFICIENCY AND INDEPENDENCE.

CONDITION

(The following is from: Oregon State Plan, Construction of Facilities for the Mentally Retarded, Community Mental Health Service, Mental Health Division, 1969.)

"Mental Retardation" encompasses a wide range of deviance from minimal to profound. The distinction between normality and the mildest degree of mental retardation is arbitrarily defined. Mildly retarded persons are far more comparable to those who are labeled normal than to the most profoundly retarded. For this reason, although there are many more near-normal retarded than profoundly retarded, fewer specialized services and facilities are required for the mildly retarded.

Categories of services are established according to the practical level of functioning and age, rather than the cause of the retardation. Nevertheless, etiology may have to be considered in the treatment or education for a particular individual. Practical distinctions must be based on extent of impairment and take into account the various factors which contribute to intellectual and social functioning. The manifestations of these levels of function change with age. The Mental Health Division has adopted the classification of the mentally retarded as recommended by the American Association for Mental Deficiency (1961): Educable (EMR); Trainable (TMR); and Severely Profound (SPMR).

As stated above, mental retardation is defined as impairment of ability to learn and to adapt to the demands of society. These demands are not the same in every culture and vary with the age of the individual. Society as a whole does little to assess the intellectual or social accomplishments of the preschool child. During the school years; however, the individual is evaluated very critically in terms of social and academic accomplishment. In later life, the intellectual inadequacy again may be less evident, if social performance meets minimal demands. Numerous surveys directed toward determining the frequency and magnitude of mental retardation have shown that the number of individuals reported as retarded is highest during the school years. Less than one-fifth as many children in the age group 0-4 were reported by these surveys as mentally retarded, as were reported in the age group 10-14. Similarly, only one-fourth as many persons in the age group 20 and over were identified as mentally retarded in the age group 10-14.

This variation by age is, to some extent, determined by differential survival rates and other demographic factors. The very high prevalence at ages 10-14 is due, primarily, to the increased recognition of intellectual handicap of children within the school systems, while the low number of infants from 0-1 year of age identified as retarded is attributed, in part, to the fact that their intellectual deficit is not yet apparent. Of striking significance is the fact that more than half of the individuals considered retarded during adolescence are no longer so identified in adulthood.

In view of these considerations, only gross estimates of the overall magnitude of the problem can be made. One such estimate may be derived through measures of intelligence. The numbers who are mentally retarded by this criterion can be calculated roughly on the basis of

of the experience with intelligence testing. Experience has shown that virtually all children with I.Q.'s below 70 (as determined by nationally standardized tests) have significant difficulties in learning and in adapting adequately to their environment. About three percent of the school age population score below this level.

Many of the severely and profoundly retarded are physically handicapped to such an extent that families do not seek group programs for them. A few of these children may be known to agencies serving the physically handicapped.

Recent efforts to establish day training centers have demonstrated both the usefulness of group programs and the possibilities for training in fundamental functions. In addition, facilities are needed to house programs for the treatment of associated physical and sensory disabilities.

The total number of severely and profoundly retarded adults in Oregon is uncertain, but probably does not exceed 920. Greater life expectancy may be expected to increase the numbers of the severely and profoundly retarded and to influence the pattern of demands for both day and residential care in the next decade. A significant number of severely and profoundly retarded children even now remain at home, at least until adolescence. Some adults come to the attention of agencies only when age or infirmity of parents becomes a factor. In the past decade, a pronounced increase both in the total number and proportion of the severely and profoundly retarded in residential care has been noted. At present, they constitute somewhat less than one-fourth of the patients of all ages in public residential institutions for the retarded. Approximately one-sixth of these profoundly retarded patients are over 40 years of age.

Oregon was one of the last states to provide funds for classes for the trainable mentally retarded. Prior to 1969-70, schools operated by Associations for Retarded Children or other concerned groups provided the only trainable mentally retarded programs.

In 1955, the Legislature made the special class program for the educable mentally retarded permissive for all school districts. Legislative enactment made the special class program mandatory after July 1, 1964 for all school districts with 12 or more eligible children. In 1964-65, 3,664 educable mentally retarded children were served by special classes; in 1969-70, approximately 5,000. At least 8,000 more children need special programs.

CURRENT PROGRAMS AND ACTIVITIES [1]

1. REFERENCE SOURCES:
"Directory - Mental Retardation Facilities and Services in Oregon" (Governor's Committee on Mental Retardation, June 1968).

"Rationale and Proposal for Services to the Mentally Retarded in Oregon" (Report of Governor's Committee on Mental Retardation, 1968, pp. 5-28).

Diagnosis, Evaluation and Planning

Diagnosis, evaluation and planning are provided by Crippled Children's Division, Fairview Hospital and Training Center, and four county child development clinics. Some county mental health clinics offer minimal services. Limited services are also available from selected pediatricians and dentists.

The Mental Retardation Services Section of the Mental Health Division has the requisite authority, but insufficient funds, to establish diagnosis, evaluation and planning programs.

Classes for Educable Mentally Retarded

It is estimated that 5,000 of the over 13,000 school age educable mentally retarded are being served in 335 classes in the state under the jurisdiction of the Oregon Board of Education.

Financial Support:

1970-71 Federal Assistance	$17,000 (Title VI) 52,812 (Title III)

Classes for Trainable Mentally Retarded

In 1969-70, 483 of an estimated 2,274 school age trainable mentally retarded were served in 48 classes under the jurisdiction of the Mental Retardation Services Section of the Mental Health Division. Nine private schools operated by local Associations for Retarded Children, or as a separate entity, received no per capita monies from local school districts. Two Intermediate Education Districts and 3 public schools paid per capita monies and assumed responsibility for trainable mentally retarded classes.

Projected figures for 1970-71 indicate approximately 165 school districts will pay per capita costs.

Financial Support:

1970-71 Federal Assistance	$20,372 (Title VI) 11,375 (Public Law 91-230 Section 105)
1969-71 State Assistance	$400,000

Local assistance from school districts, Associations for Retarded Children, community resources, and tuition.

Activity Centers

There are approximately seven Activity Centers in Oregon, two of which have received federal staffing grants.

Day Training Centers

There are just a few existing day training centers and pre-school programs in Oregon. For the most part, they are privately operated, and are not coordinated by any state agency. Three school districts have provided pre-school programs in 1969-70, and will continue in 1970-71.

Financial Support:

Federal Assistance $14,899 (Title VI)

Sheltered Workshops

At the present time, there are approximately 21 programs providing varying degrees of workshop services to retarded adults. Sheltered workshops are partially under the jurisdiction of the Division of Vocational Rehabilitation. Maximum training and evaluation of Division of Vocational Rehabilitation clients is 18 months.

Financial Support:

Federal Assistance - staffing grants
building grants

State Assistance - Division of Vocational Rehabilitation

Local Assistance - (Community Resources)

Community Residential Living

There are few community residential facilities. Presently in Oregon there are 2 half-way houses, 4 boarding facilities in private schools, and a minimal number of short- and long-term foster homes.

The Public Welfare Division is authorized to provide monies for semi-skilled nursing home care under Title XIX.

Financial Support:

Federal Assistance (Title XIX)

Local Assistance from parent fees, fund drives, etc.

Institutional Living

There are three institutions for the retarded in Oregon under the jurisdiction of the Mental Retardation Services Section, Mental Health Division: Fairview Hospital and Training Center, Salem; Eastern Oregon Hospital and Training Center, Pendleton; and Columbia

Park Hospital and Training Center, The Dalles. Present population of these institutions, respectively is 2,040; 456; and 490.

Financial Support:

Federal Assistance 1969-71	$ 174,306	(Title I - 89-313) (Public Law 91-230 - Section 105)
State Assistance 1969-71	26,985,388	

Parent Counseling

Minimal parent counseling is offered. Three pilot programs offering counseling services were conducted in 1969-70 by Teaching Research (Oregon State System of Higher Education). Out-patient clinic counseling is available at Fairview Hospital and Training Center. Local Associations for Retarded Children also provide counseling to parents.

Mental Retardation Services Section, Mental Health Division has the authority, but insufficient funds, to establish parental counseling programs.

AUTHORITIES

Mental Health Division
- ORS. 430.760-820 (Trainable mentally retarded classes, parental counseling, diagnosis and evaluation)
- ORS. 427.428 (Institutions)
- ORS. 430.020 (Mental Retardation Section)

Oregon Board of Education
- ORS. 343.410-490 (Classroom services, educable mentally retarded)
- ORS. 343.552-558 (Teacher preparation, scholarships)
- Title I, III, IV

Division of Vocational Rehabilitation
- ORS. 344.520 and 344.710-730 (Sheltered Workshops)

OBJECTIVES

1. Reduce the incidence of mental retardation.
2. Establish a continuum of coordinated community services to assure that the needs of retardates are adequately met.
3. Ameliorate cultural and economic factors that contribute to retardation in the individual.

4. Improve the level of care at state institutions for the mentally retarded.

RECOMMENDATIONS AND METHODS

1. *EXPAND PROGRAMS TO PREVENT MENTAL RETARDATION.*

   Methods

   a. *Local health departments provide pre- and postnatal care classes for expectant parents.*

   b. *Oregon State Board of Health and local health departments continue programs aimed at eradicating rubella.*

   c. *Schools and public health departments conduct immunization clinics for preschool chidren aimed at the eradication of rubeola (measles).*

2. *COORDINATE ALL EFFORTS FOR THE DIAGNOSIS, EVALUATION, FOLLOW-UP, AND PLANNING FOR THE RETARDED.*

   Methods

   a. *Mental Health Division provide regional and community-based Fixed Points of Referral[1] to coordinate interdisciplinary diagnosis, evaluation, and planning for the retarded in the given geographic area. Follow-up programs and reassessment must be continuous throughout the lifetime of the retardate or as long as it is needed. Identification through medical or educational systems should be communicated immediately to the Fixed Point of Referral where appropriate entries would be made in a central registry.*

   b. *Physicians should be encouraged to utilize all the available community resources in planning the regimen of care for the mentally retarded.*

   c. *Wherever appropriate, community-based services should be used as an alternative to institution-based services.*

   d. *The Governor's Health Planning Committee establish a standing committee related to mental retardation for the coordination and planning of mental retardation services.*

3. *ESTABLISH ADDITIONAL DAY TRAINING CENTERS WITH PRESCHOOL TRAINING AND CONTINUING SERVICE PROGRAMS FOR THE RETARDED.*

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1. *A Fixed Point of Referral is an office, located in a mental health clinic or similar facility within the community, staffed by one or more specialists in mental retardation, whose purpose is to provide or refer on a community level, the wide array of necessary services for the mentally retarded.*

Method

The Oregon Association for Retarded Children recommend legislation in 1971 to give the Mental Health Division authority and funds to establish and coordinate day training centers.

4. *ESTABLISH CLASSES FOR THE TRAINABLE MENTALLY RETARDED IN PRIVATE SCHOOLS, INDIVIDUAL SCHOOL DISTRICTS, OR INTERMEDIATE EDUCATION DISTRICTS TO ACCOMMODATE 1,000 MENTALLY RETARDED CHILDREN.*

Methods

a. *The biennial appropriation be increased to $1,080,000 and approved as part of the 1971-73 biennial budget of the Mental Health Division for the purpose of providing trainable mentally retarded classroom services for 1,000 children.*

b. *Increase the appropriations to the Mental Health Division in succeeding bienniums to reimburse (up to 100%) school districts for the costs of providing approved services for the trainable mentally retarded in excess of the budgeted per capita cost of educating the normal child.*

c. *Intermediate education districts or school districts provide special education services to all handicapped school-age children, including trainable mentally retarded.*

d. *Mental Health Division, in conjunction with community resources, establish regional boarding schools for trainable mentally retarded in the sparsely populated areas of the state. (See Recommendation 8.)*

e. *Educational Coordinating Council assess the need for special education teachers and make recommendations to the State Board of Education for providing an adequate number of teachers of the handicapped.*

5. *PROVIDE SPECIAL CLASSES OR PROGRAMS WITHIN SELECT REGULAR CLASSES FOR THE EDUCABLE MENTALLY RETARDED.*

Methods

a. *The Oregon State Board of Education investigate the methods used by school districts to identify the mentally retarded.*

b. *Mental Health Division utilize community resources to assist the educable mentally retarded to achieve social and vocational independence.*

6. *ESTABLISH DEVELOPMENTAL CENTERS AVAILABLE FOR THOSE RETARDATES NOT QUALIFIED FOR PLACEMENT IN SHELTERED WORKSHOPS.*

Methods

a. *The Oregon Association for Retarded Children present a legislative proposal in the 1971 session to provide for the establishment of developmental centers giving the Mental Health Division the authority and appropriations to implement and coordinate this program.*

b. *Mental Health Division work closely with the Division of Vocational Rehabilitation in developing activity center programs and guidelines to facilitate the flow of clients from activity centers to sheltered workshops.*

c. *Mental Health Division, together with Educational Coordinating Council, develop programs within selected universities and community colleges to train developmental center personnel.*

7. *INCREASE THE NUMBER OF SHELTERED WORKSHOPS IN MAJOR POPULATION CENTERS THROUGHOUT THE STATE AND EXTEND THE MAXIMUM TRAINING PERIOD IN SHELTERED WORKSHOPS.*

Methods

a. *Division of Vocational Rehabilitation, in conjunction with community resources, establish sheltered workshops in major population centers with state and matching federal funds.*

b. *"Mini" sheltered workshops should be established in communities where the operation of a large sheltered workshop would not be economically feasible.*

c. *Division of Vocational Rehabilitation provide counseling and financial subsidy to businesses to operate a program for mental retardates.*

d. *Public Welfare Division request the 1971 Legislature to provide a subsidy to workshops for those individuals who qualify for an extended training program (beyond the present 18-month limitation).*

8. *ESTABLISH COMMUNITY LIVING FACILITIES SUCH AS HALFWAY HOUSES, FOSTER CARE HOMES, AND SHELTERED HOUSING AS MAY BE REQUIRED THROUGHOUT THE STATE.*

Methods

a. *Mental Health Division, in conjunction with community resources, provide domiciliary facilities in those areas of the state with sheltered workshops where living facilities are needed.*

b. *Oregon Association for Retarded Children propose legislation in 1973 to establish a guardianship program as a safeguard to the retardate.*

c. *Encourage communities to establish both short- and long-range foster homes incorporating screening and programming procedures.*

d. *Oregon Association for Retarded Children submit legislation in 1971 to provide Mental Health Division with the authority and funds to establish community group living facilities for the mentally retarded.*

9. *DEVELOP RESOURCES FOR PROVIDING MEDICAL AND DENTAL ASSISTANCE TO THE MENTALLY RETARDED WHO ARE NOT ABLE TO ACQUIRE THESE SERVICES THROUGH THEIR PERSONAL PHYSICIAN OR DENTIST.*

Methods

a. *The Oregon Association for Retarded Children promote the establishment of the multiple-discipline teams to provide patient care for the mentally retarded.*

b. *University of Oregon Medical School and University of Oregon Dental School, in conjunction with Oregon Medical Association and Oregon Dental Association, promote the establishment of training programs for medical and dental professionals in the area of treatment and/or diagnosis of the mentally retarded.*

c. *University of Oregon Medical School and University of Oregon Dental School, in conjunction with Oregon Medical Association and Oregon Dental Association, establish continuing education programs for those professionals already in practice.*

d. *Oregon Medical Association and Oregon Dental Association develop a referral system to provide care for mental retardates in their communities who have not established a relationship with a personal physician or dentist.*

e. *University of Oregon Medical School and University of Oregon Dental School establish satellite clinics and/or itinerant services to bring medical and dental services on a regular basis to mental retardates in communities where a scarcity of qualified health manpower makes such services difficult to obtain.*

10. *UPGRADE THE INSTITUTIONAL SERVICES FOR THE MENTALLY RETARDED.*

Methods

a. *All new residences for the mentally retarded constructed by the Mental Health Division be limited to no more than 24 patients.*

b. *Mental Health Division use SCOPE staffing methodology as benchmark standards in all institutions to improve staffing ratios where benefit can be demonstrated.*

OPERATIONAL PROBLEMS

1. Legislative authorization is necessary for day training centers, activity centers, and community living facilities.

2. Local resources (e.g., mental health clinics) have not provided authorized services to the mentally retarded due to lack of trained staff in the area, lack of funds, or apparent reluctance to accept the responsibility.

3. School districts have failed to "identify" the educable mentally retarded in the "normal" classroom situation. If there are none identified, no special services are needed. Some classroom situations for the educable mentally retarded do not meet physical standards.

4. It is estimated that a 10-year lag exists between the findings of research and their application in the field. This is especially apparent in the medical profession.

EVALUATION CRITERIA

Evaluation of educable mentally retarded classes is under the jurisdiction of the Oregon Board of Education, who conducts a standard evaluation of the total program every five years. One criterion for success would be the numbers of educable mentally retarded who have been provided specialized services, and who are able to re-enter society as contributing citizens. This can only be achieved through an efficient follow-up program.

Evaluation of trainable mentally retarded is conducted, for the most part, by those providing the services. Teaching Research, a division of the Oregon State System of Higher Education has evaluated special projects within this program for Title VI.

There is a need for an evaluation system for all agencies serving the mentally retarded. Three methods could be employed to assess the

progress toward meeting the objectives:

1. statistical and scientific data,
2. on-the-spot evaluation of existing programs by a team of experts, and
3. consumer satisfaction.

PRIORITY

To be determined.

EXHIBIT 1

OREGON MENTAL RETARDATION INSTITUTIONS

COST OF MAINTENANCE

Year	Average Daily Population	Total Annual Expenditure	Total Annual Expenditure Per Patient
1949-50*	1219[1]	$ 1,206,561	$ 989.80
1954-55*	1793[2]	1,784,577	995.30
1959-60*	2518[3]	3,886,272 [4]	1.543.40
1964-65*	2974	6,492,966 [5]	2,149.62
1969-70**	2964	13,283,645 [6]	4,481.66

1. ADP for 1948-50 period.
2. ADP for 1954-56 period.
3. ADP for 1958-60 period - for all M.R.'s in institutions.
4. 1/2 total expenditure as shown in Biennial Report.
5. Expenditure represents 2% of total -- portion of M.R.'s to total ADP for Eastern Oregon Hospital and Training Center.
6. Expenditure represents 50% of total -- M.R.'s 52% of total ADP for Eastern Oregon Hospital and Training Center.

Source:
*Biennial Report of Oregon State Board of Control for periods ending: June 30, 1950, 1956, 1960, & 1966.
**Average Inpatient Populations (a monthly report from Mental Health Division) for June, 1970.
Expenditure data from D.K. Vincent, Fiscal Analyst, Mental Health Division.

EXHIBIT 2

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN OREGON
BY AGE RANGE FOR EACH COUNTY
1967-68

Counties	Civilian Population 7-1-67	Distribution of Population by Age Range			Number of Mentally Retarded by Age Range			Total Number Mentally Retarded by County
		0 - 5[a]	6 - 19[b]	20+[c]	0 - 5[d]	6 - 19[e]	20+[f]	
Baker	15,700	1,790	4,270	9,640	9	128	145	282
Benton	46,710	5,325	12,705	28,680	27	381	430	838
Clackamas	141,130	16,089	38,387	86,654	80	1,152	1,300	2,532
Clatsop	27,630	3,150	7,515	16,965	16	225	254	495
Columbia	24,850	2,833	6,759	15,258	14	203	229	446
Coos	51,880	5,915	14,111	31,854	30	423	478	931
Crook	8,850	1,009	2,407	5,434	5	72	82	159
Curry	12,420	1,416	3,378	7,626	7	101	114	322
Deschutes	27,460	3,130	7,469	16,861	16	224	253	493
Douglas	74,540	8,498	20,275	45,767	42	608	687	1,337
Gilliam	3,030	345	824	1,861	2	25	28	55
Grant	7,300	832	1,986	4,482	4	60	67	131
Harney	7,140	814	1,942	4,384	4	58	66	128
Hood River	14,210	1,620	3,865	8,725	8	116	131	255
Jackson	94,420	10,764	25,682	57,974	54	770	870	1,694
Jefferson	10,140	1,156	2,758	6,226	6	83	93	182
Josephine	36,270	4,135	9,866	22,269	21	296	334	651
Klamath	47,700	5,438	12,975	29,287	27	389	439	855
Lake	6,160	702	1,676	3,782	4	50	57	111
Lane	202,740	23,113	55,145	124,482	115	1,655	1,867	3,637
Lincoln	23,400	2,668	6,365	14,367	13	191	216	420
Linn	66,590	7,591	18,113	40,886	38	543	613	1,194
Malheur	25,640	2,923	6,974	15,743	15	209	236	460
Marion	148,580	16,934	40,414	91,232	85	1,212	2,368	2,665
Morrow	4,540	518	1,235	2,787	3	37	42	82
Multnomah	552,280	62,960	150,220	339,100	315	4,508	5,088	9,911
Polk	33,490	3,818	9,109	20,563	19	273	308	600

EXHIBIT 2 (Cont.)

Counties	Civilian Population 7-1-67	Distribution of Population by Age Range			Number of Mentally Retarded by Age Range			Total Number Mentally Retarded by County
		0 - 5[a]	6 - 19[b]	20+[c]	0 - 5[d]	6 - 19[e]	20+[f]	
Sherman	3,080	351	838	1,891	2	25	28	55
Tillamook	15,900	1,813	4,325	9,762	9	130	146	285
Umatilla	43,530	4,963	11,840	26,727	25	355	401	781
Union	17,790	2,028	4,839	10,923	10	145	164	319
Wallowa	5,960	679	1,621	3,660	3	49	55	107
Wasco	23,260	2,652	6,327	14,281	13	190	214	417
Washington	127,210	14,502	34,601	78,107	72	1,038	1,171	2,281
Wheeler	1,720	196	468	1,056	1	14	16	31
Yamhill	40,750	4,646	11,084	25,020	23	333	375	731
Totals	1,994,000	227,316	542,368	1,224,316	1,137	16,271	18,365	35.773

[a]11.4 percent of total population.

[b]27.2 percent of total population.

[c]61.4 percent of total population.

(The above percentages are based upon: Population Estimates, Department of Finance, Budget Division, May 1968, Appendix B. page 67).

[d]0.5 percent of age range.

[e]3.0 percent of age range.

[f]1.5 percent of age range.

(The above percentages are based upon: Monograph Supplement to American Journal of Mental Deficiency, January 1964, Volume 68, No. 4).

EXHIBIT 3

ESTIMATED NUMBER OF MENTALLY RETARDED PERSONS IN OREGON
BY AGE RANGE AND LEVEL OF RETARDATION
BY COUNTY
1967-68

Counties	Total Preschool Mentally Retard.	EMR[a]	TMR[b]	S/PMR[c]	Total School Age. M.R.	EMR[d]	TMR[e]	S/PMR[f]	Total Adult Ment. Retard.	EMR[g]	TMR[h]	S/PMR[i]
Baker	9	2	5	2	128	104	18	6	145	116	22	7
Benton	27	6	16	5	381	310	53	18	430	344	64	22
Clackamas	80	18	48	14	1,152	939	161	52	1,300	1,040	195	65
Clatsop	16	4	10	2	225	183	31	11	254	203	38	13
Columbia	14	3	8	3	203	165	28	10	229	183	35	11
Coos	30	7	18	5	423	345	59	19	478	382	72	24
Crook	5	1	3	1	72	59	10	3	82	66	12	4
Curry	7	2	4	1	101	82	14	5	114	91	17	6
Deschutes	16	4	10	2	224	182	31	11	253	202	38	13
Douglas	42	9	25	8	608	495	85	28	687	550	103	34
Gilliam	2	.	2	.	25	20	3	2	28	22	5	1
Grant	4	1	2	1	60	49	8	3	67	54	10	3
Harney	4	1	2	1	58	47	8	3	66	53	10	3
Hood River	8	2	5	1	116	94	16	6	131	105	19	7
Jackson	54	12	32	10	770	627	108	35	870	696	130	44
Jefferson	6	1	4	1	83	68	12	3	93	74	14	5
Josephine	21	5	13	3	296	241	41	14	334	267	50	17
Klamath	27	6	16	5	389	317	54	18	439	351	66	22
Lake	4	1	2	1	50	41	7	2	57	46	8	3
Lane	115	25	69	21	1,655	1,349	232	74	1,867	1,494	280	93
Lincoln	13	3	8	2	191	156	27	8	216	173	32	11
Linn	38	8	23	7	543	442	76	25	613	490	92	31
Malheur	15	3	9	3	209	170	29	10	236	189	35	12
Marion	85	19	51	15	1,212	988	170	54	1,368	1,094	206	68
Morrow	3	1	2	.	37	30	5	2	42	34	6	2
Multnomah	315	69	189	57	4,508	3,674	631	203	5,087	4,070	763	254
Polk	19	4	11	4	273	222	38	13	308	246	47	15

EXHIBIT 3 (Cont.)

Counties	Total Preschool Mentally Retard.	EMR[a]	TMR[b]	S/PMR[c]	Total School Age M.R.	EMR[d]	TMR[e]	S/PMR[f]	Total Adult Ment. Retard.	EMR[g]	TMR[h]	S/PMR[i]
Sherman	2	.	2	.	25	20	3	2	28	22	5	1
Tillamook	9	2	5	2	130	106	18	6	146	117	22	7
Umatilla	25	6	15	4	355	289	50	16	401	321	60	20
Union	10	2	6	2	145	118	20	7	164	131	25	8
Wallowa	3	1	2	.	49	40	7	2	55	44	8	3
Wasco	13	3	8	2	190	155	27	8	214	171	32	11
Washington	72	16	43	13	1,038	846	145	47	1,171	937	174	59
Wheeler	1	.	1	.	14	11	2	1	16	13	2	1
Yamhill	23	5	14	4	333	271	47	15	375	300	56	19
Totals	1,137	250	682	205	16,271	13,255	2,274	742	18,366	14,693	2,754	919

[a] 22 percent of mentally retarded persons in age range 0-5 years.

[b] 60 percent of mentally retarded persons in age range 0-5 years.

[c] 18 percent of mentally retarded persons in age range 0-5 years.

[d] 18.5 percent of mentally retarded persons in age range 6- 9 years.

[e] 14 percent of mentally retarded persons in age range 6-19 years.

[f] 4.5 percent of mentally retarded persons in age range 6-19 years.

[g] 80 percent of mentally retarded persons in age range 20 years and over.

[h] 15 percent of mentally retarded persons in age range 20 years and over.

[i] 5 percent of mentally retarded persons in age range 20 years and over.

EXHIBIT 4

SPECTRUM OF MENTAL RETARDATION
DEVELOPMENTAL CHARACTERISTICS, SERVICES, FACILITIES

DEGREES OF MR	CHARACTERISTICS OF PRE-SCHOOL 0-5 YEARS	SERVICES	FACILITY	CHARACTERISTICS OF SCHOOL AGE 6-19 YEARS	SERVICES	FACILITY	CHARACTERISTICS OF ADULT 20 AND OVER	SERVICES	FACILITY
PROFOUND (I.Q. 0-20 APPROX.)	GROSS RETARDATION; MINIMAL CAPACITY FOR FUNCTIONING IN SENSOR/MOTOR AREAS; NEEDS NURSING CARE.	PERSONAL CARE; TREATMENT; DIAGNOSIS AND EVALUATION.	INSTITUTION	SOME MOTOR DEVELOPMENT PRESENT; MAY RESPOND TO MINIMAL OR LIMITED TRAINING IN SELF-HELP.	PERSONAL CARE; TREATMENT; TRAINING; DIAGNOSIS AND EVALUATION;	INSTITUTION	SOME MOTOR AND SPEECH DEVELOPMENT; MAY ACHIEVE VERY LIMITED SELF CARE; NEEDS NURSING CARE.	PERSONAL CARE; TREATMENT; TRAINING; DIAGNOSIS AND EVALUATION.	INSTITUTION
SEVERE (I.Q. 20-35 APPROX.)	POOR MOTOR DEVELOPMENT; SPEECH IS MINIMAL; GENERALLY UNABLE TO PROFIT FROM TRAINING IN SELF-HELP; LITTLE OR NO COMMUNICATION SKILLS.	PERSONAL CARE; TREATMENT; DIAGNOSIS AND EVALUATION.	HOME SETTING (FAMILY); D&E CLINIC.	CAN TALK OR LEARN TO COMMUNICATE; CAN BE TRAINED IN ELEMENTAL HEALTH HABITS; PROFITS FROM SYSTEMATIC HABIT TRAINING.	PERSONAL CARE; TREATMENT; TRAINING; DIAGNOSIS AND EVALUATION.	INSTITUTION AND/OR RESIDENTIAL; D&E CLINIC.	MAY CONTRIBUTE PARTIALLY TO SELF-MAINTENANCE UNDER COMPLETE SUPERVISION; CAN DEVELOP SELF-PROTECTION SKILLS TO A MINIMAL USEFUL LEVEL IN CONTROLLED ENVIRONMENT.	PERSONAL CARE; TREATMENT; TRAINING; DIAGNOSIS AND EVALUATION.	INSTITUTION AND/OR RESIDENTIAL; D&E CLINIC.
MODERATE (I.Q. 35-50 APPROX.)	CAN TALK OR LEARN TO COMMUNICATE; POOR SOCIAL AWARENESS; FAIR MOTOR DEVELOPMENT; PROFITS FROM TRAINING IN SELF-HELP; CAN BE MANAGED WITH MODERATE SUPERVISION.	PERSONAL CARE; TREATMENT; TRAINING; DIAGNOSIS AND EVALUATION.	HOME SETTING (FAMILY); DAY; D&E CLINIC.	CAN PROFIT FROM TRAINING IN SOCIAL AND OCCUPATIONAL SKILLS; UNLIKELY TO PROGRESS BEYOND SECOND GRADE LEVEL IN ACADEMIC SUBJECTS; MAY LEARN TO TRAVEL ALONE IN FAMILIAR PLACES.	PERSONAL CARE; TRAINING; EDUCATION; TREATMENT; DIAGNOSIS AND EVALUATION.	HOME SETTING (FAMILY); DAY; RESIDENTIAL DAY; D&E CLINIC.	MAY ACHIEVE SELF MAINTENANCE IN SKILLED OR SEMI-SKILLED WORK UNDER SHELTERED CONDITIONS; NEEDS SUPERVISION AND GUIDANCE WHEN UNDER MILD SOCIAL OR ECONOMIC STRESS.	PERSONAL CARE; TREATMENT; SHELTERED WORKSHOP; DIAGNOSIS AND EVALUATION.	HOME SETTING (FAMILY); RESIDENTIAL; DAY; D&E CLINIC.
MILD (I.Q. 50-70 APPROX.)	CAN DEVELOP SOCIAL AND COMMUNICATION SKILLS; MINIMAL RETARDATION IN SENSOR/MOTOR AREAS; OFTEN NOT DISTINGUISHED FROM NORMAL UNTIL LATER AGE.	PERSONAL CARE; TREATMENT; DIAGNOSIS AND EVALUATION; TRAINING; EDUCATION.	HOME SETTING (FAMILY); D&E CLINIC; DAY.	CAN LEARN ACADEMIC SKILLS UP TO APPROXIMATELY SIXTH GRADE LEVEL BY LATE TEENS; CAN BE GUIDED TOWARD SOCIAL CONFORMITY.	PERSONAL CARE; EDUCATION; DIAGNOSIS AND EVALUATION.	HOME SETTING (FAMILY); DAY; D&E CLINIC.	CAN USUALLY ACHIEVE SOCIAL AND VOCATIONAL SKILLS ADEQUATE TO MINIMUM SELF-SUPPORT BUT MAY NEED GUIDANCE AND ASSISTANCE WHEN UNDER UNUSUAL SOCIAL OR ECONOMIC STRESS.	PERSONAL CARE; SHELTERED WORKSHOP; DIAGNOSIS AND EVALUATION.	HOME SETTING (FAMILY); DAY; D&E CLINIC.

SUICIDE

GOAL PREVENT SUICIDES IN OREGON.

CONDITION

During 1969 there were 289 deaths attributed to suicide in Oregon. This is an estimated rate of 14.0 per 100,000 population. Suicide was the eleventh ranking cause of death, but second only to accidents for youthful victims. The average age of the suicide victims in 1969 was 48 years. During the past three years the suicide rate in Oregon has continued above the national average of 10.8 per 100,000 (Table 1). Oregon is among the top 20% of all states for suicide deaths.

TABLE 1

NUMBER OF DEATHS DUE TO SUICIDE
IN OREGON - 1967-69

Year	Number	Rate Per 100,000*	
1969	289	14.0	Average for
1968	302	14.7	3 years per
1967	268	13.4	14.0/100,000

*Estimate based on state population of 2,058,247, Portland State, Center for Population Research.

There are also apparent geographical differences within the state, although it is difficult to generalize and draw meaningful conclusions from data when the population base is small. Table 2 on the following page gives rate per 100,000 in Oregon by county for a five-year period (1964-1968).

Because of the nature of suicide and the problem of correctly determining cause of death, the actual rate per 100,000 is perhaps 25 to 33% greater than the reported deaths, according to Louis Weirner, Statistician for the New York City Health Department. In addition, seven to eight times as many people attempt suicide and fail. Of those that attempt and fail, 10% eventually succeed.

TABLE 2

MEAN NUMBER OF SUICIDES AND
MEAN SUICIDE RATE PER 100,000 POPULATION
BY COUNTY OF RESIDENCE
OREGON, 1964-1968

County	Five Year Total[1]	Mean Number Per Year	Estimated Civilian Population, 7-1-68[2]	Mean Rate Per 100,000 Population
Baker	24	4.8	16,328	29.4
Lake	8	1.6	6,376	25.1
Lincoln	29	5.8	24,492	23.7
Gilliam	3	.6	2,726	22.0
Clatsop	28	5.6	27,457	20.4
Josephine	34	6.8	35,665	19.1
Tillamook	16	3.2	16,714	19.1
Klamath	45	9.0	47,977	18.8
Deschutes	26	5.2	28,019	18.6
Union	17	3.4	18,986	17.9
Crook	8	1.6	9,205	17.4
Multnomah	443	88.6	542,992	16.3
Jefferson	7	1.4	9,312	15.0
Coos	40	8.0	54,055	14.8
Douglas	51	10.2	70,354	14.5
Grant	5	1.0	6,928	14.4
Hood River	10	2.0	14,071	14.2
Umatilla	31	6.2	43,570	14.2
-- -- -- -- -- -- -- -- -- -- -- -- State Rate -- -- -- -- -- -- -- --				13.8
Morrow	3	.6	4,465	13.4
Wasco	14	2.8	21,047	13.3
Jackson	60	12.0	92,828	12.9
Wallowa	4	.8	6,185	12.9
Linn	41	8.2	65,712	12.5
Clackamas	96	19.2	155,355	12.4
Curry	8	1.6	13,186	12.1
Marion	90	18.0	149,750	12.0
Yamhill	22	4.5	40,062	11.2
Harney	4	.8	7,343	10.9
Lane	109	21.8	201,583	10.9
Malheur	12	2.4	24,184	9.9
Washington	63	12.6	134,004	9.4
Columbia	13	2.6	28,791	9.0
Polk	11	2.2	32,929	6.7
Benton	9	1.8	47,049	3.8
Sherman	0	0	2,541	0
Wheeler	0	0	1,759	0
OREGON	1,387	277.4	2,004,000	13.8

1. Statistical Reports, Oregon State Board of Health, Portland, 1964, 1965, 1966, 1967, 1968.

2. Estimate of Civilian Population, July 1, 1968, U.S. Bureau of the Census (Series P-25, No. 414, January 28, 1969).

In most cases, the symptoms of depression and suicide can be detected and, with proper treatment, have a very positive prognosis. Many of those who can be helped in a crisis situation are able to overcome their depression and resume productive lives.

There are certain statistically identified high-risk groups who, because of the tragic nature of their deaths, demand special public concern. These are young students, persons recently divorced, and middle-aged alcoholic males. In many cases, they have the potential for a reasonably satisfying and productive life if they can overcome the immediate crisis confronting them. If they can be identified at the point of emergence, proper intervention could ward off the final act of self-destruction.

Though suicide attempts are not always predictable, there are certain identifiable personality types which in combination with a myriad of other factors can cause a person to attempt suicide. The etiology, though often obscure, seems to point to a variety of personal problems that are cumulative in nature and, by addition of one more crisis, is enough to tip the balance. Some of these factors are: fear of insanity; loss of love; guilt feelings; feelings of failure; poverty; sudden loss of wealth; feelings of hopelessness; and diagnosis of a fatal or seriously debilitating disease.

If we examine these general reasons, it becomes obvious that no public or private agency can hope to completely eradicate suicide. In addition, there is a host of concomitant moral and political questions which must be examined by a public agency relative to the extent it can intervene in the lives of individual citizens. It is clear, however, that the rate of suicide in Oregon is excessive by national rates and standards; and, therefore, public agencies have a responsibility to reduce the incidence.

CURRENT PROGRAMS AND ACTIVITIES

Almost every public and private agency relating to health, welfare, and safety occasionally has some direct involvement with suicide. Few programs in Oregon have been designed specifically to manage potential suicide victims; most notable are the "hot line" suicide-prevention centers in the Portland and Corvallis metropolitan areas. There are many other agencies in Oregon that also interface with the problem of suicide. A categorical listing follows:

1. Suicide-prevention centers

2. Other crisis intervention centers

3. Law enforcement agencies

4. Ministers

5. Mental health service agencies

6. Medical practitioners

7. Behavioral science professionals

8. Counselling centers

9. Educational institutions

10. Legal practitioners

11. Public health nurses

12. Personnel offices of private firms

AUTHORITIES

Aiding and abetting an individual who is attempting suicide is a felony under ORS 163.050. So far as can be determined this is the only reference to suicide in the Oregon Revised Statutes.

In general, for agencies listed in Current Programs and Activities above, the authorities for dealing with the specific problem of suicide are not outlined in any systematic way. The exceptions may be the centers specifically designed to abate suicide. Some organizations and individuals have, as part of their oath or doctrine, the preservation of life -- most notably, the police and medical professionals. The listing of helping agencies and individuals under Current Programs and Activities of this outline reflects the general groups concerned with the problem.

OBJECTIVE

Reduce the rate of suicides in Oregon 50% by 1975 (from 14 to 7 per 100,000 population).

RECOMMENDATIONS AND METHODS

1. *IMPROVE THE KNOWLEDGE BASE ON SUICIDE AND GAIN A BETTER UNDERSTANDING OF THE ENDOGENOUS AND EXOGENOUS FACTORS WHICH CONTRIBUTE TO ITS EMERGENCE.*

Methods

a. *Mental Health Division abstract baseline information on all suicides and attempted suicides from death records, police reports, etc., in order to establish profiles of persons attempting and committing suicide.*

b. *Mental Health Division support research to be conducted by institutions of higher learning in Oregon into the factors contributing to suicide, and continue to evaluate the effectiveness of suicide centers and "hot lines" in the Portland and Corvallis areas.*

2. *EXPAND PUBLIC EDUCATION PROGRAMS IN ALL OREGON COMMUNITIES TO INCREASE PUBLIC AWARENESS OF THE SYMPTOMS OF MENTAL ILLNESS, ESPECIALLY DEPRESSION, SO THAT APPROPRIATE INTERVENTION CAN OCCUR AT THE POINT OF EMERGENCE FOR THOSE CONSIDERING OR ATTEMPTING SUICIDE.*

Methods

a. *Mental Health Division Regional Directors and local Mental Health Associations design and promote a public education campaign consisting of lectures, printed material, and radio and television coverage. The educational programs to include information on the available counseling services in the community.*

b. *Mental Health Division, in cooperation with local interest groups in the community, establish training sessions for those specific groups of professionals and laymen who are most apt to interface with those contemplating suicide. The training programs should include physicians, ministers, police, and bartenders and should stress the identification of presuicidal conditions.*

c. *Mental Health Regional Directors establish training programs for personnel directors, foremen, supervisors of major employers, and union leaders on the recognition of suicidal tendencies among employees and ways to assist employees who are experiencing failure or fearing it.*

3. *PROMOTE A POSITIVE PHYSICAL AND INTELLECTUAL ENVIRONMENT IN EARLY CHILDHOOD FOR ALL CHILDREN.*

Methods

a. *Mental Health Division and Oregon Medical Association develop a brochure outlining the information which parents should know about the psychological aspects of early childhood development. This brochure to be distributed to all parents of children seen by pediatricians, at local health department clinics, school health offices, as well as the general public.*

b. *Mental Health Division and the Board of Education establish seminar programs for all kindergarten, elementary, and junior high school teachers on the identification of pre-conditions to mental illness.*

c. *Local mental health clinics and the Mental Health Division provide consultation to all schools on the handling of problem children.*

d. *Local mental health clinics, Mental Health Division, and local Mental Health Associations provide support service and counseling for the families of those children identified as having emotional or mental problems.*

4. *ESTABLISH EARLY AND APPROPRIATE INTERVENTION AND COMPREHENSIVE TREATMENT PROGRAMS FOR THOSE ATTEMPTING SUICIDE DURING ACUTE PSYCHOLOGICAL STRESS, AND ESTABLISH ADEQUATE FOLLOW-UP CARE WITHIN CLOSE PROXIMITY TO THEIR HOME COMMUNITY.*

Methods

a. *Mental Health Division expand community mental health center programs so that immediate professional service can be provided through outreach efforts in the community to those individuals under acute psychological stress. These centers would be operated at hours convenient to the clients and should have 24-hour-a-day phone coverage. Special attention should be given to close cooperation with law enforcement agencies to improve communication and emergency services at the point of emergence. (A description of the district-based concept for mental health centers is in Exhibit 1, p. 371.)*

b. *Mental Health Division and local mental health associations assist communities to establish halfway houses or other group live-in homes for those who find their home environment too stressful, those who have experienced depression, or those who have demonstrated suicidal tendencies.*

OPERATIONAL PROBLEMS

1. Insufficient funds, manpower, and equipment to fully develop a program which would specifically address itself to the problem of suicide.

2. Lack of public knowledge of sources of help for crisis conditions.

EVALUATION CRITERIA

Reduction in the rate of suicide in Oregon and increases in referrals to mental health agencies during crisis situations.

PRIORITY

To be determined.

PERSONAL HEALTH PROBLEMS
Communicable Disease

HEPATITIS

GOAL THE ERADICATION OF HEPATITIS.

CONDITION

Hepatitis is endemic to Oregon. In 1969 Oregon had the second highest incidence rate in the country (40.6 per 100,000 population), nearly twice the national average. Part of this difference may be due to better reporting of the disease in Oregon.

Young adults have the highest incidence of hepatitis; the increasing incidence among young adults and adolescents is partly due to the rise in drug abuse. Patients are frequently incapacitated from one to three weeks, often longer, and there is no specific therapy to shorten the course of the disease. Each year there are from one to ten deaths, usually young adults.

The control program is complicated by the lack of a general test for the specific agent (the cause of hepatitis is presumed, on epidemiologic grounds, to be a virus but the virus itself has not yet been cultured). Infectious hepatitis can be transmitted by fecal-oral route and by contaminated blood products (blood and plasma transfusion and needle exposure, including drug abuse). Serum hepatitis (long incubation viral hepatitis) is usually transmitted by blood products and needle exposure.

Viral Hepatitis
Rates per 100,000 Population

Year	United States	Oregon
1965	17.5	32.1
1966	16.8	55.4
1967	19.7	43.2
1968	22.7	40.3
1969	23.9	40.6

An accurate analysis of the situation and identification of preventable modes of transmission require prompt investigation and case finding around all reported cases. The time lags between the onset of illness, the diagnosis by the physician, and the receipt of the report coupled with the many demands on the time of public health nurses and sanitarians, often prevent prompt investigation.

Nonreporting of diagnosed cases in many areas, combined with the wide clinical spectrum of severity of illness (many cases are not accompanied

by jaundice and/or are mild enough so a physician is not consulted) creates a situation where the reported incidence is less than actual incidence.

Improved reporting from physicians will follow if health department investigators produce information leading to control of the disease in household contacts, promptly identify common source outbreaks, and institute meaningful control measures.

CURRENT PROGRAMS AND ACTIVITIES

Currently, the National Hepatitis Surveillance Program conducted by the Communicable Disease Center of the U.S. Public Health Service studies trends of reported hepatitis incidence in each state and in the nation. The Oregon State Board of Health, Epidemiology Section, cooperates in this study. Consultation is given to county health departments in evaluating unusual incidences in local situations. Each reported case is visited by either a public health nurse or sanitarian. Passive immunization with gamma globulin to high-risk groups, e.g., household contacts, is available only in some counties. The Oregon State Board of Health does not provide gamma globulin for viral hepatitis prophylaxis.

The American National Red Cross produces gamma globulin and will supply it at their production cost to the Oregon State Board of Health. Red Cross anticipates testing their blood donors for the Australian Antigen in early 1971.

AUTHORITIES

Oregon State Board of Health has statutory responsibility for control of communicable disease.

OBJECTIVE

Reduce incidence of viral hepatitis 50% (from 40 to 20 per 100,000 population) by 1973.

RECOMMENDATIONS AND METHODS

1. *PROTECT HIGH-RISK GROUPS.*

   Methods

   a. *Local public health offices investigate reported cases and provide passive immunization with gamma globulin when indicated to appropriate high-risk groups, household contacts, etc.*

b. *Oregon State Board of Health allocate state and/or other funds to provide gamma globulin prophylaxis to local health departments, holding some gamma globulin in reserve at the state level to help control major outbreaks as they occur.*

c. *Oregon State Board of Health expand education programs warning of hepatitis risks and advising professionals and the public that syringes and needles should be sterilized at high temperatures, and that new disposable equipment should be used wherever feasible.*

d. *Hospitals and health professionals take precautions to insure that blood and blood products be free from viral hepatitis.*

2. *DETECT AND CORRECT ENVIRONMENTAL SITUATIONS FAVORING FECAL-ORAL TRANSMISSION OF DISEASE.*

Methods

a. *Oregon State Board of Health and Department of Environmental Quality continue to improve present inspection activities to prevent epidemics resulting from transmission through water supplies.*

b. *Department of Agriculture continue to improve present inspection activities, to prevent epidemics resulting from transmission through milk and food.*

c. *Oregon State Board of Health request legislation providing necessary enforcement mechanisms for control over single-family water supplies particularly in rental situations.*

d. *Local governments establish regulations requiring inspection of all new wells.*

3. *EXPEDITE CASE REPORTING AND FOLLOW-UP.*

Method

Oregon State Board of Health and Oregon Medical Association request physicians to immediately report hepatitis cases to the local health departments by telephone.

OPERATIONAL PROBLEMS

1. Shortage of investigative manpower.
2. Shortage of funds for gamma globulin prophylaxis.

EVALUATION CRITERIA

1. Oregon State Board of Health to review the trend in Oregon's hepatitis rate and make comparisons with national rates.

2. Oregon State Board of Health evaluate follow-up of contacts.

PRIORITY

To be determined.

INFLUENZA

GOAL REDUCE DISABILITY AND DEATH RESULTING FROM INFLUENZA.

CONDITION

The incidence of influenza displays a very cyclical pattern. The cyclic characteristic is even greater than the table below indicates because the "flu season" usually occurs during the winter months and consequently bridges two "reporting years."

Incidence and Mortality from Influenza and Pneumonia in Oregon

Year	Cases		Deaths	
	Rate/100,000 Population	Number	Rate/100,000 Population	Number
1960	1885.9	33,356	30.0	530
1961	1814.4	32,956	37.3	677
1962	1445.8	26,407	35.1	641
1963	1710.9	31,757	36.3	673
1964	1912.0	36,442	33.7	643
1965	739.5	14,584	26.7	527
1966	3697.8	73,946	38.3	766
1967	1145.0	22,972	27.6	553
1968	1730.6	35,494	29.7	610
1969			34.1	698

The potential for eradicating influenza is nil; even control is difficult. There is, however, a potential for reducing morbidity and mortality. Influenza is the fifth largest cause of all deaths following heart, cancer, stroke, and accidents. It ranks fourth as a reported cause of death among children from birth to age fourteen years. The illness results in a significant amount of absenteeism and high usage of hospital services. Immunization has not been totally effective.

CURRENT PROGRAMS AND ACTIVITIES

Oregon State Board of Health, Vital Statistics Section, collects and publishes annually morbidity and mortality data.

Oregon State Board of Health, Epidemiology Section, collects and reports morbidity information.

Private physicians and hospitals are the sources for morbidity and mortality information.

Private physicians and local public health departments provide immunization services on an individual basis and through employer-coordinated clinics.

AUTHORITIES

ORS 433.005 - ORS 433.035: Oregon State Board of Health general regulations regarding communicable diseases.

OBJECTIVES

1. Reduce the incidence of influenza.
2. Eliminate unnecessary influenza deaths.
3. Increase the effectiveness of immunization.
4. Increase public awareness of need for immunization to avoid potential hazards of influenza infections.

RECOMMENDATIONS AND METHODS

1. *ACCOMPLISH MASS IMMUNITY TO THE INFLUENZA STRAINS TO WHICH THE POPULATION IS LIKELY TO BECOME EXPOSED.*

   Methods

   a. *The health profession, and appropriate laboratories, maintain constant surveillance of the current strains of influenza virus being propagated, so that influenza vaccine may be restructured to assure effective protection against these strains.*

   b. *Oregon State Board of Health develop programs for immunization using family physicians and/or local health departments as a source of immunizations.*

   c. *Oregon State Board of Health develop and promote education programs via mass media on the need for immunization and self-isolation when a person develops any respiratory infection.*

   d. *Oregon State Board of Health and Oregon Medical Association develop and promote information programs to encourage private physicians to immunize patients, especially those in high risk categories.*

   e. *Oregon State Board of Health develop programs for employer participation:*

      1) *Developing employee awareness of need for immunization and the dangers of influenza.*

2) *Enlisting employer participation for mass immunization of employees.*

f. *Oregon State Board of Health develop and promote information programs for school children and teachers.*

g. *Oregon State Board of Health provide free influenza immunization for those unable to pay.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Oregon State Board of Health measure improvement in terms of decreased morbidity and mortality.

Oregon Regional Medical Program measure improvement in decreased hospital days used.

PRIORITY

To be determined.

RHEUMATIC FEVER

GOAL ERADICATION OF RHEUMATIC FEVER.

CONDITION

The incidence of rheumatic fever has declined significantly in the past few years, with only 8 cases reported in 1969 (see Chart 1). Two major reasons for the reduction are the increased use of the State Board of Health Laboratory by physicians and institutions for analysis of throat cultures and increased effectiveness of antibiotics for controlling strep infection and preventing rheumatic fever.

It is estimated that 0.5% of those who have a symptomatic or an asymptomatic strep infection develop rheumatic fever. In addition to attacking the heart, rheumatic fever occasionally damages joints in the body or destroys portions of the brain causing convulsions, changes in personality, or reduction of intellectual ability.

Laboratory detection is the only accurate method of identifying streptococci. At the present time, there is no vaccine available affording permanent immunity against streptococcal infections and rheumatic fever. Early treatment of "strep" is the most effective method of preventing rheumatic fever.

CURRENT PROGRAMS AND ACTIVITIES

In 1965, the Oregon State Board of Health Public Health Laboratory expanded its capabilities for conducting analysis of mailed-in throat cultures. The State Board of Health Laboratory provides free laboratory services to all Oregon physicians sending in throat culture specimens. A total of 524 physicians and 55 institutions currently utilize the Public Health Laboratory. Chart 1 illustrates the impact this service has had in the reporting and detection of streptococcal infections.

During the fiscal year 1970, a total of 37,251 specimens for Group A streptococci were examined, of which 7,821 showed laboratory evidence of this organism.

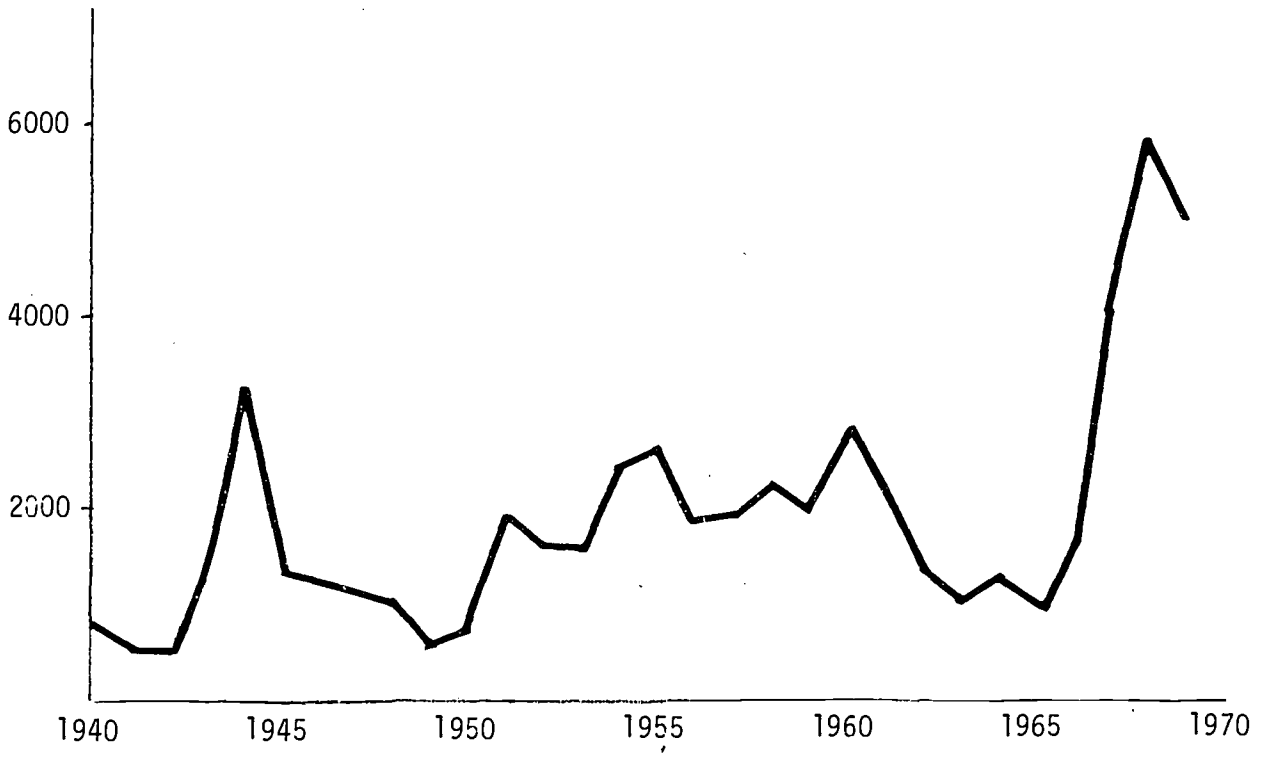
The Rheumatic Fever Control Program, sponsored by the Oregon Heart Association, Oregon Medical Association, and the Oregon State Pharmaceutical Association, makes available low cost drugs to those individuals who have had rheumatic fever to prevent recurrence.

AUTHORITIES

To be researched.

CHART 1

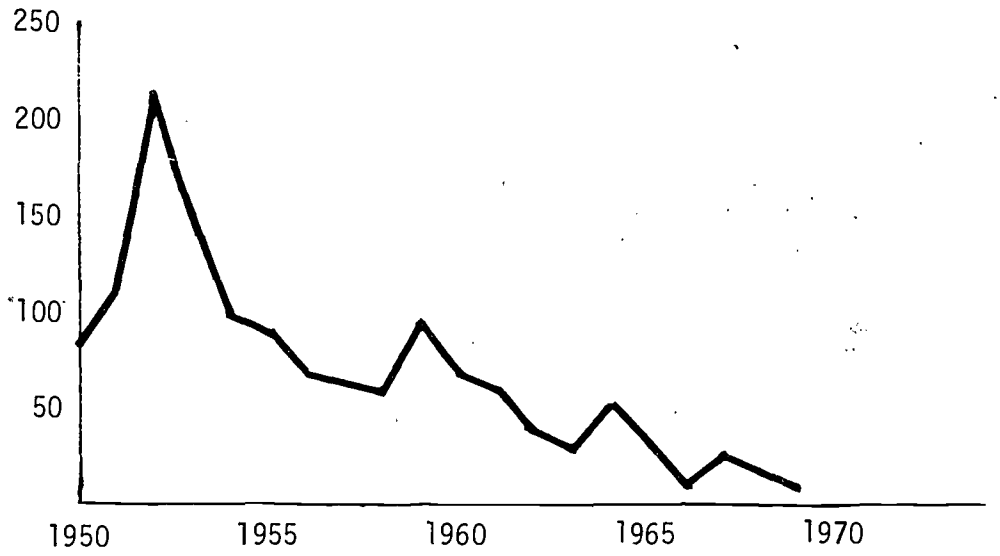
REPORTED CASES OF HEMOLYTIC STREPTOCOCCAL INFECTION[1] IN OREGON, 1940-1969



1. Includes Scarlet Fever and Streptococcal Sore Throat

Source: Oregon State Board of Health, 1969 Statistical Report, p.134

REPORTED CASES OF RHEUMATIC FEVER IN OREGON, 1950-1969



Source: Dr. William E. Morton, Department of Public Health and Preventive Medicine, University of Oregon Medical School

OBJECTIVES

1. Assure accurate diagnosis of all streptococcal respiratory infections.

2. Promote increased awareness among physicians of the availability of an inexpensive, fast, accurate method of identifying strep infection.

3. Assure prompt and adequate treatment of all persons with diagnosed streptococcal respiratory infection.

RECOMMENDATIONS AND METHODS

1. *OREGON MEDICAL ASSOCIATION, OREGON HEART ASSOCIATION, OREGON STATE PHARMACEUTICAL ASSOCIATION, AND THE OREGON STATE BOARD OF HEALTH, THROUGH THE RHEUMATIC FEVER CONTROL PROGRAM, ENCOURAGE PHYSICIANS AND INSTITUTIONS TO CONTINUE SENDING THROAT CULTURES TO THE PUBLIC HEALTH LABORATORY WHEN THE DIAGNOSIS OF STREP INFECTION IS SUSPECTED.*

2. *OREGON HEART ASSOCIATION AND OREGON MEDICAL ASSOCIATION EXPAND PROFESSIONAL EDUCATION PROGRAMS INSTRUCTING PHYSICIANS TO ROUTINELY USE MICRO-BIOLOGIC METHODS FOR IDENTIFYING STREPTOCOCCAL DISEASE.*

OPERATIONAL PROBLEMS

No vaccine has been developed to immunize against Group A streptococcal infections or rheumatic fever.

EVALUATION CRITERIA

Continued reduction in the incidence of rheumatic fever.

PRIORITY

To be determined.

RUBELLA

GOAL ERADICATION OF RUBELLA.

CONDITION

Rubella, also known as German measles or three-day measles, is a virus disease usually characterized by a rash that lasts from one to seven days, fever, headache, and swelling of the lymph nodes, especially in the back of the neck. It should be noted, however, that the clinical diagnosis of rubella is extremely unreliable. A person can be infected without any of the above symptoms, or may have all the classic signs and be infected with another virus. Rubella usually occurs during childhood, and about 85 percent of the population have had the disease by the time they reach 19 years of age. However, for those who contract it after the age of puberty, particularly females, it can become serious, and may cause pain and swelling in the joints, hemorrhages beneath the skin, and occasionally encephalitis (inflammation of the brain).

The major public health threat is seen when women contract rubella during the first trimester of pregnancy. Recent studies indicate that rubella is still a serious threat through the second trimester.[1] In both instances, the virus is transmitted from the mother to the growing fetus. Depending on the severity of the infection and the stage of pregnancy when contracted, the fetus may be killed, or afflicted by deafness, blindness, mental retardation, heart disease, blood disorders of the liver, spleen, and bones, or combinations of these conditions.

In Oregon, there are from 400 to 3,000 cases of rubella reported annually. Rubella is characterized by cyclic epidemic periods (approximately every 5-7 years) in which the number of cases increases considerably. For example, reported cases in 1959 were 7,098, and in 1965, 12,956. As the rubella "season" generally spans two calendar years (from October through May), the calendar year reports partially mask the years of peak incidence.

During the epidemic year 1964-65, there were 120 known cases of children born with rubella syndrome in Oregon. It is difficult to diagnose deafness, cataracts, glaucoma, mental retardation, and other manifestations of congenital rubella syndrome in small infants, since frequently it is not until they should have been able to walk and talk, read and write, that it is realized that they had been injured as fetuses. Thus, it often takes from three to five years to diagnose and recognize fully the extent of damage caused to fetuses by this disease. Even today, rubella syndrome is being diagnosed in some of the children born at the end of the 1965 epidemic.

1. Sever, M.D., Ph.D; Hardy, M.D.; Nelson, M.D.: and Gilkeson; "Rubella in the Collaborative Perinatal Research Study," American Journal of Diseases of the Child, Vol. 118, July 1969.

If we conservatively anticipate 6,500 cases of rubella during the 1970-71 season, we can expect 50 cases of rubella syndrome and a cost to the State of $2 million. This estimate is based on studies which show that it costs Oregon from $40,000 to $50,000 for the care of each rubella-injured child. National estimates are as high as $65,392. These estimates do not include losses from fetal deaths and miscarriages, potential earning power or emotional traumas for the children, their parents, and relatives. Even in non-epidemic years, such as 1969 when there were only 734 cases of rubella reported in Oregon, six cases of rubella syndrome are anticipated; these will result in a cost to the State of $240,000.

As of June 30, 1970, Oregon's hospitals for the mentally retarded had approximately 17 known residents who had been diagnosed as having encephalopathy associated congenital rubella. This by no means gives a comprehensive picture of the total number effected in the State. Both the School for the Deaf and the School for the Blind have children who have been impaired. In addition, a number of rubella damaged children are in private care facilities and special educational programs for the retarded.

A live virus vaccine to prevent rubella and the rubella syndrome has been developed. As of July 1, 1969, Oregon had an estimated 467,000 rubella susceptible children between one and twelve years of age -- the target group which generally transmits rubella to pregnant women. Rubella vaccine became available in Oregon in July, 1969, and since that time 60,000 doses have been administered: 25,000 of them federally purchased, 25,000 purchased by private physicians, and 10,000 purchased by local health departments or other local agencies. An additional 148,000 doses from federal sources became available for FY 1971. This left Oregon with an estimated 259,000 rubella susceptible children between one and twelve years of age as of July 1, 1970.

CURRENT PROGRAMS AND ACTIVITIES

The Oregon State Board of Health received authorization from the Emergency Board to distribute 226,050 doses of vaccine.[1] This major effort includes a statewide promotion and education program utilizing all forms of mass media to inform the public of the dangers of rubella and to motivate parents to have their children immunized.

The Oregon State Board of Health is providing free laboratory services for blood samples sent by private physicians and family planning clinics. Rubella tests are routinely performed on all pre-marital and pre-natal blood samples sent to the laboratory.

Family planning clinics and private physicians will be supplied free vaccine by the State Board of Health for patients who are unable to pay.

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1. The Oregon State Board of Health requested sufficient vaccine to immunize approximately 93% of the estimated susceptible population. An immunization program that vaccinates between 80-90% of the susceptible population is considered sufficient to prevent an epidemic.

AUTHORITIES

To be researched.

OBJECTIVES

1. Reduction of the estimated 50 rubella syndrome cases expected during the 1970-71 rubella season to 5 cases.

2. Reduction of rubella birth anomalies to no more than 3 cases per year by 1973.

3. Eradication of the rubella syndrome by 1975.

RECOMMENDATIONS AND METHODS

THE OREGON STATE BOARD OF HEALTH HAS DEVELOPED AN EXCELLENT RUBELLA PROGRAM OF MASSIVE EDUCATION AND IMMUNIZATION WHICH APPEARS TO BE MEETING THE NEEDS AND FULFILLING THE OBJECTIVES. THE PROGRAM SHOULD BE CONTINUED INTO THE 1971-73 BIENNIUM, WITH ADJUSTMENTS MADE IN THE TARGET GROUPS CONCENTRATED ON, AS REQUIRED.

OPERATIONAL PROBLEMS

It is difficult to reach poor and rural populations with either educational campaigns or immunizations.

EVALUATION CRITERIA

Oregon State Board of Health to measure: 1) Reduction in the number of rubella cases and rubella syndrome cases, and 2) Percentage of target population immunized.

PRIORITY

To be determined.

SYPHILIS AND GONORRHEA

GOAL PREVENT AND CONTROL SYPHILIS AND GONORRHEA

CONDITION

Oregon rates for infectious syphilis have fluctuated only slightly over the past four years with 2.1 cases per 100,000 population in fiscal year 1969. With federal assistance in recent years, a functional statewide case-finding and case-prevention program, with the assistance of effective drugs, has reduced the incidence of early syphilis to the surveillance level. Surveillance activities have subsequently brought about a reduction in the number of untreated latent and late syphilis cases. These activities must be maintained if syphilis is to be controlled and eventually eradicated.

Syphilis occurs predominantly among youth and young adults: 30% of the cases occurred in the 19-24 year age group; 25% among the 25-29 age group; and 20% among the 30-39 age group.

The gonorrhea case rate in Oregon has exhibited an alarming rising trend during the last five years. Should this trend continue, it is projected that by the end of 1971 there will be in excess of 8,000 reported new cases in Oregon (see Exhibit 1). This represents an estimated increase of 270% over the 2,500 cases reported in 1965. The rising trend is particularly evident among youth.

The rate per 100,000 population among persons aged 15-19 increased from 262.5 in 1965 to 420.5 in 1968 (a startling 165% increase in three years). Among those aged 20-24, the rate rose from 798.3 to 849.9 per 100,000 population (see Table 1).

Oregon's highest infectious venereal disease morbidity is in the Portland metropolitan area, including Multnomah, Washington, and Clackamas Counties. Approximately 68% of gonorrhea morbidity and 63% of the reported syphilis cases occur in this area.

The increase of gonorrhea can be attributed to lack of diagnostic techniques, particularly for women; the large number of asymptomatic individuals (few women develop symptoms or experience pain in the early stages); difficulty in treating resistant strains; inadequate reporting (less than one-fifth of the privately diagnosed cases are reported); and lack of public awareness of the symptoms or the fact that untreated gonorrhea can cause sterility, heart trouble, peritonitis, arthritis, blindness, or even death.

REPORTED GONORRHEA AND INFECTIOUS SYPHILIS MORBIDITY AND AGE SPECIFIC CASE RATES PER 100,000 POPULATION FOR OREGON, 1958-1969

Table 1

GONORRHEA[1]

Year	Total Cases	Rate/ 100,000	Total Cases 15-19	Rate/ 100,000	Total Cases 20-24	Rate/ 100,000
1970	6,793					
1969	5,779	281.8				
1968	4,056	197.8	828	420.5	1,499	849.9
1967	3,363	167.6	610	342.7	1,319	948.9
1966	2,811	140.6	569	321.5	1,037	816.5
1965	2,520	127.8	441	262.5	966	798.3
1964	2,177	114.2	408	251.8	822	702.5
1963	1,783	96.1	234	169.0	682	691.9
1962	1,287	70.5	242	180.2	449	451.4
1961	1,258	69.3	209	156.3	419	423.3
1960	1,331	75.3	239	197.0	473	389.3
1959	1,029	57.9	198	167.6	338	281.4
1958	916	53.0	207	180.6	241	209.7

Table 2

SYPHILIS[2]

Year	Total Cases	Rate/ 100,000	Total Cases 15-19	Rate/ 100,000	Total Cases 20-24	Rate/ 100,000
1970	177					
1969	201	9.8				
1968	199	9.7	11	5.5	28	15.9
1967	206	10.3	7	3.7	17	10.3
1966	222	11.1	12	6.4	22	14.1
1965	427	22.4	9	4.9	27	18.5
1964	377	19.8	6	3.7	28	23.9
1963	593	31.9	12	8.7	37	37.5
1962	561	30.7	10	7.3	31	32.0
1961	524	28.8	6	4.5	23	23.2
1960	637	36.0	19	14.6	34	35.3
1959	746	42.0	15	11.6	22	22.3
1958	716	41.4	22	17.8	26	26.3

1. New cases.
2. Total cases both new (infectious) and latent.

Sources: Oregon State Board of Health Vital Statistics Section & VD Statistical Letter USPHS.

CURRENT PROGRAMS AND ACTIVITIES

The Oregon State Board of Health administers the Venereal Disease Program. This program is staffed by one director, who spends 50% of his time in venereal disease investigation, two venereal disease investigators (employees of National Communicable Disease Center), and three clerical personnel. During the 1969-71 biennium, this program suffered a severe cutback in funds and a 50% reduction in staff. In the beginning of the biennium, there were four venereal disease investigators and one full-time director, with a budget of $122,091 ($74,781 in federal monies and $47,310 from the State General Fund). As of September, 1970, the total budget for this section was adjusted to $104,836 ($60,836 federal and $44,000 General Fund).

The federal government has stipulated that the federal support (Public Health Service assignees and funds) to this program must be applied to syphilis control. No staff positions for gonorrhea control are funded out of the State General Fund. This results in syphilis control activities having far more emphasis than gonorrhea control. In actuality, gonorrhea control activities occur only when time is available from syphilis investigation; approximately 35% of staff efforts are devoted to gonorrhea control work and 65% to syphilis control work.

The venereal disease program provides epidemiologic service to local health departments and private physicians throughout the state. Interviews are conducted with all individuals identified with early syphilis and with some male gonorrhea patients; contacts are referred to diagnosis facilities. This program provides drugs free of charge for treatment of indigent patients by county health departments and private physicians. The program also maintains a complete control registry on reported gonorrhea and syphilis patients.

The size and scope of venereal disease programs in local health departments vary considerably. For example, Multnomah County has a full-time venereal disease investigator with nurses providing treatment and some case-finding[1] assistance. Other counties utilize their nursing staff for venereal disease treatment and a minimal amount of case-finding work. Smaller county health departments have only limited treatment and case-finding capabilities.

Approximately six months after the State Comprehensive Health Planning Committee called attention to the alarming rise in the gonorrhea rate, the Gonorrhea and Syphilis Prevention (GASP) Committee organized in the Portland area to improve venereal disease control activities. The committee is made up of representatives of Multnomah County Medical Society, Oregon State Board of Health, State Board of Education, four county health departments, four county intermediate education districts, and the Parent Teachers' Association.

1. In this report, case-finding includes patient interviewing, contact referral, diagnosis, and treatment.

Inquiries were directed to the Oregon Medical Association, the Oregon Osteopathic Association, and the Oregon Board of Education to determine the extent of program activities conducted by these organizations. None of these organizations conduct activities that could be classed as substantive programs directed specifically at gonorrhea control.

ORS 106.071, Section 2 states that before issuing a medical certificate for a marriage license, the physician shall apply or, in a laboratory approved by the Oregon State Board of Health, have applied a blood test approved by the Oregon State Board of Health for the determination of syphilis. Fees for premarital examinations are statutorily limited to $7.50.

In the three years 1967, 1968, and 1969, there were approximately 47,000 marriages performed in Oregon. These required 94,000 blood tests. Out of this number of tests, there were only 10 cases identified of which only two were potentially infectious. In the whole of 1969, no infectious cases were identified.

AUTHORITIES

Oregon State Board of Health - Statutory - ORS 433.035
- ORS 434.010
- ORS 434.190

Local Health Departments - Statutory

OBJECTIVES

1. Reduce syphilis (all stages) from 9.6 to 6.0 cases per 100,000 population by 1975.

2. Reduce the rate of gonorrhea so that by 1973 there is a 25% decline from the 1970 rate.

3. Assure treatment for all infected individuals.

4. Develop accurate diagnostic techniques for gonorrhea in women by 1973.

5. Attain an educated public knowledgeable of the medical consequences of gonorrhea and syphilis, methods of transmission, and treatment.

RECOMMENDATIONS AND METHODS

1. *INTENSIFY SCREENING OF POTENTIAL GONORRHEA CASES AND INTERVIEWING OF DIAGNOSED GONORRHEA PATIENTS AMONG HIGH-RISK POPULATIONS (INDIANS, JOB CORPSMEN, MIGRANTS, MERCHANT SEAMEN, PORTLAND METROPOLITAN AREA, AND CLATSOP AND LANE COUNTIES).*

Methods

a. *Oregon State Board of Health request State General Funds to expand the gonorrhea control program with additional venereal disease investigators.*

b. *Local health departments develop the capability to perform laboratory analysis of gonorrhea cultures. (The laboratory work for gonorrhea can be performed in a local health department with a minimum of laboratory equipment. This would significantly enhance the reliability of diagnosis.)*

c. *Comprehensive Health Planning Association for the Portland Metropolitan Area refer the problem of developing an aggressive program to control and reduce gonorrhea, to the Gonorrhea and Syphilis Prevention (GASP) Committee in Portland.*

d. *Oregon State Board of Health interview all males and some females with gonorrhea and refer identified contacts to a diagnostic/treatment facility.*

e. *Family planning clinics to include gonorrhea screening as part of their services.*

2. *MAKE CONDOMS READILY ACCESSIBLE.*

Method

Board of Pharmacy to revise Division 7 of their Administrative Rules to provide for condoms to be displayed on drugstore shelves and available in restroom vending machines.

3. *ALL PHYSICIANS REPORT ALL DIAGNOSED AND/OR TREATED VENEREAL DISEASE CASES.*

Method

Oregon Medical Association strongly encourage and educate physicians to report all venereal disease cases.

4. *PROMOTE PUBLIC EDUCATION CAMPAIGN THROUGH SCHOOLS AND MASS MEDIA, EMPHASIZING PREVENTION AND THE MEDICAL CONSEQUENCES OF UNTREATED VENEREAL DISEASE.*

Methods

a. *State Board of Education, in conjunction with the State Board of Health, expand the scope of the venereal disease material taught in health education courses in the state school systems.*

b. Oregon State Board of Health develop and implement a wide-spread public education program, utilizing mass media to instruct the public in the medical consequences of untreated venereal disease, the tremendous increase of facilities available for treatment, and the importance of assisting public health officials in locating sexual contacts.

c. Oregon State Board of Health increase the number of workshops to assist high-school teachers to develop ongoing venereal disease prevention programs in schools.

5. *IMPROVE DIAGNOSTIC TECHNIQUES TO DETECT GONORRHEA IN WOMEN.*

Method

University of Oregon Medical School seek federal funds to initiate research to develop an improved technique to detect gonorrhea in women.

OPERATIONAL PROBLEMS

1. While there is a law requiring the reporting of all positive venereal disease cases to the Oregon State Board of Health, physician reporting remains very low. Oregon State Board of Health estimated that in 1969 only 20% of the gonorrhea cases were reported and 16% of the syphilis cases. According to the Journal of the American Medical Association, physicians in private practice treat 80% of the venereal disease cases, but report only 11% to public health departments.

2. The Venereal Disease Program is presently operating under a 25% reduction of staff and funds this fiscal year as compared to last fiscal year.

3. Gonorrhea is very difficult to detect in women, as they frequently are not aware that they are infected.

4. The federal government support is specific to syphilis. If it were not, the money could be used for gonorrhea.

EVALUATION CRITERIA

Reduction in the rates of gonorrhea and syphilis as stated in the Objectives.

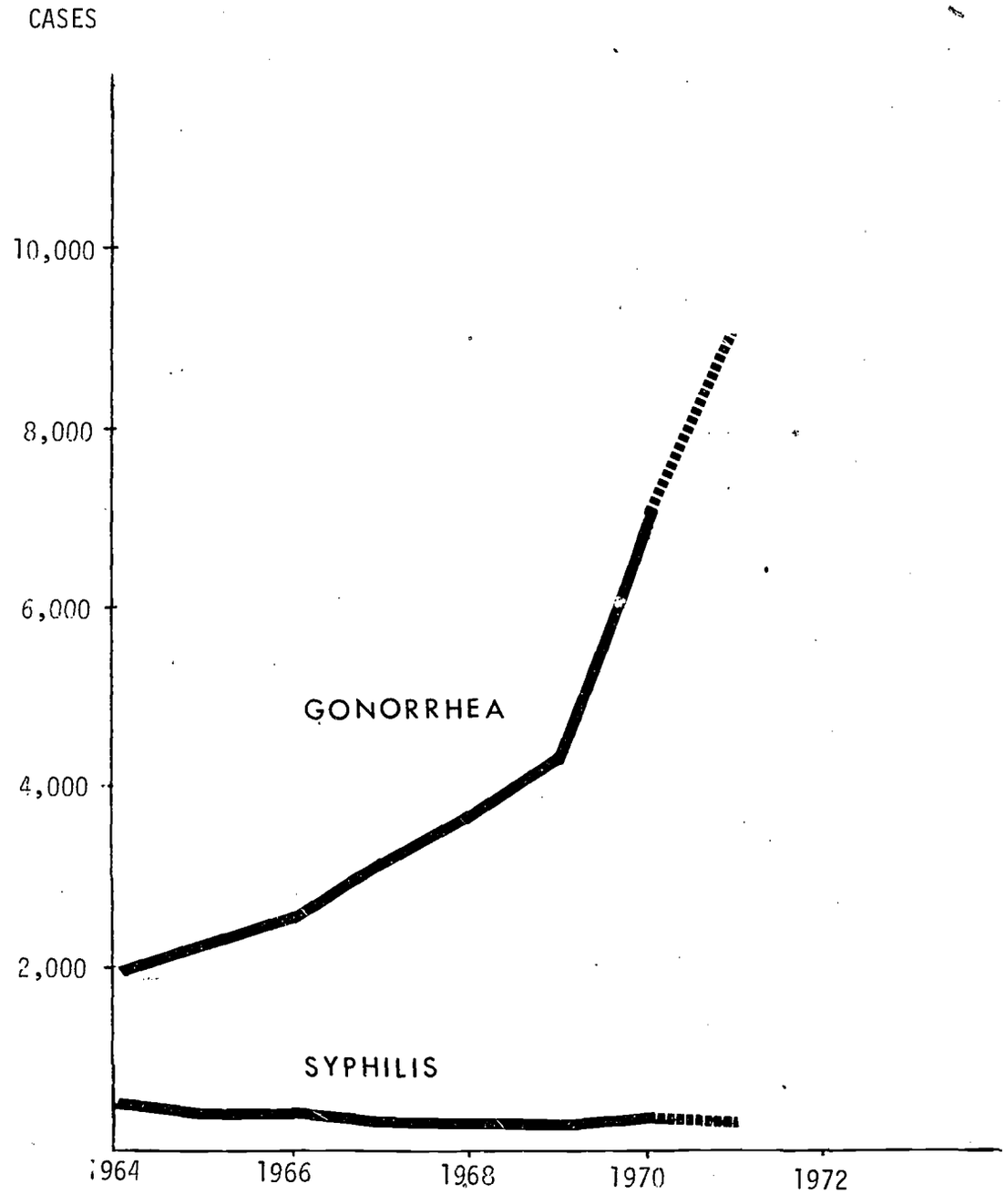
PRIORITY

To be determined.

EXHIBIT 1

STATE OF OREGON

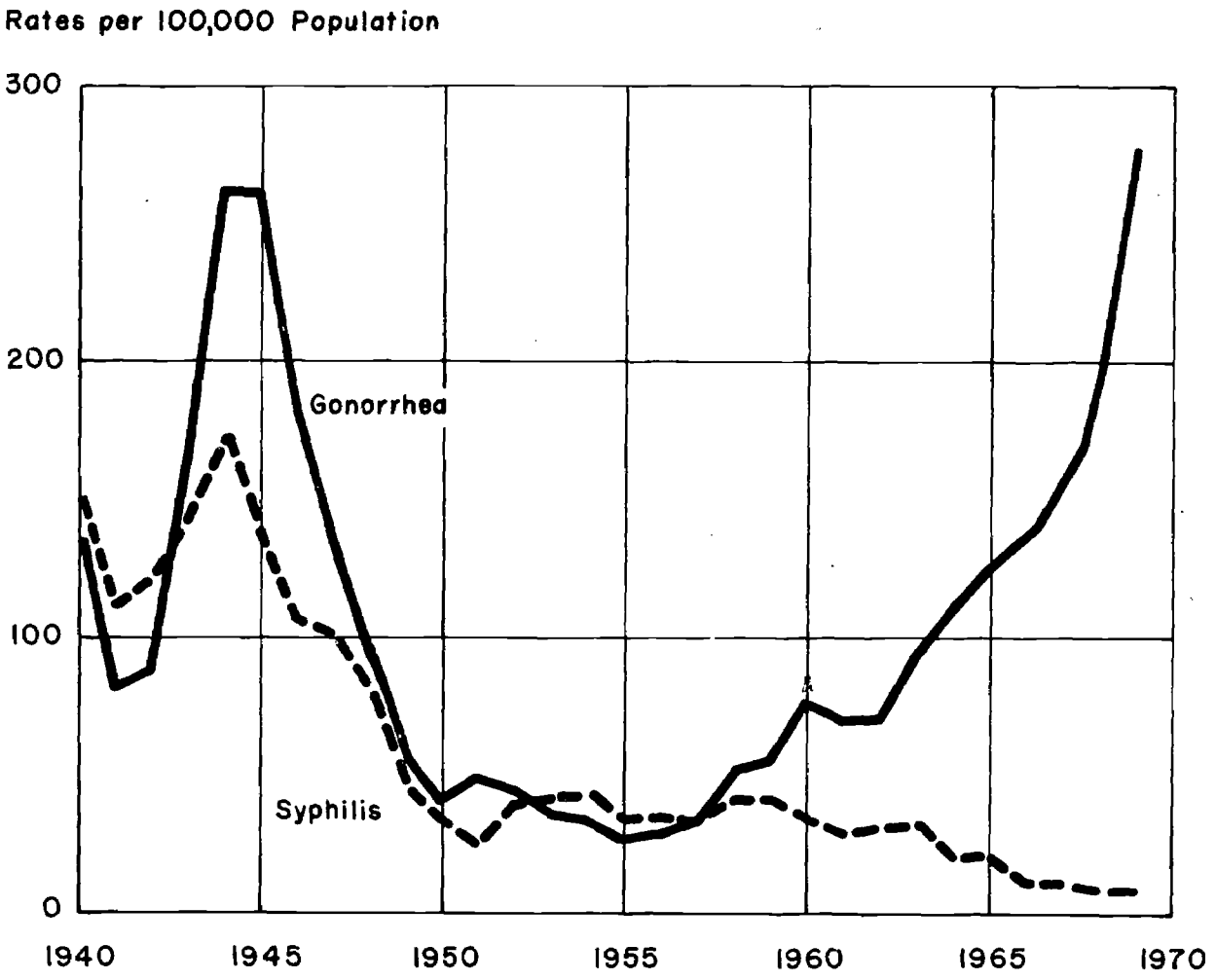
SYPHILIS (ALL STAGES) AND GONORRHEA
MORBIDITY FOR FISCAL YEARS 1964 - 1969
WITH PROJECTED FIGURES FOR FISCAL YEARS
1970 - 1971*



SOURCE: PHS V.D. Statistical Letter, November 1964-1969
*Projection based on rate of increase to calendar 1969

EXHIBIT 2

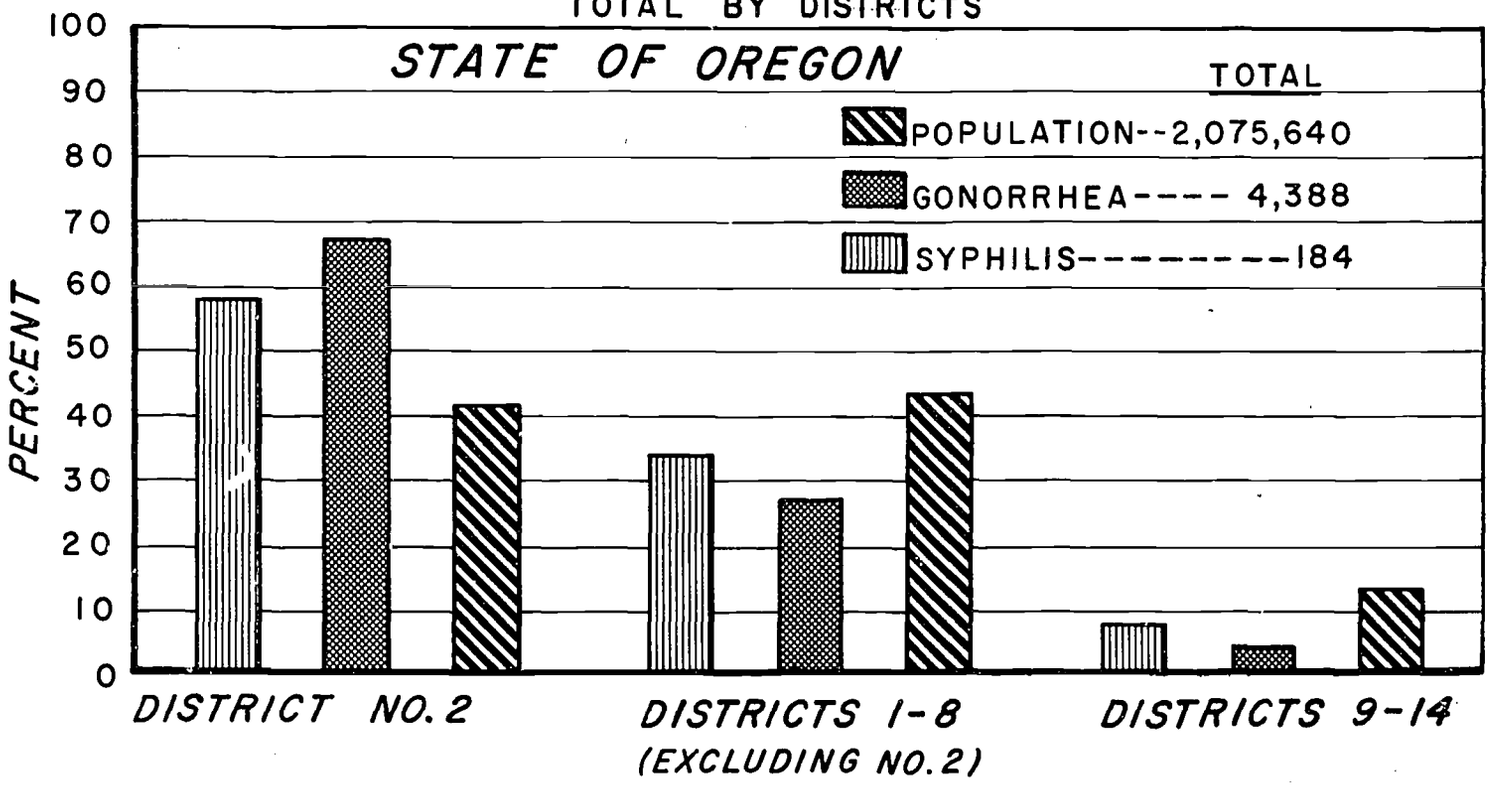
SYPHILIS AND GONORRHEA CASE RATES, OREGON
1940 - 1969



Source: Oregon State Board of Health, 1969 Statistical Report, p. 144

EXHIBIT 3

SYPHILIS (ALL STAGES) AND GONORRHEA REPORTED FOR FISCAL YEAR 1969 BY STATE OF OREGON DISTRICTS, WITH PERCENT OF TOTAL BY DISTRICTS



SOURCE: OREGON STATE BOARD OF HEALTH STATISTICS

EXHIBIT 4

REPORTED CASES OF VENEREAL DISEASES BY COUNTY OF RESIDENCE AND BY TYPE OF INFECTION, OREGON, 1969

COUNTY OF RESIDENCE	SYPHILIS				GONORRHEA		OTHER
	TOTAL		Primary & Secondary	Early Latent Syphilis	Number	Rate	
	Number	Rate					
STATE	201	9.7	43	32	5,779	277.6	3
Baker	1	6.1	-	-	20	121.9	-
Benton	3	5.9	-	1	32	62.7	-
Clackamas	12	7.3	2	5	183	111.0	-
Clatsop	2	6.9	-	-	112	388.9	-
Columbia	-	-	-	-	15	49.8	-
Coos	3	5.2	-	1	86	150.3	-
Crook	-	-	-	-	15	154.2	-
Curry	-	-	-	-	7	53.1	-
Deschutes	-	-	-	-	16	54.8	-
Douglas	5	6.7	4	-	77	103.8	1
Gilliam	-	-	-	-	-	-	-
Grant	-	-	-	-	-	-	-
Harney	1	13.7	1	-	10	137.5	-
Hood River	2	14.2	1	-	26	184.0	-
Jackson	8	8.5	1	-	108	115.3	-
Jefferson	4	44.2	-	2	14	154.9	-
Josephine	2	5.6	-	-	62	172.3	-
Klamath	3	6.0	1	-	56	112.5	-
Lake	1	14.7	-	-	1	14.7	-
Lane	16	7.6	5	-	736	351.5	-
Lincoln	1	4.0	-	-	32	127.3	-
Linn	-	-	-	-	67	97.3	-
Malheur	1	4.0	-	-	17	68.3	-
Marion	20	12.8	2	5	379	243.6	-
Morrow	2	43.5	2	-	1	21.7	-
Multnomah	93	16.6	17	15	3,421	611.4	2
Polk	-	-	-	-	43	131.0	-
Sherman	1	42.2	-	-	-	-	-
Tillamook	1	5.6	-	-	15	84.0	-
Umatilla	5	11.0	-	1	31	68.3	-
Union	1	5.1	-	-	4	20.4	-
Wallowa	-	-	-	-	-	-	-
Wasco	-	-	-	-	4	18.5	-
Washington	10	7.0	6	2	161	112.4	-
Wheeler	-	-	-	-	1	53.2	-
Yamhill	3	7.3	1	-	27	65.8	-

All rates per 100,000 population

Source: Oregon State Board of Health, 1969 Statistical Report, p. 146

EXHIBIT 8

SELECTED VENEREAL DISEASE MORBIDITY DATA FOR CITIES WITH POPULATION OVER 200,000

Annual Rates per 100,000 Population
(Known Military Cases Excluded)

Fiscal Year 1969

Cities By DHEW Regions	SYPHILIS												GONORRHEA				TOTAL OTHER VENEREAL DISEASES 3/	
	TOTAL 2/				PRIMARY AND SECONDARY				EARLY LATENT		LATE & LATE LATENT		CONGENITAL					
	Total		Private Cases		Total		Private Cases		Total		Total		Total		Total		Private Cases		Total	
	Cases	Rates	Cases	Per-cent	Cases	Rates	Cases	Per-cent	Cases	Rates	Cases	Rates	Cases	Rates	Cases	Rates	Cases	Per-cent	Cases	Rates
Boston	905	149.1	530	58.6	120	19.8	16	13.3	83	13.7	667	109.9	35	5.8	3862	639.5	668	17.2	5	.8
Providence	248	135.5	104	41.9	18	9.8	4	22.2	29	15.8	84	45.9	0	-	608	332.2	251	41.3	0	-
REGION I CITY TOTAL	1153	145.9	634	55.0	138	17.5	20	14.5	112	14.2	751	95.1	35	4.4	4490	568.4	919	20.5	5	.6
Buffalo 4/	260	23.8	86	33.1	21	1.9	5	23.8	9	.8	223	20.4	7	.6	2161	197.9	612	28.3	0	-
Jersey City	199	74.0	107	53.8	32	11.9	17	53.1	44	16.4	117	43.5	6	2.2	234	87.0	94	40.2	2	.7
Newark	746	192.3	290	38.8	174	44.7	37	21.3	86	22.1	453	116.5	35	9.0	5258	1351.7	1014	19.3	3	.8
New York	13516	167.9	8703	64.4	2467	30.6	1205	48.8	1978	24.6	8935	111.0	138	1.7	35528	441.2	11132	31.3	37	.5
Philadelphia	1616	88.8	843	47.0	229	11.2	51	22.3	137	6.7	1430	70.0	20	1.0	12741	623.3	3954	31.0	24	1.2
Pittsburgh 4/	755	47.5	489	64.8	81	5.1	23	28.4	46	2.9	617	38.8	11	.7	1842	115.8	651	35.3	2	.1
Rochester 4/	230	34.4	71	30.9	124	18.6	37	29.8	32	4.8	72	10.8	2	.3	2006	300.3	735	36.6	0	-
Syracuse	53	25.7	41	74.5	7	3.3	4	57.1	0	-	46	21.5	2	.9	1231	575.2	835	67.8	0	-
REGION II CITY TOTAL	17501	122.8	10640	60.5	3135	21.9	1379	44.0	2332	16.3	11893	83.1	221	1.5	61001	426.0	19027	31.2	68	.5
Baltimore	1933	209.4	613	31.7	313	33.9	72	23.0	367	39.8	1163	126.2	30	3.3	8612	933.0	625	7.3	13	1.4
Charlotte	154	59.7	11	7.1	62	24.0	5	8.1	52	20.2	36	14.0	4	1.6	2617	1091.9	68	2.4	11	4.3
Louisville 4/	395	55.6	219	55.4	50	7.4	9	18.0	24	3.6	278	41.2	6	.9	2383	353.6	33	1.4	0	-
Norfolk	241	77.7	134	55.6	26	8.4	2	7.7	21	6.8	187	60.3	6	1.9	3488	1125.2	406	11.6	6	1.9
Richmond	159	73.3	54	34.0	60	27.6	9	15.0	18	8.3	73	33.6	6	2.7	1802	830.4	622	34.5	3	1.4
Washington, D. C.	1493	189.6	425	28.5	539	68.2	99	18.4	445	56.3	488	61.8	21	2.7	13935	1763.9	636	4.6	187	23.7
REGION III CITY TOTAL	4375	137.9	1456	33.3	1050	33.1	196	18.7	927	29.2	2245	70.8	73	2.3	33037	1041.5	2390	7.2	220	6.9
Atlanta 4/	828	134.5	267	32.2	271	44.4	26	9.6	167	27.3	365	63.0	5	.8	14545	2380.5	1035	7.0	92	15.1
Birmingham 4/	224	32.9	40	17.9	160	23.5	30	18.8	59	8.7	3	.4	2	.3	2010	295.6	108	5.4	3	.4
Jacksonville 4/	327	62.2	114	34.9	139	26.4	50	36.0	122	23.2	63	12.0	3	.6	1274	242.2	39	3.1	2	.4
Memphis 4/	325	44.4	135	41.5	77	10.5	12	15.6	18	2.5	224	30.6	6	.8	7467	1020.1	439	5.9	9	1.2
Miami 4/	933	81.9	254	27.2	370	32.5	120	32.4	263	23.1	268	25.3	12	1.1	3300	289.7	124	3.8	81	7.1
Mobile 4/	56	15.7	25	44.6	11	3.1	2	18.2	24	6.7	20	5.6	0	-	1451	407.6	309	21.3	13	3.7
Tampa 4/	147	31.7	53	36.1	71	15.3	21	29.6	32	6.9	44	9.5	0	-	2571	554.1	359	14.0	9	1.9
REGION IV CITY TOTAL	2840	63.0	888	31.3	1099	24.4	261	23.7	685	15.2	1027	22.8	28	.6	32618	723.6	2403	7.4	209	4.6
Akron	178	59.5	124	69.7	12	4.0	0	.0	24	8.0	139	46.5	3	1.0	2344	783.9	493	21.0	2	.7
Chicago	5615	158.7	2961	52.7	907	25.6	206	22.7	936	26.5	3653	103.3	119	3.4	37334	1055.2	4760	12.8	30	.8
Cincinnati	461	92.6	264	57.3	29	5.8	8	27.6	75	15.1	347	69.7	10	2.0	1522	305.6	451	29.6	7	1.4
Cleveland	1676	206.2	853	50.9	178	21.9	57	32.0	414	50.9	1038	127.7	46	5.7	6728	827.6	2937	43.7	38	4.7
Columbus	328	58.5	171	52.1	30	5.3	9	30.0	46	8.6	235	41.9	15	2.7	2875	512.5	812	28.2	18	3.2
Dayton	250	94.3	161	64.4	37	14.0	10	27.0	49	18.5	155	58.5	9	3.4	1212	457.4	583	48.1	7	2.6
Detroit	2991	166.9	1733	57.9	494	30.9	184	37.2	705	44.1	1642	102.6	78	4.9	8034	502.1	1277	15.9	143	8.9
Indianapolis	722	139.1	356	49.3	251	48.4	70	27.9	153	29.5	294	56.6	24	4.6	3314	638.5	715	21.6	3	.6
Milwaukee	533	70.9	401	75.2	11	1.5	4	36.4	53	7.0	450	59.8	19	2.5	4102	545.5	785	19.1	0	-
Toledo	176	46.1	116	66.3	36	9.3	11	30.6	46	12.4	80	20.7	14	3.6	856	221.8	197	23.0	1	.3
REGION V CITY TOTAL	12932	140.1	7142	55.2	1985	21.5	559	28.2	2505	27.1	8033	87.0	337	3.7	68321	740.1	13030	19.1	249	2.7
Des Moines	163	78.7	108	66.3	15	7.2	5	33.3	1	.5	145	70.1	1	.5	772	372.9	272	35.2	0	-
Kansas City	975	179.2	596	61.1	17	3.1	9	52.9	18	3.3	907	166.7	22	4.0	3851	707.9	715	18.6	1	.2
Minneapolis 4/	76	8.4	39	51.3	33	3.6	14	42.4	17	1.9	23	2.5	3	.3	1563	172.3	555	35.5	0	-
Omaha	236	64.3	127	53.8	13	3.5	5	38.5	17	4.6	191	52.0	15	4.1	1510	411.4	407	27.0	0	-
St. Louis	1468	212.1	803	54.7	138	19.9	31	22.5	133	19.2	1138	164.5	44	6.4	7525	1087.4	218	2.9	71	10.3
St. Paul	37	11.7	20	54.1	10	3.2	6	60.0	4	1.3	22	7.0	1	.3	736	232.9	293	39.8	0	-
Wichita 4/	323	92.6	204	61.7	20	5.7	11	55.0	18	5.2	276	79.1	9	2.6	1151	329.8	271	23.5	1	.3
REGION VI CITY TOTAL	3278	96.9	1957	59.7	246	7.3	81	32.9	208	6.2	2702	79.9	95	2.8	17108	505.9	2731	16.0	73	2.2
Albuquerque 4/	234	72.0	93	39.7	14	4.3	5	35.7	44	13.5	174	53.5	2	.6	635	195.4	94	14.8	1	.3
Dallas 4/	967	85.6	137	14.2	523	46.3	95	18.2	288	25.5	154	13.6	2	.2	9278	821.1	75	.8	0	-
El Paso 4/	381	102.4	172	45.1	88	23.7	38	43.2	58	15.6	224	60.2	11	3.0	685	184.1	179	26.1	1	.3
Fort Worth 4/	254	41.4	103	40.6	121	19.7	35	28.9	77	12.6	52	8.5	4	.7	4179	681.7	1027	24.6	2	.3
Houston 4/	2043	141.0	886	39.5	717	45.1	196	27.3	618	38.8	878	55.2	30	1.9	10539	662.4	789	7.5	96	6.0
New Orleans	904	135.9	135	14.9	238	35.8	5	19.3	127	19.1	525	78.9	14	2.1	3283	493.7	51	1.6	50	7.5
Oklahoma City 4/	298	59.1	194	65.1	21	4.2	7	33.3	18	3.6	197	39.1	5	1.0	1768	350.8	210	11.9	1	.2
San Antonio 4/	610	74.3	225	36.9	179	21.8	63	.2	192	23.4	235	28.6	4	.5	1088	132.5	408	37.5	0	-
Tulsa 4/	327	84.9	244	74.6	16	4.2	6	37.5	22	5.7	253	65.7	16	4.2	699	181.6	45	6.4	1	.3
REGION VII CITY TOTAL	6218	97.1	2189	35.2	1917	29.9	491	25.6	1444	22.5	2692	42.0	88	1.4	32154	501.9	2878	9.0	152	2.4
Denver 4/	192	38.2	84	43.8	23	4.6	7	30.4	28	5.6	136	27.0	5	1.0	2169	431.2	421	19.4	1	.2
REGION VIII CITY TOTAL	192	38.2	84	43.8	23	4.6	7	30.4	28	5.6	136	27.0	5	1.0	2169	431.2	421	19.4	1	.2
Honolulu	25	7.2	16	64.0	7	2.0	4	57.1	3	.9	14	4.0	1	.3	433	124.8	278	64.2	0	-
Los Angeles 4/	5605	82.6	3670	63.2	719	10.2	373	51.9	839	11.9	4070	57.9	177	2.5	33857	481.8	12654	37.4	34	.5
Oakland 4/	302	32.2	138	45.7	84	8.9	43	51.2	96	10.2	119	12.7	3	.3	4364	464.7	1268	29.1	0	-
Phoenix 4/	363	40.5	164	45.2	67	7.5	21	31.3	52	5.8	225	25.1	6	.7	2503	279.4	250	10.0	9	1.0
Portland	75	19.4	44	58.7	18	4.7	10	55.6	11	2.8	43	11.1	3	.8	2383	617.4	992	41.6	0	-
San Diego 4/	320	25.5	106	33.1	49	3.9	16	32.7	32	2.6	235	18.7	4	.3	2592	206.7	473	18.2	13	1.0
San Francisco	823	113.2	313	38.0	313	43.1	139	44.4	314	43.2	195	26.8	1	.1	13999	1925.6	1142	8.9	29	4.0
San Jose	248	29.4	170	59.0	34	3.5	21	61.8	41	4.2	192	19.6	21	2.1	2124	217.2	932	46.2	7	.7
Seattle 4/	114	11.0	28	24.6	34	3.3	13	38.2	30	2.9	50	4.8	0	-	4696	453.3	668	14.2	0	-
Tucson 4/	118	35.3	47	39.8	23	6.9	10	43.5	18	5.4	72	21.6	0	-	400	119.8	106	26.5	1	.3
REGION IX CITY TOTAL	8233	99.1	4696	57.0	1348	9.7	650	48.2	1436	10.3	5215	37.5	216	1.6	67351	483.7	13913	28.1	93	.7
U. S. TOTAL (Cities Only)	56802	101.0	29586	52.3	10941	19.5	3644	33.3	9677	17.2	34694	61.7	1098	2.0	318249	565.9	62712	19.7	1070	1.9
San Juan 4/	1005	126.6	117	11.6	503	63.4	54	10.7	129	16.2	361	45.5	12	1.5	1732	218.1	3	.2	1	.1
U. S. & TERRITORY (Cities Only)	57807	101.3	29803	51.6	11444	20.1	3698	32.3	9806	17.2	35055	61.4	1110	1.9	319981	560.9	62715	19.6	1071	1.9

1/ Population estimates as of December 31, 1967. Copyright, Sales Management Survey of Buying Power, reproduction not licensed. Rates less than .05 not shown.

2/ Includes cases with stage "not stated".

3/ The U. S. Total for Other Venereal Diseases includes: 622 cases of Chancroid, 68 cases of Granuloma Inguinale, and 380 cases of Lymphogranuloma Venereum.

4/ County data. Oakland is Alameda County less Berkeley.

Source: Form PHS 9.688
DHEW-PHS-NCDC-VD Branch
Research and Control Statistics
11/3/69 LBH:emb

TUBERCULOSIS

GOAL THE ERADICATION OF TUBERCULOSIS

CONDITION

The following tables present a brief summary of tuberculosis as a public health problem for the State of Oregon:

	1965	1966	1967	1968	1969
New cases reported	361	386	322	290	357
New case rate	18.3	19.3	16.0	14.1	17.2
Number persons reported as reactivations	65	39	65	61	56
Advanced disease	175	187	161	158	159
Number hospitalized	250	262	202	176	208

From the active case register, those with tuberculosis clinically active or inactive less than 5 years:

	1965	1966	1967	1968	1969
Total at home on drugs	623	820	824	919	931
Active disease at home on drugs	235	217	205	165	200

Considerable progress in the control of tuberculosis has been made in the past, in particular since the dramatic discovery and enlightened use of anti-tuberculosis drugs. As exhibited above, however, many of the indices used as a public health measure demonstrate a plateau level of control. Of the new cases first reported, for example, too high a percentage have advanced disease.

The reservoir, from which comes most active disease, is made up of persons who show a quantitatively significant reaction to the tuberculin skin test. Certain high-risk groups can be further identified to make up a segment estimated at 10% of the population. These include approximately 2/1,000 school children and 45/1,000 adults skin tested yearly, 8/1,000 persons in urban areas and 2/1,000 in rural areas screened through mobile chest x-ray units. The Central Case Registries maintained in the Oregon State Board of Health Tuberculosis and Chest Diseases Section Office list 1,665 persons reported to have active tuberculosis or inactive tuberculosis less than 5 years and approximately 7,000 with tuberculosis inactive more than 5 years. Approximately 2/1,000 persons listed reactivate their disease each year.

Tuberculosis is an infectious and contagious disease acquired as a result of continued exposure to the contaminated environment of an "open" case, a "spreader", and the portal of entry is almost always the respiratory tract. Recovery or improvement from an inactive disease state produces no immunity and a vaccine for prevention is only partially effective. The high incidence of reactivation, particularly in those persons who are considered medically recalcitrant, presents a complex problem. For the protection of the public health, the role of government has historically been accepted in this field.

Recovery from advanced disease takes time, adequate medication and medical or surgical attention; the disability period usually exceeds 3 months.

Most patients with active tuberculosis will benefit from hospitalization; the decision as to which patient should be hospitalized will vary with the convictions and practices of each patient's physician.

Tuberculosis is directly related to the quality of life, being perpetuated under conditions of socio-economic stress, public health ignorance, alcoholism and mycobacterial persistence (a quality of the disease itself).

CURRENT PROGRAMS AND ACTIVITIES

Statewide Programs

Oregon State Board of Health, Portland
Tuberculosis and Chest Diseases
Section staff - 10

Public health administration and statistics, central case registry, casefinding, surveillance, mobile x-ray service, outpatient chest clinic service for 24 counties, medical and public health nursing consultative service, tuberculosis drug and antigen distribution. Annual cost (1969-70) was $213,545.

Oregon State Board of Health and Multnomah County Division of Public Laboratories.

Bacteriological and biochemical service. Annual costs (1969-70) were:

Oregon State Board of Health	$28,714
Multnomah County	6,507
Total	$35,221

Statewide Treatment Facilities

University State Tuberculosis Hospital, Portland
Staff - 68.16
Bed capacity - 79
Average patient census - 66

Complete medical and surgical care for tuberculosis patients and/or other pulmonary patients, including outpatient clinic service, research and rehabilitation and professional education. Annual cost (1969-70) was $735,417.

Julius L. Meier Tuberculosis Clinic, Portland
Staff - 3.10
Outpatient Clinic visits - 2,800

Provides outpatient clinic service for tuberculosis victims in the Portland Metropolitan Area, and provides follow-up services for ex-tuberculosis patients. Annual cost (1969-70) was $29,151.
(The Julius L. Meier Clinic is funded and/or staffed through Multnomah County Division of Public Health and the State of Oregon; it is physically located at the University State Tuberculosis Hospital)

Veterans Administration Hospital, Portland
Staff - 10
Bed capacity - 56
Average patient census - 53
Outpatient Clinic visits - 500

One tuberculosis ward with complete medical and surgical care for tuberculosis patients and/or other pulmonary diseases, including post hospitalization care and follow-up, research and teaching. Annual cost (1969-70) was $615,639.

Veterans Administration
Regional Office - Portland
Staff - 1
Clinic visits per year - 1,260

Outpatient clinic service for service-connected tuberculosis cases and pre-hospitalization examination for nonservice-connected tuberculosis cases.

Statewide Educational Programs

Oregon Tuberculosis and Respiratory Disease Association
Statewide affiliated local associations and county councils
Staff - 24

Public and professional education, demonstration, research and legislation programs related to tuberculosis and respiratory diseases. Annual cost (1969-70) was $70,000.

Local Programs

Multnomah County Division of Public Health, Portland
Tuberculosis Control Section Staff - 16

Public health administration and statistics, central case registry, casefinding, surveillance, mobile and fixed x-ray centers at Health Department, City Jail, and Rocky Butte Jail, outpatient chest clinic service primarily for core area residents and suspects from county chest x-ray screening and tuberculin testing. Annual cost (1969-70) was $306,345.

Local Health Departments (excluding Multnomah County)

Public health nursing, including tuberculin skin testing, casefinding, surveillance, contact investigation and support to Oregon State Board of Health Tuberculosis Outpatient Clinic Service. Annual cost (1969-70) was $183,000.

Columbia Park Hospital and Training Center, The Dalles.

Tuberculosis outpatient clinic service and follow-up; residual caseload from local counties is primarily of patients formerly hospitalized at Columbia Park.

General Tuberculosis Control

Private physicians, and private and public institutions, facilities and programs throughout the state such as:

1. Migrant Health Program
2. Educational Institutions (Oregon State University, University of Oregon, Eastern Oregon College, Oregon College of Education, Southern Oregon College, Community colleges)
3. Correctional Institutions (State Penitentiary, Oregon State Correctional Institution, Hillcrest School, MacLaren School)
4. School for the Blind
5. School for the Deaf
6. Mental Institutions (Oregon State Hospital, Fairview Hospital and Training Center, Eastern Oregon State Hospital)
7. Care Facilities (nursing homes, homes for aged, hospitals)
8. Welfare Division
9. Vocational Rehabilitation Division
10. Department of Agriculture
11. Indian Health Service (Chemawa Indian School, Warm Springs Indian Reservation, Umatilla Indian Reservation)
12. U.S. Public Health Service Outpatient Department

The scope of these tuberculosis programs vary according to needs, the facilities that are available and/or their responsibilities and wherever practical are in accordance with recommendations of the State Tuberculosis Controller.

AUTHORITIES

General provisions for Tuberculosis Control are contained in the following

Oregon Revised Statutes and Oregon Administrative Rules and Regulations:

1. ORS 342.601 and 602 relate to teachers health certificates.

2. ORS 437.010 and 437.030 relate to case reporting, recording, investigation and control. ORS 437.020 and 437.040 relate to fumigation of premises and effects; this is outdated in view of present knowledge.

3. ORS 431.110, 431.130 and OAR 21.005 through 21.080 give the Board of Health authority to regulate tuberculosis as a communicable disease problem.

4. OAR Chapter 333 - Section 26.005 and 26.025 relate to tuberculosis control in extended care facilities.

5. ORS 616.745 and 616.735 and 628.270 relate to requirements for food handlers and communicable diseases.

Other Regulations and Agency Requirements:

Admission policies for State Tuberculosis Hospital
Waiver of residence regulations
Requirements for aliens

Oregon Tuberculosis and Respiratory Disease Association - Bylaws of the association and contract with National Tuberculosis and Respiratory Disease Association.

Advisory Committees and Councils

Oregon Council of Tuberculosis

Members:

Multnomah County Division of Public Health
Multnomah County Tuberculosis Control Division
Oregon Council of Local Health Officers
Oregon Conference of Local Health Officers
Oregon Medical Association
Oregon Nurses Association
Oregon Osteopathic Association
Oregon State Board of Health
Oregon Thoracic Society
Oregon Academy of General Practice
Oregon State Public Welfare
University of Oregon Medical School
Veterans Administration Hospital
Oregon Tuberculosis and Respiratory Diseases Association

OBJECTIVES

1. Establish efficient casefinding methods to identify all tuberculosis cases.

2. Assure adequate treatment for all persons with a diagnosis of active tuberculosis.

3. Develop an adequate follow-up system so that by 1973 every person identified as being infected with tuberculosis will be assured regular medical follow-up.

4. Secure treatment for tuberculosis patients in general hospitals and eliminate the public image of tuberculosis as a state institutional care responsibility.

RECOMMENDATIONS AND METHODS

1. *ENCOURAGE TUBERCULIN SKIN TESTING FOR ALL PERSONS PREVIOUSLY UNTESTED, EMPHASIZING CHILDREN ENTERING SCHOOL, TENTH GRADE STUDENTS, SCHOOL EMPLOYEES, WELFARE RECIPIENTS, MIGRANT LABORERS, AND OTHER GROUPS WITH SPECIAL MEDICAL PROBLEMS. LIMIT CHEST X-RAY SURVEY AS A CASEFINDING METHOD TO ADULT GROUPS PREVIOUSLY IDENTIFIED AS HIGH RISK (SKID-ROW INHABITANTS, RESIDENTS ON INDIAN RESERVATIONS, EMPLOYEES IN SELECTED HAZARDOUS INDUSTRIES, AND PERSONS ADMITTED TO EXTENDED CARE FACILITIES).*

   Methods

   a. *Oregon Tuberculosis and Respiratory Disease Association; Tuberculosis and Chest Diseases Section, Oregon State Board of Health; areawide comprehensive health planning committees; and local health departments cooperate to stimulate and implement a consistent program for casefinding and case management, according to recommendations outlined in the Program by Priority which has been approved by the Oregon Tuberculosis Council and the Conference of Local Health Officers.*

   b. *Oregon State Board of Health propose legislation to delete ORS Sections 437.020, .030, and .040 which refer to identification of residence and fumigation.*

   c. *Tuberculosis and Chest Diseases Section, Oregon State Board of Health; Oregon Tuberculosis and Respiratory Disease Association; and the University of Oregon Medical School promote orientation and in-service courses in tuberculosis casefinding, reporting, and control for professional and non-professional personnel.*

   d. *Oregon Tuberculosis and Respiratory Disease Association and Tuberculosis and Chest Diseases Section, Oregon State Board of Health continue public education about tuberculosis.*

2. *IDENTIFY AND MEDICALLY EVALUATE ALL PERSONS IN CONTACT WITH ACTIVE TUBERCULOSIS THROUGH TUBERCULIN SKIN TEST AND CHEST X-RAY FILM, IF INDICATED, AND PROVIDE CHEMOPROPHYLAXIS WHEN NEEDED.*

   Method

   Local public health nurses expand the ratio of contacts examined to new cases reported to average at least 10 to 1. Special

emphasis should be given to complete evaluation of contacts to children.

3. *ENCOURAGE PROMPT REPORTING OF ACTIVE AND INACTIVE CASES OF TUBERCULOSIS TO OREGON STATE BOARD OF HEALTH.*

4. *PROVIDE FOR THE TREATMENT OF THOSE WITH TUBERCULOSIS IN SELECTED GENERAL HOSPITALS WHEN FEASIBLE.*

Method

Board of Higher Education conduct a feasibility study to determine the advisability of phasing out the University of Oregon Tuberculosis Hospital as a specialty hospital and propose alternative methods of care for those infected with tuberculosis.

1) *Transfer University of Oregon Tuberculosis Hospital funds to Oregon State Board of Health, Tuberculosis and Chest Diseases Section for hospitalization and other care costs of those persons infected with tuberculosis.*

2) *Convert University of Oregon Tuberculosis Hospital building into an extended care facility, a generalized chest unit, or otherwise expand facilities of the Medical School.*

3) *The Oregon State Board of Health, with the Oregon Tuberculosis Council acting as an advisory group, establish guidelines and policies for general hospitals regarding admission and care of tuberculosis patients, to coincide with the possible closure of the University of Oregon Tuberculosis Hospital.*

5. *LOCAL HEALTH DEPARTMENTS MAINTAIN A WORKING REGISTER AND FOLLOW-UP SYSTEM OF TUBERCULOSIS CASES.*

6. *MAKE OUTPATIENT AND MEDICAL EVALUATION SERVICES AVAILABLE IN ALL AREAS AND TO ALL PATIENTS: EXPAND THESE SERVICES IN AREAS WHERE THERE IS A LARGE AT-RISK POPULATION (INCLUDE CHEST X-RAYS, LABORATORY SERVICES, PUBLIC HEALTH NURSING, EVALUATION, AND SUPERVISION).*

Method

Local health offices and Tuberculosis and Chest Diseases Section, Oregon State Board of Health continue to operate and staff chest clinics, establish and maintain adequate tuberculosis registries and effect surveillance and follow-up of people infected with tuberculosis.

7. *PROVIDE PROPHYLACTIC ANTI-TUBERCULOSIS DRUGS, IN CONFORMANCE WITH AMERICAN THORACIC SOCIETY STANDARDS, TO ALL PERSONS WITH A DIAGNOSIS OF ACTIVE TUBERCULOSIS.*

Method

Oregon State Board of Health furnish anti-tuberculosis drugs to indigent and medically indigent patients.

OPERATIONAL PROBLEMS

1. Shortage of local health department staff and money to provide lifetime surveillance and/or supervision of persons with tuberculosis.

2. Bias against or lack of adequate information by the public and professionals regarding tuberculosis and modern preventive and treatment techniques.

3. Lack of physicians' and nurses' training and experience in dealing with tuberculosis patients and their contacts.

4. Inadequate communication among agencies dealing with health and social services problems of people infected with tuberculosis.

EVALUATION CRITERIA

Evaluation to be performed by Oregon State Board of Health, Tuberculosis and Chest Diseases Section based on annual report.

PRIORITY

To be determined.

PERSONAL HEALTH PROBLEMS
Non-Communicable Disease

ALLERGIC DISEASE

GOAL INSURE EARLY DETECTION AND TREATMENT OF OREGONIANS SUFFERING FROM ALLERGIC CONDITIONS.

CONDITION

An allergy is a hyper-sensitive state, acquired through exposure to a particular substance inhaled (inhalants), swallowed (ingestants), touched (contactants), or injected (injectants). The most common types of allergies include hay fever, bronchial asthma, hives, and eczema. In addition, an allergic reaction may result from certain foods, insect stings, and drugs, especially the antibiotics.

It is estimated that about 1 out of every 10 people in Oregon (approximately 208,000 persons) suffer some sort of allergic disease. Asthma and hay fever account for about 73% of those with allergic conditions.

Allergic conditions are the leading chronic disease among children, accounting for one-third of all the chronic conditions in children under 17 years of age. National surveys of school children have shown prevalence rates of 1 in every 5 children having a major allergy, yet only 1 in 3 of these allergic children receives any medical attention. On the national level, school children lose 36 million days from school and spend 13 million days in bed due to allergies. Adults lose 25 million man days from work at a cost of $400 billion each year.

Medical expenditures for allergy are high. Allergy patients require an average of 3 times as many medical visits as do those suffering from other types of illness. The annual cost to allergy victims for antihistamines and other medicines prescribed by physicians are estimated to average about $25.00 per person.

Because of the wide variety of allergens, continued research is necessary to identify those substances which cause reactions, as well as to determine effective preventive and treatment procedures. The increase in smog and pollution will cause increasing allergic conditions. Special emphasis in research should be centered on the psychological aspects of allergic reactions, especially asthma. Oftentimes severe attacks in asthmatic children are precipitated by a stressful emotional climate in the home.

CURRENT PROGRAMS AND ACTIVITIES

Most of the treatment for allergic conditions is provided by the private physician, however, a few public programs are in operation.

The Oregon Chapter of the Allergy Foundation of America provides public information and education on allergy diseases, supports research and professional training in allergy, and assists allergic patients and their families in obtaining medical care. The activities of the Oregon Allergy Foundation are centered primarily in Portland. All patients served by the Allergy Foundation are referred by physicians.

The University of Oregon Medical School provides care and treatment of allergic patients through the adult and pediatric allergy clinics. The Medical School also conducts research projects on allergies and their treatment.

Emanuel Hospital in Portland has the only Allergy Conditioning Program in the state. The program is designed to teach children the proper breathing and exercises to relieve pulmonary distress.

Camp Sumner, affiliated with the Children's Orthopedic Hospital in Seattle, is a two-week camp for allergic youngsters. Although the camp is primarily for residents of Washington, a few Oregon children are accepted for the program.

Research in immunology and allergy is also conducted at the Oregon Regional Primate Center.

AUTHORITIES

University of Oregon Medical School - Statutory

OBJECTIVES

1. By 1972, establish statewide public education programs to inform the general public of the nature of allergies and the means to control and prevent allergic conditions.

2. By 1975, establish professional training programs in allergy detection and treatment for health professionals.

3. Increase the availability of diagnostic and treatment services for allergic patients.

4. Expand research efforts in the detection, treatment, and factors related to allergic diseases.

RECOMMENDATIONS AND METHODS

1. *INCREASE PUBLIC AWARENESS OF THE EXISTENCE AND ETIOLOGY OF ALLERGIC DISEASES THROUGH THE ESTABLISHMENT OF A STATEWIDE PUBLIC EDUCATION CAMPAIGN.*

Methods

a. *Oregon Allergy Foundation, in cooperation with the Oregon State Board of Health, expand public educational activities designed to give the general public a better understanding of allergic disease and available treatment facilities.*

b. *Oregon Allergy Foundation encourage all persons allergic to specific drugs and medicines to wear a "Medic-Alert" bracelet or other identification to prevent treatment which might result in anaphylactic shock in emergency situations.*

2. *INCREASE PROFESSIONAL AWARENESS OF THE CAUSES AND TREATMENT OF ALLERGIC CONDITIONS.*

Methods

a. *University of Oregon Medical School develop a curriculum for the training of allergists.*

b. *Board of Education, Board of Higher Education, and schools of nursing include allergies in the training programs for nurses and other allied health professionals.*

3. *ESTABLISH ALLERGY DETECTION AND TREATMENT FACILITIES IN KEY CITIES OF OREGON SERVING THE MORE DENSELY POPULATED AREAS.*

Methods

a. *Oregon Association of Hospitals, in cooperation with Allergy Foundation, identify selected regional hospitals for the establishment of allergy clinics.*

b. *Allergy clinics establish physical fitness programs for the asthmatic child where he can be taught to breathe properly, strengthen respiratory muscles, correct his posture, abort an asthmatic attack, improve coordination, and accept himself and his disability.*

c. *Allergy clinics make mental health specialists available or contract with local mental health clinics to provide counseling and therapy services to those allergy patients with psychosomatic symptoms.*

d. *Oregon Medical Association encourage physicians to refer families and patients with suspected psychological factors affecting allergies to local mental health clinics for counseling.*

e. *The Allergy Foundation, in cooperation with other voluntary agencies and Community Action Programs, provide transportation to allergy treatment centers for those needing assistance.*

4. *IDENTIFY AND, WHEN FEASIBLE, REMOVE THOSE ENVIRONMENTAL CONDITIONS CAUSING OR CONTRIBUTING TO ALLERGIC REACTIONS OF A SUFFICIENTLY LARGE POPULATION.*

Methods

a. *Department of Environmental Quality continue to enforce air pollution regulations in Oregon.*

b. *Local communities take preventive action to control biological and chemical allergens such as the cutting and spraying of noxious weeds in parks, vacant lots, and along highways.*

5. *ENCOURAGE AND SUPPORT RESEARCH EFFORTS INTO THE CAUSATIVE FACTORS OF ALLERGIES AND IMPROVED TREATMENT PROCEDURES.*

Methods

a. *Allergy Foundation encourage and coordinate research projects in allergies at institutions of learning in Oregon.*

b. *Allergy Foundation and Oregon Medical Association distribute research findings to all physicians and other health professionals.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

To be determined.

PRIORITY

To be determined.

ARTHRITIS AND RHEUMATISM

GOAL EARLY IDENTIFICATION AND TREATMENT OF OREGONIANS SUFFERING FROM ARTHRITIS OR RHEUMATISM AND THE IDENTIFICATION OF CAUSATIVE FACTORS.

CONDITION

"Arthritis" literally means inflammation of a joint. However, the term is used to describe nearly one-hundred different conditions which cause pain in joints and connective tissue throughout the body.

The most widespread kinds of arthritis include rheumatoid arthritis, osteoarthritis, akylosing spondylitis (a chronic inflammatory arthritis of the spine), and gout. Arthritis is a chronic condition and can lead to severe crippling and deformity if untreated.

The cause of arthritis is not known; consequently, there is no cure for the disease. However, a few effective treatment methods to control arthritis and prevent deformities and crippling are known. The treatment program for the arthritic patient varies with the severity of the disease, but includes medication, rest, exercise, splints, walking aids, heat, and sometimes surgery.

It is estimated that 1 out of every 11 Oregonians (approximately 180,000 persons) suffer from arthritis. Although arthritis can occur at all ages, it is predominant among the aged.

Both in terms of human suffering and expense, the costs of arthritis are high. National data indicate that arthritic patients, on the average, have 5 days of restricted activity annually. Medical costs of arthritis in Oregon average about $15 per patient per month. The annual cost to the national economy due to arthritis, in lost wages and medical care bills, totals $3.6 billion.

CURRENT PROGRAMS AND ACTIVITIES

Most of the activities in the area of arthritis other than individual physician treatment of the afflicted patient are conducted by the Oregon Arthritis and Rheumatism Foundation. The Foundation provides a variety of services including public education, professional education, patient services, and support of research activities. The public educational activities include the distribution of literature on arthritis through the mass media, forums, and panels at various community organizations. In cooperation with the Oregon Medical Association and Regional Medical Program, the Foundation participates in statewide continuing education courses and teaching clinics in arthritis and rheumatism.

The major activity of the Foundation is to act as a referral service and provide counseling to arthritic patients in the state. The Foundation provides free drugs to the needy, therapeutic and self-help devices, and transportation to medical facilities for care or therapy. The Portland Motor Corps operates 3 vehicles 5 days a week. Two of the cars have lift gates for wheelchair patients. In other areas of the state, the Arthritis and Rheumatism Foundation pays for the cost of public transportation of arthritic patients. Most of the patient-service activities of the Foundation are centered in the Portland area. Programs for the treatment of arthritic patients centered in local general hospitals have been established in Roseburg, Eugene, and Salem.

The Rheumatology Clinic at the University of Oregon Medical School is the principal source of treatment for persons suffering from arthritis. Other Portland facilities providing physical therapy for arthritis include Holladay Park Hospital, Emanuel Hospital, the Jewish Community Center, and Flanders Therapy Center.

Major clinical research activities in arthritis are conducted in the Rheumatology Division of the University of Oregon Medical School. Research is financed through an endowment from the Arthritis and Rheumatism Foundation and the National Institutes of Health.

AUTHORITIES

University of Oregon Medical School - Statutory

OBJECTIVES

1. By 1972, establish a statewide public education campaign to inform all Oregonians of the early signs and symptoms of arthritis.

2. Expand professional education in the care and treatment of arthritic patients.

3. Improve access to treatment facilities for arthritic patients.

4. Expand research activities into the cause and cure of arthritis.

RECOMMENDATIONS AND METHODS

1. *INCREASE PUBLIC AWARENESS OF THE SYMPTOMS OF ARTHRITIS AND THE NEED FOR EARLY MEDICAL CARE TO ALLEVIATE EXCESSIVE PAIN AND PREVENT SERIOUS DEFORMITY AND CRIPPLING.*

   Methods

   a. *Oregon Arthritis and Rheumatism Foundation, in cooperation with the Chronic Disease Section of the Oregon State Board of Health, establish public education programs in local communities.*

b. *Oregon Arthritis and Rheumatism Foundation, in cooperation with Oregon Medical Association and Oregon Regional Medical Program, distribute arthritis research findings to all Oregon physicians.*

2. *EXPAND COURSES IN THE CARE AND TREATMENT OF ARTHRITIS AND RHEUMATISM FOR HEALTH PROFESSIONALS.*

Methods

a. *Schools of nursing establish training in arthritis and physical therapy as part of their curriculum.*

b. *University of Oregon Medical School establish post graduate education courses in rheumatic diseases.*

3. *EXPAND DIAGNOSTIC AND TREATMENT SERVICES FOR ARTHRITIC PATIENTS IN OREGON.*

Methods

a. *Establish regional therapy centers for the treatment of arthritis and other disabling conditions. (For detailed description of regional centers for the disabled see the Rehabilitation Section of the Plan.)*

b. *University of Oregon Medical School, in cooperation with county medical societies and local general hospitals, establish traveling diagnostic clinics staffed by a team of health professionals to service remote areas of the state.*

c. *Multiphasic screening centers include blood testing for rheumatoid arthritis.*

4. *EXPAND HOME HEALTH CARE SERVICES FOR ARTHRITIC PATIENTS IN ORDER TO REDUCE THEIR NEED FOR COSTLY INPATIENT CARE AND IMPROVE THEIR ABILITY TO CONTINUE NORMAL DAILY LIVING.*

Method

Visiting Nurse Association, home health care agencies, Oregon State Board of Health, and Oregon Medical Association encourage physicians to utilize home health care services for arthritic patients whenever applicable. Home care services should include homemaker services as well as nursing care.

5. *PROVIDE TRANSPORTATION TO ARTHRITIC PATIENTS UNABLE TO TRAVEL ON THEIR OWN.*

Method

Oregon Arthritis and Rheumatism Foundation, in cooperation with other voluntary agencies and local community action agencies, develop a coordinated system to transport the disabled.

6. *ENCOURAGE AND SUPPORT RESEARCH ACTIVITIES INTO THE CAUSE, CURE, AND TREATMENT OF ARTHRITIS.*

Methods

a. *Oregon Arthritis and Rheumatism Foundation elicit financial support for arthritis research from the National Arthritis and Rheumatism Foundation and the National Institutes of Health.*

b. *Oregon Arthritis and Rheumatism Foundation, in cooperation with Oregon Medical Association and Oregon Regional Medical Program distribute arthritis research findings to all Oregon physicians.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

The Arthritis and Rheumatism Foundation evaluate progress in the area of arthritis by observing:

a) Reduction in number of arthritis victims with crippling and/or deformity.

b) Increased treatment centers for the arthritic disabled.

c) More extensive research into the causes and cures of arthritis and related conditions.

PRIORITY

To be determined.

BIRTH DEFECTS

GOAL REDUCE THE INCIDENCE OF BIRTH DEFECTS.

CONDITION

It is estimated that 7% of all live births in this country have disorders of body structure, function, or chemistry. This means that 1 out of 15 children born has a serious birth defect; and 1 out of 10 families is affected. In round numbers, 250,000 children are born in this country every year with one or more birth defects. About 10-15% of these can be attributed to preventable acts of the parents such as improper nutrition, drug usage, venereal disease, and inadequate prenatal care.

In Oregon, out of 32,621 live births in 1968, it is estimated that 2,300 were born with birth defects (approximately 70 per 1,000 live births), and that 2,000 were born prematurely. In addition, there were 1,091 infant deaths during 1968. Many of these deaths were related to birth defects.

Large expenditures are required to meet the special needs of a large proportion of the victims of birth defects. Such things as special equipment, tutoring, and extensive medical attention are financially demanding.

Beyond the financial demands, the presence of birth defects frequently induces emotional traumas for the affected families. Even though only a small proportion of birth defects occur because of the acts of the parents (e.g. venereal disease, drug usage), it is typical for parents of birth defective children to suffer from feelings of guilt.

CURRENT PROGRAMS AND ACTIVITIES

Present programs and activities dealing with birth defects can be classified into (1) preventive efforts, (2) treatment and family assistance to affected families, and (3) research.

Prevention

The National Foundation - March of Dimes - conducts an educational program with students and under-educated adults to inform them of the need for good general health practices to guard against birth defects. Topics covered include nutrition, drug usage, adequate prenatal care, and general health. In suspected hereditary problem cases, couples are

referred for genetic counseling to the Center at Sacred Heart Hospital in Eugene, Oregon State Board of Health, local health departments, or their private physicians. With the increased availability of genetic counseling, couples will be able to examine their genetic backgrounds and make educated predictions about prospective offspring.

Treatment and Assistance

The National Foundation - March of Dimes - finances Birth Defect Centers across the country. There are two such centers in Oregon. One is affiliated with Sacred Heart Hospital in Eugene and one is part of the pediatrics department of the University of Oregon Medical School. The main concern of the centers is to bring together all appropriate medical and auxiliary personnel in one location to provide comprehensive care. In addition to physicians and supporting medical personnel, the centers are staffed with a medical social worker who assists the family to comprehend both intellectually and emotionally the facts of the situation. The Sacred Heart Center is especially concerned with genetic counseling services; the Medical School Center is especially concerned with metabolic defects.

The Oregon chapter of the National Foundation subsidizes families in need of assistance for medical and associated expenses relating to birth defect victims.

Research

Nationally, there is a wide range of research being conducted to gain greater understanding of the nature and treatment of birth defects. A primary recipient of research grants from the National Foundation is the Salk Institute for Biological Studies in La Jolla, California. In Oregon, ancillary research is being conducted in conjunction with the Birth Defect Center at the Medical School. In addition, the new medical specialty of fetology is concerned with the diagnosis of birth defects in utero in order to initiate pre-birth therapy.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1975, reduce the incidence of birth defects 15%.

2. Increase public awareness and knowledge about birth defects so that high-risk potential parents can take available preventive steps.

3. Expand and improve the medical services, both preventive and treatment, to persons born with birth defects and their families.

4. Accelerate research into the nature and causes of birth defects.

RECOMMENDATIONS AND METHODS

1. *INCREASE PUBLIC AWARENESS AND KNOWLEDGE OF BIRTH DEFECTS.*

Methods

a. *State Board of Education, in cooperation with the University of Oregon Medical School and the State Board of Health, encourage schools to include within the curriculum topics on the parents' responsibility to the child; the effects of poor nutrition, venereal disease, and drugs on children; and hereditary factors relating to birth defects.*

b. *Oregon State Board of Health, the National Foundation, and other voluntary groups establish a public information campaign about birth defects. Such efforts could be made through radio, television, and newspapers as well as presentations to clubs and organizations.*

2. *IDENTIFY HIGH-RISK POTENTIAL PARENTS AND PROVIDE THEM WITH ADEQUATE COUNSEL AND CARE.*

Methods

a. *Oregon State Board of Health and local public health nurses discourage childbearing among high-risk groups including those with known genetic disorders, drug addicts, etc.*

b. *Local health departments, in cooperation with the State Board of Health and the University of Oregon Medical School, expand genetic counseling services to all potential parents through family planning clinics.*

c. *Oregon Medical Association encourage physicians to counsel patients on the relationship of genetics to birth defects as part of pre-pregnancy care.*

d. *Local health departments establish prenatal care clinics and provide nutrition counseling to medically indigent expectant mothers.*

3. *MAKE PREVENTIVE MEDICATIONS AVAILABLE TO ALL HIGH-RISK TARGET POPULATIONS.*

Methods

a. *Oregon State Board of Health make Rho Gam (incompatibility vaccine) available in every obstetrics department.*

b. *Oregon State Board of Health budget funds to provide the vaccine to all indigent patients when needed.*

c. *Health insurance companies be encouraged to cover the expense of Rho Gam for insureds.*

d. *Oregon State Board of Health, through health education and special immunization clinics conducted in cooperation with the Oregon Medical Association, encourage all parents to have children vaccinated for rubella.*

4. *ACCELERATE RESEARCH INTO THE NATURE, CAUSES, AND TREATMENT OF BIRTH DEFECTS.*

Methods

a. *The National Foundation act as a clearing house for the results of research and coordinate proposed research efforts.*

b. *The National Foundation and other interested groups cooperate with the State Board of Higher Education to request the Legislature to make more funds available for research on birth defects at the University of Oregon Medical School and other appropriate institutions.*

5. *IMPROVE DELIVERY OF MEDICAL AND AUXILIARY SERVICES TO AFFECTED FAMILIES.*

Method

Health insurance companies be encouraged to include extended services to newborns within their coverage so that parents of children born with birth defects are not reduced to penury.

OPERATIONAL PROBLEMS

Insufficient staff and funds to expand programs. Lack of knowledge of the causative factors of birth defects.

EVALUATION CRITERIA

Oregon State Board of Health to evaluate progress toward the objectives through decreases in the rate of children born in Oregon with birth defects.

PRIORITY

To be determined.

CANCER

GOAL PREVENT PREMATURE DEATH AND REDUCE DISABILITY DUE TO CANCER.

CONDITION

In 1969, 287 Oregonians died from cancer for a rate of 157.9 per 100,000 population. If the present trend continues, approximately 518,910 persons in Oregon will develop cancer (one out of every four persons) and 311,346 will die from the disease.

Cancer is the leading cause of death in the nation and in Oregon. The average age of death due to cancer is 68, although it is the leading disease-causing death of children.

Cancer is the leading cause of death among women aged 30-54; cancer of the breast is the leading cause of death among women 40-44 years of age. Because of the widespread use of the Pap Test, the incidence of cancer of the uterus has declined about 50% in a generation. Cancer of the skin and of the colon-rectum strike more Americans than any other type of cancer.

Approximately 52,000 patients a year are cured of cancer (without evidence of the disease for five years). The ratio of lives saved to lives lost has increased from 1 in 5 in 1930 to 1 in 3 in 1956. The charts on the following pages indicate national trends in cancer morbidity and mortality.

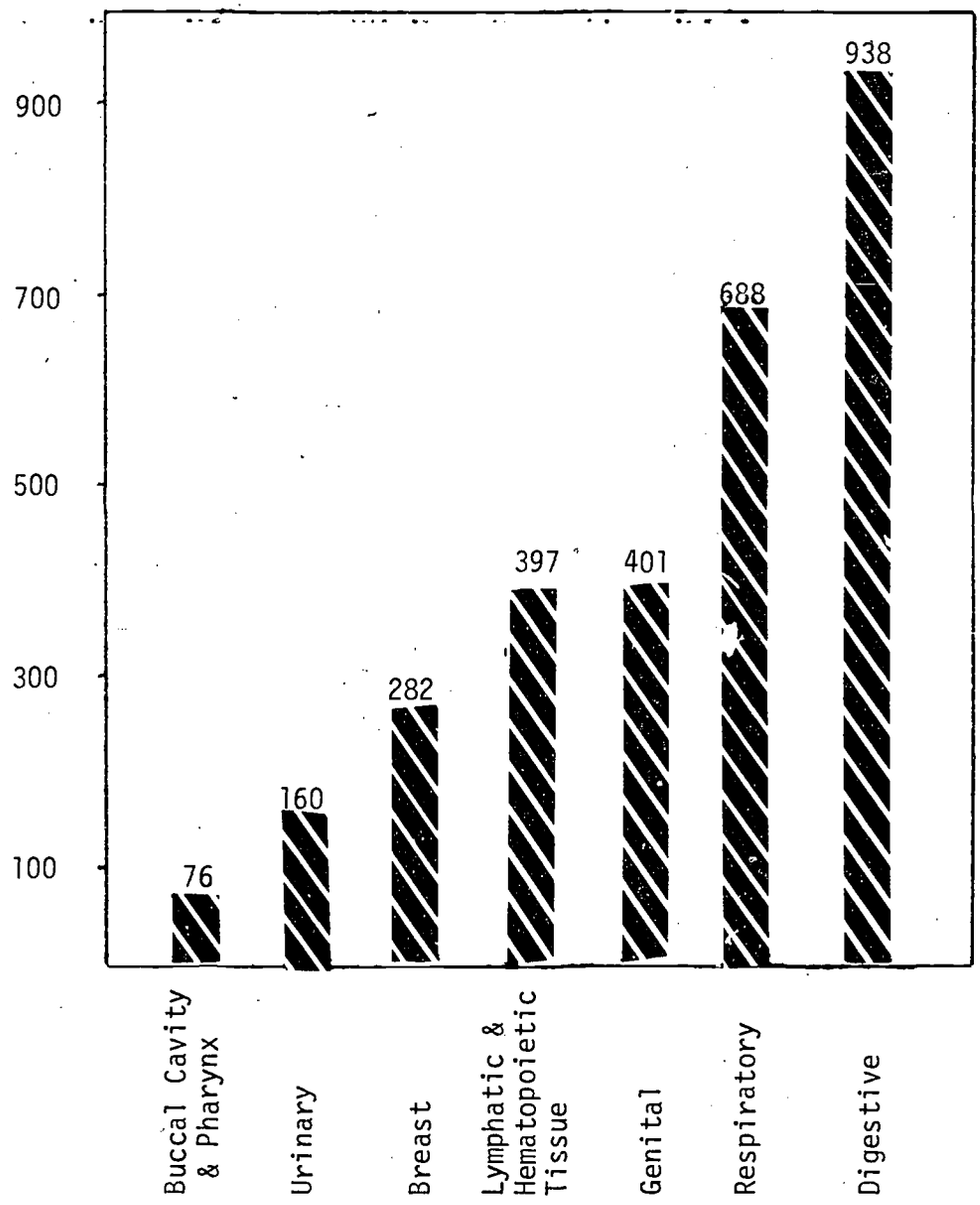
CURRENT PROGRAMS AND ACTIVITIES

There is no specialized cancer hospital in Oregon, but cancer consultation and treatment services are available at Sacred Heart General Hospital in Eugene; Tumor Clinics at Rogue Valley Memorial Hospital and Providence Hospital in Medford; St. Anthony's Hospital in Pendleton; Bess Kaiser, Emanuel, Good Samaritan, Adventist, Physicians and Surgeons, Providence, St. Vincent's, University of Oregon Medical School Hospitals and Clinics, Woodland Park and Veterans' Administration Hospitals in Portland; Salem Hospital, Memorial Unit, in Salem; Mercy and Douglas Community Hospitals in Roseburg; Columbia and Memorial Hospitals in Astoria; St. Charles Memorial Hospital in Bend; and Physicians Medical Center in McMinnville. In addition, every physician's office should be a cancer detection center.

The Oregon State Board of Health, Chronic Disease Section, operates a cancer control program. The program includes: professional and public education on cancer through seminars, training sessions, presentations at schools, community groups, and the mass media; promotion of cervical

CHART 1

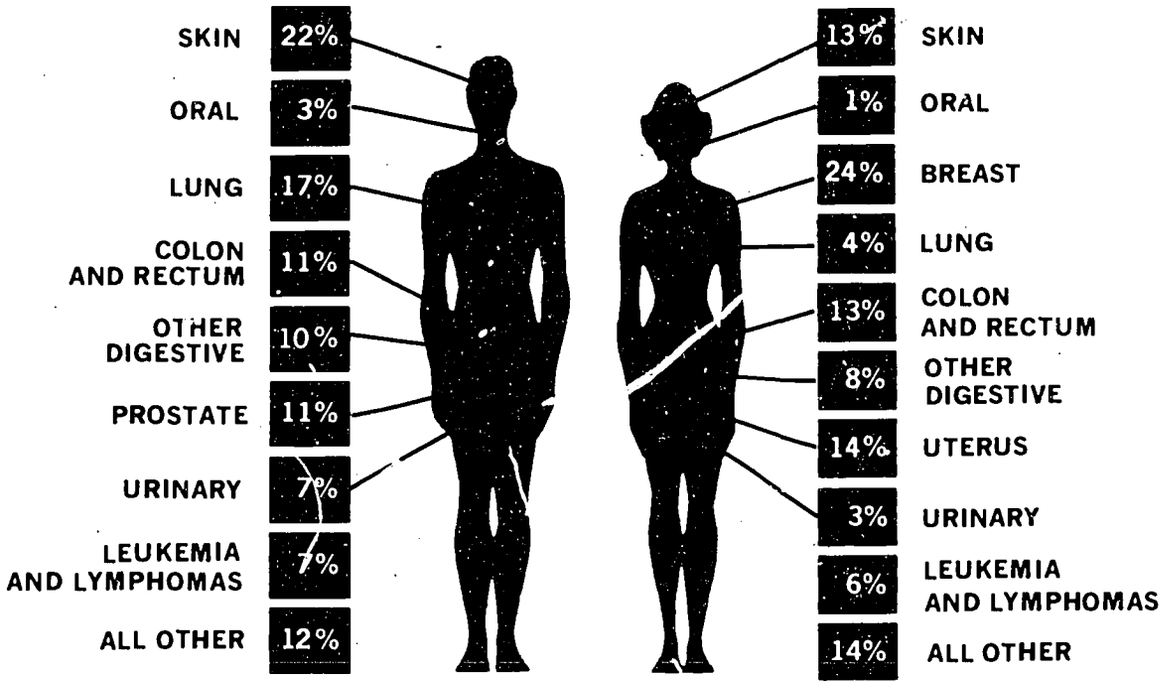
RESIDENT DEATHS FROM MALIGNANT
NEOPLASMS BY PRIMARY SITE, OREGON 1969



Source: 1969 Statistical Report, Vital Statistics Section, OSBH, p. 87.

CHART 2

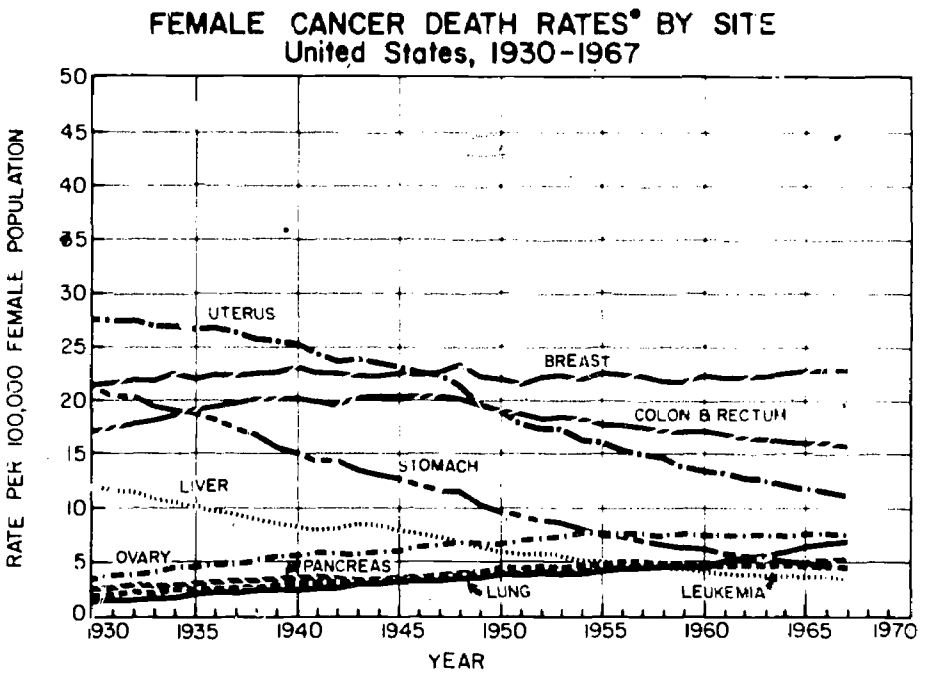
CANCER INCIDENCE BY SITE AND SEX



Age-Adjusted Death Rates per 100,000 Population of Selected Sites of Cancer, U. S., 1930-1967

Graphs show the extent of the increase in lung cancer in men and the decrease in uterine cancer in women. The reasons are explained elsewhere. But the sweeping decrease in stomach cancer and steady increase of leukemia remain mysteries of the kind that only further research will solve.

CHART 3

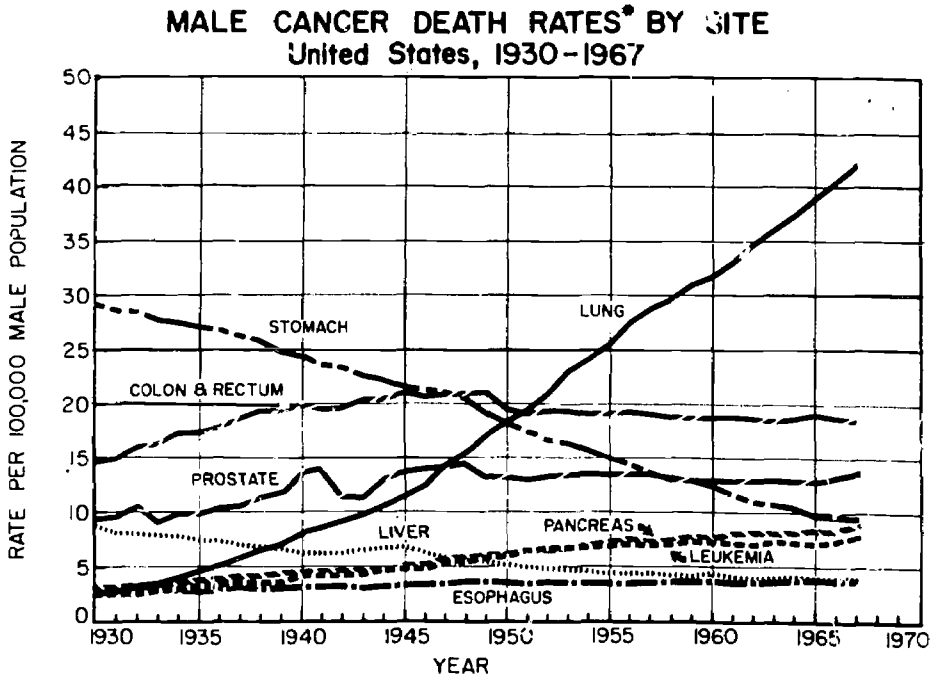


*Rate for the female population standardized for age on the 1940 U.S. population

Sources of Data: National Vital Statistics Division and Bureau of the Census, United States

EPIDEMIOLOGY AND STATISTICS DEPT
AMERICAN CANCER SOCIETY, 7-69

CHART 4



*Rate for the male population standardized for age on the 1940 U.S. population.

Sources of Data: National Vital Statistics Division and Bureau of the Census, United States.

EPIDEMIOLOGY AND STATISTICS DEPT
AMERICAN CANCER SOCIETY, 7-69

CHART 5

Reference Chart: Leading Cancer Sites, 1970

SITE	ESTIMATED NEW CASES 1970	ESTIMATED DEATHS 1970	WARNING SIGNAL WHEN LASTING LONGER THAN TWO WEEKS SEE YOUR DOCTOR	SAFEGUARDS	COMMENT
BREAST	69,000	30,000	LUMP OR THICKENING IN THE BREAST	ANNUAL CHECKUP MONTHLY BREAST SELF EXAMINATION	THE LEADING CAUSE OF CANCER DEATH IN WOMEN
COLON AND RECTUM	75,000	46,000	CHANGE IN BOWEL HABITS. BLEEDING	ANNUAL CHECKUP. INCLUDING PROCTOSCOPY.	CONSIDERED A HIGHLY CURABLE DISEASE WHEN DIGITAL AND PROCTOSCOPIC EXAMINATIONS ARE INCLUDED IN ROUTINE CHECKUPS
LUNG	68,000	62,000	PERSISTENT COUGH OR LINGERING RESPIRATORY AILMENT.	PREVENTION HEED FACTS ABOUT SMOKING. ANNUAL CHECKUP CHEST X-RAY.	THE LEADING CAUSE OF CANCER DEATH AMONG MEN. THIS FORM OF CANCER IS LARGELY PREVENTABLE.
ORAL (INCLUDING PHARYNX)	14,000	7,000	SORE THAT DOES NOT HEAL. DIFFICULTY IN SWALLOWING	ANNUAL CHECKUP.	MANY MORE LIVES SHOULD BE SAVED BECAUSE THE MOUTH IS EASILY ACCESSIBLE TO VISUAL EXAMINATION BY PHYSICIANS AND DENTISTS.
SKIN	112,000	5,000	SORE THAT DOES NOT HEAL OR CHANGE IN WART OR MOLE	ANNUAL CHECKUP. AVOIDANCE OF OVEREXPOSURE TO SUN.	SKIN CANCER IS READILY DETECTED BY OBSERVATION. AND DIAGNOSED BY SIMPLE BIOPSY
UTERUS	47,000	13,000	UNUSUAL BLEEDING OR DISCHARGE.	ANNUAL CHECKUP INCLUDING PELVIC EXAMINATION AND PAPANICOLAOU SMEAR.	UTERINE CANCER MORTALITY HAS DECLINED 50% DURING THE LAST 25 YEARS. WITH WIDER APPLICATION OF THE "PAP" SMEAR MANY THOUSAND MORE LIVES CAN BE SAVED
KIDNEY AND BLADDER	32,000	15,000	URINARY DIFFICULTY BLEEDING - IN WHICH CASE CONSULT YOUR DOCTOR AT ONCE.	ANNUAL CHECKUP WITH URINALYSIS.	PROTECTIVE MEASURES FOR WORKERS IN HIGH RISK INDUSTRIES ARE HELPING TO ELIMINATE ONE OF THE IMPORTANT CAUSES OF THESE CANCERS
LARYNX	7,000	3,000	HOARSENESS - DIFFICULTY IN SWALLOWING.	ANNUAL CHECKUP. INCLUDING MIRROR LARYNGOSCOPY.	READILY CURABLE IF CAUGHT EARLY
PROSTATE	35,000	17,000	URINARY DIFFICULTY.	ANNUAL CHECKUP. INCLUDING PALPATION.	OCCURS MAINLY IN MEN OVER 60. THE DISEASE CAN BE DETECTED BY PALPATION AND URINALYSIS AT ANNUAL CHECKUP
STOMACH	17,000	16,000	INDIGESTION.	ANNUAL CHECKUP.	A 40% DECLINE IN MORTALITY IN 20 YEARS. FOR REASONS YET UNKNOWN
LEUKEMIA	19,000	15,000	LEUKEMIA IS A CANCER OF BLOOD-FORMING TISSUES AND IS CHARACTERIZED BY THE ABNORMAL PRODUCTION OF IMMATURE WHITE BLOOD CELLS. ACUTE LEUKEMIA STRIKES MAINLY CHILDREN AND IS TREATED BY DRUGS WHICH HAVE EXTENDED LIFE FROM A FEW MONTHS TO AS MUCH AS THREE YEARS. CHRONIC LEUKEMIA STRIKES USUALLY AFTER AGE 25 AND PROGRESSES LESS RAPIDLY		
			CANCER EXPERTS BELIEVE THAT IF DRUGS OR VACCINES ARE FOUND WHICH CAN CURE OR PREVENT ANY CANCERS THEY WILL BE SUCCESSFUL FIRST FOR LEUKEMIA AND THE LYMPHOMAS.		
LYMPHOMAS	23,000	18,000	THESE DISEASES ARISE IN THE LYMPH SYSTEM AND INCLUDE HODGKIN'S AND LYMPHOSARCOMA. SOME PATIENTS WITH LYMPHATIC CANCERS CAN LEAD NORMAL LIVES FOR MANY YEARS.		

CHART 6

Man's Progress Against Cancer

CATEGORY	1937	1970
Saved (alive five years after treatment)	Fewer than one-in-five	One-in-three
Uterine cancer	Chief cause of cancer death in women	Death rate cut more than 50%. Could be reduced much more.
Lung cancer	Mounting: no prospect of control	Still mounting: but upward of 75% could be prevented
Research support	Less than $1,000,000	More than $250,000,000
Cancer programs approved by American College of Surgeons	240 in U.S.A. and Canada	880 plus expansion of teaching, research, treatment centers
State control measures	Seven states	All 50 states
Chemotherapy	Almost no research	Major research attack has produced more than 25 useful drugs
One-in-two patients could be saved today by early diagnosis and prompt treatment		

Table 1

DEATHS FROM MALIGNANT NEOPLASMS BY SITE AND BY COUNTY OF RESIDENCE, OREGON, 1969

COUNTY OF RESIDENCE	TOTAL		PRIMARY SITE				
	Number	Rate 1/	Digestive Organs	Respiratory System	Breast & Genito-Urinary Organs	Lymphatic & Hematopoietic Tissues	Other & Unspecified
STATE	3,287	157.9	938	688	843	397	421
Baker	26	158.4	9	5	6	2	4
Benton	43	84.3	14	5	11	4	9
Clackamas	205	124.4	54	43	55	28	25
Clatsop	65	225.7	15	15	20	6	9
Columbia	51	169.2	9	14	15	4	9
Coos	88	153.8	28	19	13	11	17
Crook	11	113.1	2	4	4	-	1
Curry	16	121.4	3	6	6	1	-
Deschutes	50	171.1	12	13	13	7	5
Douglas	105	143.6	21	28	33	10	13
Gilliam	5	185.5	1	1	-	2	1
Grant	9	121.7	5	1	-	3	-
Harney	9	123.7	1	2	3	1	2
Hood River	27	191.1	6	7	11	-	3
Jackson	165	176.1	44	40	45	11	25
Jefferson	9	99.6	1	2	1	2	3
Josephine	62	172.3	22	13	15	7	5
Klamath	79	158.8	24	18	17	9	11
Lake	9	132.4	1	4	2	1	1
Lane	250	119.4	80	50	64	38	18
Lincoln	45	179.1	17	10	9	4	5
Linn	113	164.1	38	21	32	12	10
Malheur	23	92.4	9	3	5	5	1
Marion	233	149.7	59	40	57	49	28
Morrow	7	152.2	1	2	2	-	2
Multnomah	1,100	196.6	313	240	276	122	149
Polk	43	131.0	16	7	13	3	4
Sherman	2	84.4	1	1	-	-	-
Tillamook	25	140.0	13	3	4	3	2
Umatilla	84	185.1	23	13	27	8	13
Union	28	142.9	6	7	5	7	3
Wallowa	6	93.2	4	1	-	-	1
Wasco	32	148.4	13	7	8	3	1
Washington	186	129.8	51	31	45	26	33
Wheeler	9	478.7	1	1	5	-	2
Yamhill	67	163.3	21	11	21	8	6

1/ All rates per 100,000 population

Source: Oregon State Board of Health, 1969 Statistical Report, p. 89.

cancer detection centers; rehabilitation services for colostomy cancer patients through referrals to Ostomy Clubs; smoking and health programs for high school students. During the 1971-73 biennium, the Section will establish a new public education program on breast cancer detection, including teaching sessions on breast self-examination at high schools and colleges in Oregon.

The cancer projects of the Oregon Regional Medical Program concentrate primarily on continuing education. The Circuit Course for health professionals has devoted approximately one-third of its presentations to the general area of cancer. The Central Oregon Heart, Cancer, and Stroke Pilot Project in Bend provides in-service training to Central Oregon nurses who care for cancer patients. In addition, a grant request (Educational Opportunities for the Oregon Regional Physician in the Diagnosis and Therapy of Cancer) has been submitted to the National Advisory Council for funding. This project will provide an intensive one-month in-residence course on cancer for eight physicians each year. The philosophy of this program is to produce in the smaller medical communities of Oregon at least one physician who is knowledgeable in the sophisticated diagnostic and therapeutic methods of cancer management.

The University of Oregon Medical School has a School of Cytotechnology and also maintains a bone tumor registry.

Screening centers and mobile units provide early detection of lung cancer by chest X-rays. Planned Parenthood Association of Oregon, Inc., emphasizes breast self-examination and Pap tests for uterine cancer. Cobalt treatment is available in Medford, Eugene, Salem, and Portland.

American Cancer Society, Oregon Division, operates with and under the approval of the Oregon Medical Association and county medical societies.

National and local American Cancer Society grants are awarded Oregon researchers dedicated to finding a cure for cancer, better methods of treating the disease, and improved ways for prevention or detection of cancer. Research grants in Oregon during 1968-69 totaled $148,708 from the national organization and $103,283 from the Oregon Division. The University of Oregon Medical School has a special Grant-in-Aid of $300,000 over a ten-year period.

American Cancer Society provides materials on cancer (publications, films, exhibits, etc.) without charge to physicians, medical students, dentists, nurses, and members of allied professions. Special meetings, courses, fellowships, and scholarships to teach techniques for the early detection and management of cancer are offered; and speakers, exhibits, and other programming assistance are made available to professional societies.

In addition, the Cancer Society implements a continuous educational campaign on cancer's early warning signals and the importance of early cancer detection. Special efforts are made to reach population groups with high rates, such as low socio-economic groups, heavy smokers, etc.

The American Cancer Society assists patients in their physiological and and psychological rehabilitation. The program includes information and counseling service regarding existing facilities and services related to cancer within the community, provision of dressings and comfort items, loan of sick room equipment, and transportation to and from treatment centers. The Society attempts to assure the highest level of health care attainable for each patient, and to bridge the gap between public and private sectors. A pilot program, "Reach to Recovery" has been initiated for the rehabilitation of the mastectomy patient.

The American Cancer Society supports cancer registries and tumor clinics in approved hospitals and medical centers in Oregon. Grants are made to the Visiting Nurse Association of Portland, Visiting Nurse Service of Yamhill County, Family Counseling Service, New Voice Club of the Northwest, Portland Center for Hearing and Speech, Inc., and enterostomal therapy training for ostomies.

AUTHORITIES

To be researched.

OBJECTIVES

1. Encourage, foster, and conduct programs for the continuing education and training of physicians, dentists, nurses, technicians, and others as to all matters concerned with the detection, diagnosis, treatment, and prevention of cancer.

2. Encourage, foster, and conduct programs for the continuing education of the public concerning cancer, its symptoms and detection, so as to further the timely use of medically and scientifically recognized means for the detection, diagnosis, treatment, and prevention of cancer.

3. Improve the quality of cancer screening and treatment.

4. Expand research into the causes and treatment of cancer.

RECOMMENDATIONS AND METHODS

1. *INCREASE RESEARCH IN BASIC SCIENCES AND CLINICAL INVESTIGATION AND TREATMENT OF CANCER.*

Methods

a. *American Cancer Society, Oregon Division, and University of Oregon Medical School fund research projects investigating improved methods of diagnosing and treating cancer.*

b. *American Cancer Society, Oregon Division, and University of Oregon Medical School fund basic science investigations into the causes of cancer.*

2. *INTENSIFY PUBLIC EDUCATIONAL CAMPAIGN REGARDING THE DANGERS OF CIGARETTE SMOKING, EARLY WARNING SIGNALS, AND THE IMPORTANCE OF PROMPT DIAGNOSIS.*

Methods

a. *Oregon Medical Asssociation and American Cancer Society, Oregon Division, sponsor a program to encourage physicians to routinely inform patients during their physical examination of cancer's seven warning signals and methods of self-examination.*

b. *Oregon State Board of Health and American Cancer Society, Oregon Division, continue to emphasize campaigns in schools to prevent or reduce smoking. Traveling displays demonstrating the effects of smoking on the lungs, and other displays designed to visually educate should continue to be developed. Displays to be sent to all Oregon schools in an effort to reduce the number of youths who smoke.*

c. *Community Action Programs' health committees, with the assistance of the American Cancer Society, Oregon Division, organize educational programs directed at low-income groups.*

3. *PROVIDE FINANCIAL COUNSELING TO CANCER PATIENTS IN NEED.*

Method

Oregon State Board of Health provide, through local health departments, financial counseling to cancer patients in need.

4. *PHYSICIANS INCREASE THEIR EMPHASIS ON CANCER DETECTION.*

Method

Oregon Medical Association and American Cancer Society, Oregon Division, encourage physicians to routinely perform cancer detection activities in their offices and include a proctoscopic examination on persons over 45 during the physical examination.

5. *DEVELOP A PLAN FOR THE PLACEMENT OF SPECIALIZED CANCER TREATMENT EQUIPMENT.*

Method

Oregon Regional Medical Program develop a statewide plan for locating high intensity x-ray and radioisotope treatment facilities in major population centers of the state. Consideration should be given to the cost of the equipment, expected utilization, distance to already existing facilities, and available modes of rapid transportation to these existing facilities.

6. *IMPROVE THE TREATMENT OF CANCER IN HOSPITALS, EMPHASIZING THE QUALITY OF SURVIVAL AS WELL AS CURATIVE MEASURES.*

Method

Oregon Association of Hospitals encourage hospitals to upgrade their cancer programs so that by 1973 twice as many hospitals have cancer programs approved by the American College of Surgeons.

7. *RECRUIT AND TRAIN MORE MEDICAL AND RADIATION THERAPY TECHNICIANS TO WORK IN THE FIELD OF CANCER.*

Methods

a. *Oregon Regional Medical Program support a training program for radiation therapy technicians at the University of Oregon Medical School.*

b. *University of Oregon Medical School obtain funds to support the School of Cytotechnology.*

8. *EDUCATE PHYSICIANS REGARDING NEW AND IMPROVED METHODS OF CANCER DIAGNOSIS AND TREATMENT.*

Method

Oregon Regional Medical Program and American Cancer Society, Oregon Division, intensify education of physicians regarding diagnosis and treatment of cancer.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and material, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

1. Oregon State Board of Health determine increase in the average age of death due to cancer.

2. American Cancer Society, Oregon Division, determine from hospital cancer registries:

   a. Increase in cases with localized, as opposed to disseminated, cancer.

   b. Increase in five-year survival rates for various forms of cancer.

PRIORITY

To be determined.

CARDIOVASCULAR DISEASES

GOAL PREVENT PREMATURE DEATH AND DISABILITY DUE TO CARDIOVASCULAR DISEASES.

CONDITION

Cardiovascular diseases are those pertaining to the heart and blood vessels and include heart and cardiovascular diseases, hypertension, arteriosclerosis, other diseases involving the arteries, arterioles and capillaries, venous thrombos and embolisms, and congenital amomalies.

Mortality

Available statistical data from 1969 (Oregon State Board of Health) reflect that 54% (10,680) of all Oregon deaths were due to cardiovascular diseases as follows:

Heart Disease	7,349
Stroke (cerebrovascular)	2,407
Arteriosclerosis (Hardening of the Arteries)	454
Other forms of Cardiovascular Diseases	290
Hypertension	53
Diseases of the Veins	127

Morbidity

Cardiovascular disease attacks all age groups without regard to race, color, sex, economic, or social status.

Fifteen percent of Oregon's population (300,000) have some form of cardiovascular disease; 18% of all hospital beds, 50% of all nursing home beds, 14% of all physician visits, and 10% of all drugs are for cardiovascular disease patients.

Economics

There is an estimated loss of 1,200,000 mandays of productive work because of disability due to cardiovascular diseases in Oregon, resulting in an economic loss of 40 to 50 million dollars to business and industry. Premature deaths due to cardiovascular diseases account for an additional 417 million dollars loss in expected value of future earnings. The annual medical costs for treatment of cardiovascular diseases in Oregon run upward of 30 million dollars.

Medical Resources

There is at present both a shortage and a disproportionate geographic distribution of treatment facilities and professional and allied health personnel in Oregon required for an effective program of diagnosis and treatment of cardiovascular disease patients. Medical specialists such as cardiologists, cardiovascular surgeons, pediatric-cardiologists, neurologists, etc., and modern equipment and facilities are usually found in the metropolitan areas, where consultation with other specialists is available. In the more rural areas, even in the communities having a servicing family physician, the nature of his practice may preclude his keeping current in the cardiovascular disease field through attendance at conferences, seminars, workshops, and other continuing education opportunities offered by the medical school, the Oregon Heart Association, etc. The unequal distribution of facilities, services, and manpower is further complicated by inadequate referral systems. Even in the metropolitan areas, patients are sometimes deprived of available services because of gaps in the referral system.

There are a number of considerations other than those represented by the statistical data given above for mortality, morbidity, and economic costs. Two to six school children per 1,000 have congenital heart defects. Many of these remain undetected because of inadequate screening and diagnostic equipment. These patients involuntarily compensate for their disability until later in life when more severe demands are placed on their activity with often tragic consequences.

Other problems arise from a lack of public understanding of cardiovascular diseases. The label "heart patient" often interferes with securing employment, obtaining insurance, and assuming job and community responsibilities. Heart disease becomes an automatic discriminatory factor in employment, even though there may be no real physical limitation. Discriminatory actions by insurance companies, industry, and others are often the result of lack of generally accepted guidelines and standards, even among the members of the medical profession.

CURRENT PROGRAMS AND ACTIVITIES

Federal Programs

Oregon Regional Medical Program provides funding for: Training programs for nurses and physicians in Coronary Unit Management; mobile ambulance units for treatment of heart attack patients on way to hospital; telephone relay of EKG (Bend area); stroke detection and rehabilitation demonstrations; circuit courses for physicians, nurses, and allied health personnel; educational programs for diabetics; and educational programs for stroke patients.

Funds from the National Institutes of Health support cardiovascular disease research at University of Oregon's Medical School, Regional Primate Center, and the programs of the Chronic Disease Section, State Board of Health.

The Department of Labor provides funds to state and local programs for training of nurses, paramedical personnel, therapists, technicians, and aides. These professions are needed, if adequate services are to be provided for heart and stroke patients.

Children's Bureau primarily finances programs in health departments, medical schools, colleges, institutions, and other branches of government to promulgate programs and services that will increase health services to mothers and children. Direct service, health education, screening, health counseling, and studies are supported. Although very little is done specifically for the detection and prevention of cardiovascular disease at this time, there is great potential here in the eventual decrease of these diseases, brought about by better health habits, earlier detection, and periodic screening. Genetic counseling could well lower the congenital heart defect rate.

Social Security Administration, through Medicare and Medicaid, provide funds to Social Security recipients for medical services for limited aspects of cardiovascular disease. These two programs do not provide adequately for the large number of recipients with heart disease, stroke, hypertension, and arteriosclerosis who need services.

Through the Social Security Administration, heart and stroke patients receive counseling, job training and evaluation, and medical examination to help the patient return to a productive employment. There is also a section under the Division of Vocational Rehabilitation that aids in medical service to "totally disabled" workers who are on premature Social Security, if it will help return them to employability. Workers under 65 years of age can receive Division of Vocational Rehabilitation benefits, if rendered "totally disabled" by cardiovascular disease.

Funds are allocated to Workmen's Compensation to assist workers with cardiovascular disease in evaluation and determination of extent of disability and in determination of whether disease is job-associated.

The Department of Housing and Urban Development provides funds to designated corporate groups in target areas where there is need for housing for low income groups. Funds are available (if approved) for construction of medical service facilities in low cost housing developments.

An application is pending for such a request in the Portland area. Proposal is that elderly patients having cardiovascular disease experience difficulty reaching services already provided in the community.

Distances and transportation difficulties prohibit adequate use of needed facilities, if they are to keep in good health and prevent serious impairment.

U. S. Veterans' Administration provides counseling services, medical services, and hospital facilities for veterans.

State Programs

University of Oregon Medical School is involved in 28 research projects; medical services and treatment of cardiovascular patients through the Medical School clinics; and manpower training of physicians, nurses, and technicians.

The Crippled Children's Division of the Medical School conducts 5 research projects in this field and provides medical services to those aged 21 and under.

The Oregon State Board of Health has several programs relating to cardiovascular diseases: Maternal-Child Health Division provides education, counseling, services, and screening programs (for mothers and children); Public Health Laboratory conducts testing programs, evaluations, and disease organism in Rheumatic Fever; Chronic Disease Section conducts training programs in stroke rehabilitation, smoking education activities, demonstration programs, and nursing supervision; and the Health Education Section distributes visual aids and pamphlets in field of cardiovascular disease. In addition, nutritionists work with schools, health departments, and other groups with respect to foods, diet, and food preparation as related to cardiovascular diseases.

Public Welfare Division provides family counseling and referral; finances drugs and medications for cardiovascular patients; and financial aid to nursing homes where stroke and heart patients reside.

The Division of Vocational Rehabilitation provides job counseling to heart and stroke patients; job training for patients; and funds for services to severely disabled cardiovascular patients, if there services have a potential of returning patient to employability.

Workmen's Compensation Board conducts evaluations (medical) of heart and other cardiovascular diseases as related to employment or industrial accident claim and awards compensation to those eligible.

Colleges and Universities (Oregon State, University of Oregon, Reed, Portland State, University of Portland, Southern Oregon College) conduct research projects which are supported by the Oregon Heart Association, in medical and basic science, as related to cardiovascular disease; and provide training to nurses, health educators, technicians, etc.

The Oregon Regional Primate Center conducts research projects in cardiovascular disease.

Medical Examiners evaluate the practices and policy for licensing practice as it pertains to non-medical personnel in lieu of medical personnel (ambulance drivers in Mobile Coronary Units) and in the future will evaluate other paramedical job positions.

Hospitals and Nursing Homes

There are 87 general hospitals and 282 convalescent hospitals and nursing homes. Since 18% of all hospital beds and 50% of all nursing home beds are occupied by patients with cardiovascular disease, each of the 369 institutions is involved in care and treatment to some degree. The involvement, however, varies considerably. Nursing home care in Oregon for stroke and heart patients varies from those providing physician-nursing-therapist service to those that only provide minimal nursing care. Likewise, the hospitals with available coronary care unit equipment, trained nursing personnel, and available trained physician supervisory personnel varies from hospital to hospital. Hospitals in areas where the volume of heart patients is greatest have the most sophisticated programs.

Hospitals where special cardiovascular programs are in effect include:

1. Good Samaritan, Portland, projects in stroke, physicians' education, research in artery and vein grafts, heart surgery, coronary care unit education, valve research, stroke education for patients.

2. St. Vincents, Portland, telemetry research, catheterization, pace-maker research, screening technique research, coronary care unit, nursing education, heart surgery.

3. Emanuel, Portland, research in coronary care monitoring, stroke rehabilitation, extended care unit development, nursing education.

4. Providence, Portland, research in mobile unit operation for heart attack patients, lipoprotein research, catheterization, heart surgery, physician education, nursing education.

5. Salem Memorial, Salem, coronary care training program.

6. Sacred Heart, Eugene, coronary care training program.

7. Rogue Valley Memorial, Medford, mass screening techniques, diabetes patient education.

8. St. Charles, Bend, nursing education coordinator program, data telephone EKG consultation.

9. St. Anthony and Memorial, Pendleton, coronary care unit education.

Hospitals, hospital staffs, hospital equipment, and hospital services are more adequate for heart attack patients than stroke patients, especially as they relate to rehabilitation. Outside of metropolitan areas, there

is an inadequacy of special facilities and trained therapists for stroke rehabilitation.

The State Board of Health provides training personnel to Aides and LPN's in nursing homes for instruction in stroke rehabilitation therapy. The Oregon Heart Association provides teaching manuals, visual aids, and other teaching tools. Several nursing homes have exposed their staff to Cardio-Pulmonary Resuscitation training for use with heart attack patients. Many homes request educational literature on cardiovascular diseases for distribution to patients.

Physicians

Every doctor, irregardless of specialty, will have patients with cardiovascular disease. Because of this every physician needs a basic understanding of the care of such patients. Physicians in metropolitan areas (cardiologists, internists, specialists) avail themselves of teaching opportunities at the medical school, attendance at cardiovascular disease seminars, workshops, conferences, association with colleagues, greater number of patients, availability of more sophisticated equipment, specialty referral.

Oregon Regional Medical Program conducts a circuit course providing information on heart disease and stroke. Oregon Heart Association provides speakers on cardiovascular disease to meetings of county medical societies.

Physicians are also provided with teaching tools (manuals, visual aids, pamphlets) for instructing nurses and paramedical personnel. A "Physician-In-Residence" course is being conducted at hospitals in Portland for doctors from "rural" Oregon (Oregon Regional Medical Program and Oregon Heart Association). A "data" phone EKG monitoring project at Emanuel Hospital in Portland is being planned to involve "rural" doctors in smaller hospitals. They will be able to develop their ability to work with heart patients because of a better knowledge of electrocardiogram interpretation.

Ambulance Service

Special service for heart patients by ambulance is limited to two ambulance companies and a fire department in Portland. All are the result of Oregon Regional Medical Program and the Oregon Heart Association projects.

Three ambulances are equipped with telemetry equipment for defibrillation and monitoring. Nurses and trained ambulance attendants accompany the ambulances on calls where a known heart attack patient is involved.

Two ambulances are equipped with the same equipment mentioned above, but in addition, they have equipment to communicate directly with a station at Providence Hospital. The patient's EKG is monitored simultaneously in the ambulance and at the hospital. Attendants at the hospital instruct ambulance personnel in appropriate procedures.

Voluntary Health Agencies

Oregon Heart Association provides funds for research amounting to $195,000 to $225,000 annually to medical school, Oregon Regional Primate Center, five hospitals in Portland, and five colleges and universities in Oregon. All phases of cardiovascular disease are studied.

In addition, the Oregon Heart Association spends from $80,000 to $100,000 annually for professional and public education, including: programs in all aspects of cardiovascular disease for doctors, nurses, therapists, and paramedical personnel; workshops, meetings for general and specific groups of lay people; and pamphlets, booklets, manuals, films, and visual aids for professional and public education.

Other activities, costing approximately $43,000 annually, include demonstration projects concerned with rheumatic fever control; the cardiac patient in industry; the school child; heart sound screening of 4th grade students; lipoprotein studies in Corvallis school students; nutrition programs; and EKG testing of athletes.

Oregon Society for Crippled Children and Adults provides education - instruction to patients and family members of patients pertaining to stroke rehabilitation; loan of equipment - wheel chairs, walkers, etc. - to heart and stroke patients; rehabilitation therapy (physical) to stroke patients through its mobile unit; and campships for children (summer).

National Foundation (March of Dimes) is interested in congenital defects. Detection Clinic is operated in Portland, concerned mostly in orthopedic defects of children.

American Red Cross provides first aid training (mouth to mouth resuscitation), transportation for heart and stroke patients, and blood procurement for open-heart surgery.

Portland Center for Hearing and Speech provides speech therapy for aphasia patients resulting from strokes and training of speech therapists to treat aphasia patients.

Oregon Rehabilitation Institute provides physical and occupational therapy to stroke patients.

Oregon Nurses Association cooperates with Oregon Heart Association in sponsoring workshops on coronary care unit operation for nurses.

Oregon Pharmaceutical Association, in cooperation with Oregon Heart Association, Oregon State Board of Health, and Oregon Medical Association, sponsors the Oregon Rheumatic Fever Control Program. All administrative expenses for this program are paid by Oregon Heart Association. Patients purchase the low-cost medication. Laboratory analysis of throat swabs from physicians' offices is done by State Board of Health, Public Health Laboratory.

Oregon Hospital Association conducts training of paramedical personnel (Oregon Regional Medical Program funded), including cardio-pulmonary resuscitation for heart patients; encourages the development of hospital facilities and services.

Oregon Medical Research Foundation provides funds to support cardio-vascular research primarily at Medical School and Oregon Regional Primate Research Center.

Several businesses and industries in Oregon contribute funds, equipment, and educational activities in the field of cardiovascular diseases.

Numerous businesses (insurance companies, health service providers, and health manpower sources) are also vitally interested. They generally cover proportionate costs for payment of service fees for treatment only. There is a great lack of funding services of a prevention or screening nature, especially in heart disease and stroke. Expensive treatment might be averted, if early symptoms are treated and medication provided.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1975, reduce the incidence of congenital heart disease from an estimated 7 to 5 per 1,000 live births.

2. By 1975, reduce the heart attack death rate from 350.2 to 340.2 per 100,000 population.

3. By 1975, reduce the stroke death rate from 112.5 to 108.5 per 100,000 population.

4. By 1975, reduce the incidence of diseases of the arteries and veins from 21.2 to 18.5 per 100,000 population.

RECOMMENDATIONS AND METHODS

1. *ESTABLISH EFFECTIVE PUBLIC EDUCATION PROGRAMS TO INFORM POTENTIAL VICTIMS OF HEART DISEASE, HYPERTENSION, AND CARDIOVASCULAR ACCIDENTS OF THE PREVENTIVE MEASURES THEY MAY TAKE EARLY IN LIFE TO AVERT SERIOUS ILLNESS.*

   Methods

   a. *Oregon Heart Association, Oregon Medical Association, and Oregon State Board of Health develop educational material for varying age levels identifying living patterns and other*

known risk factors such as nutrition, genetic defects, smoking, physical activity, etc., that are most likely to result in heart attacks, congenital heart defects, pulmonary embolisms, and strokes in later life.

b. *Oregon Heart Association coordinate and implement the dissemination of the educational material to local communities through discussions and programs for community organizations, schools, and through all available mass media.*

c. *Oregon Medical Association, in cooperation with Oregon State Board of Health and Planned Parenthood Associations, encourage all women to seek proper prenatal care to reduce the incidence of congenital heart problems.*

d. *Oregon State Board of Health develop resources for providing adequate prenatal care to a greater proportion of the medically-indigent female population, especially those women with a history of repeated abortions, premature births, or exposure to viral infections.*

2. *COORDINATE THE PROGRAMS AND ACTIVITIES OF ALL PROVIDERS OF SERVICES, FACILITIES, MANPOWER, AND FUNDING IN THE FIELD OF CARDIOVASCULAR DISEASES IN A GIVEN GEOGRAPHIC AREA. COOPERATIVE PARTICIPATION SHOULD BE COMPLETE, KEEPING THE HEALTH AND WELFARE OF THE INDIVIDUAL TO BE SERVED FOREMOST IN MIND.*

Methods

a. *Areawide comprehensive health planning committees survey their regions to identify all agencies, facilities, and professional and voluntary organizations involved in the field of cardiovascular disease, examine the scope of their programs and activities, and determine omissions and duplications in service to specific target populations.*

b. *Representatives from each identified agency and organization work to establish a unified, community-wide system of services and programs for cardiovascular disease patients including referrals, treatment, equipment rentals, and transportation. All present practices of medicine and public health should be incorporated into this system to achieve a coordinated service for the region.*

3. *INCREASE ACCESSABILITY TO TREATMENT CENTERS FOR PERSONS SUFFERING FROM CARDIOVASCULAR DISEASES.*

Methods

a. *Oregon Regional Medical Program promote the establishment of adequate coronary care units located strategically throughout the state to provide comprehensive medical care for cardiovascular disease patients.*

b. *University of Oregon Medical School, Oregon Regional Medical Program, and Oregon Heart Association train competent professional and ancillary personnel in the use of modern equipment and the application of modern patient management techniques pertaining to heart attacks and strokes.*

c. *Oregon Association of Hospitals identify and assist selected regional hospitals in major population centers to establish multiphasic screening centers.*

4. *EXPAND REHABILITATION PROGRAMS AND FACILITIES FOR HEART ATTACK AND STROKE VICTIMS.*

Methods

a. *Develop a statewide plan for establishing rehabilitation facilities in strategic areas throughout the state.*[1]

b. *Develop rehabilitation programs for stroke and heart attack patients which are financially feasible for persons of various economic levels.*

c. *Oregon Heart Association, in cooperation with the Department of Labor, work to remove legal barriers and hiring practices that may foster prejudicial attitudes in employers against hypertensive individuals and persons who have experienced a heart attack or stroke.*

5. *EXPAND EPIDEMIOLOGICAL AND CLINICAL RESEARCH EFFORTS TO ESTABLISH CAUSE AND EFFECT RELATIONSHIPS IN CARDIOVASCULAR DISEASES.*

Methods

a. *Oregon Heart Association encourage University of Oregon Medical School, Oregon State University, University of Oregon, Regional Primate Center, and other appropriate institutions to submit research proposals and seek funding through private, State, and federal mechanisms for projects on cardiovascular disease and related conditions.*

b. *Oregon Heart Association, Oregon Medical Association, and Oregon Regional Medical Program accelerate the dissemination of research knowledge to private practitioners in all Oregon communities through increased circuit courses for physicians and other health personnel and periodic publication of research findings in the care and treatment of persons with cardiovascular diseases.*

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1. *A more complete description of methods to expand rehabilitation programs and facilities can be found in the Rehabilitation Section of the Plan.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Evaluation of services for cardiovascular patients in Oregon can be made through observed reductions, as measured by epidemiological and vital statistics data, in congenital heart disease, heart attacks, strokes, hypertension, and other diseases of the arteries and veins; and the establishment of a coordinated, community-based system of care for cardiovascular patients.

PRIORITY

To be determined.

CEREBRAL PALSY

GOAL PREVENT CEREBRAL PALSY AND INSURE EARLY DETECTION AND TREATMENT OF THE CEREBRAL PALSIED TO RESTORE THEM TO THE MAINSTREAM OF NORMAL LIVING.

CONDITION

Cerebral palsy is a crippling condition caused by damage to the motor control centers of the brain, characterized by loss or impairment of control over voluntary muscles. The lack of control may be in the arms, legs, tongue, speech mechanism, eyes, or other movements. Damage may also affect other things - the senses of sight, hearing, touch, learning ability, and psychological adjustment. A substantial percentage of cerebral palsied have mental retardation to some degree, ranging from slow learning to serious intellectual deficit.

Cerebral palsy is not actually a disease, hereditary or contagious; nor is it restricted to children. Anything that can kill or damage brain tissue can cause cerebral palsy. In adults it can result from severe head injury, stroke, or anything which disturbs the normal flow of oxygen to the brain. Before birth, interruption of the embryo's blood supply is the most common cause of damage. German measles (rubella), influenza, and chicken pox contracted by the mother; exposure to known substances; accidents; anemia; hemorrhage or metabolic disorders; and anoxia are some of the known causes. Many are unknown.

The two generally accepted groupings of cerebral palsied are the spastics - those who move stiffly, with difficulty or not at all; and athetoids - those who move too much, involuntarily and overenergetically. Less common and sometimes listed as subdivisions are tremor, ataxia, and atonia. The severity of cerebral palsy ranges from mild to extreme. The damage tends to be permanent with little or no chance for recovery. Almost without exception, it results in a reduced productive life for the individual affected.

No valid statistics are available on the mortality rate connected with cerebral palsy. While the very severely involved may have a shortened life expectancy, those who are less severely involved can look forward to a relatively long adult life. The disability, however, will be with them throughout their entire lives.

Based on the current state population in Oregon, we can estimate that there are in excess of 5,000 cerebral palsied individuals in the

state, with about 1,500 of these under the age of 21 years. Except for the normal migration of families of severely involved children to those communities which provide a wider range of services and the specific locations of the state institutions for the mentally retarded caring for the cerebral palsied, the distribution of these handicapped persons probably follows the normal population distribution. Due to the variety of causes, the condition is not confined to any particular geographic, ethnic, or economic group except, perhaps, that the lower economic groups may not have adequate prenatal care thus increasing the chances of a less-than-desired development.

The economic costs of cerebral palsy are large. Almost 70% of those affected are over 21 years of age, and have probably lived with the disability since birth. Depending on the extent of damage, special programs of care and education are necessary. Where any degree of disability exists, the costs of medical care and lost wage productivity during a life span have been estimated at $75,000 to $150,000 per individual. The general public (and unfortunately many professionals) does not have sufficient awareness or knowledge of cerebral palsy and its effect on the individual and his family.

Because cerebral palsy is a problem which begins generally in infancy and lasts throughout the entire life of the individual, the most critical need is for that range of services for the individual and his family which will enable him to live the most useful and productive life. This includes such things as adequate medical care, comprehensive rehabilitation services, adequate residential facilities in the community, sheltered employment and income maintenance, elimination of architectural barriers, maximum educational opportunities (including sound preschool programs), physical and occupational therapy, social and recreational opportunities, and information and referral services. Other service needs include better early diagnosis and identification, identification and care of "high-risk" mothers, and more emphasis on professional education.

CURRENT PROGRAMS AND ACTIVITIES

The following state-level agencies are currently serving the cerebral palsied to some degree, although few, with the exception of Crippled Children's Division, have made any effort to spell out a recognition of the special needs of the cerebral palsied:

Public Welfare Division, Board of Education (Special Education), Division of Vocational Rehabilitation, State Board of Health (Public Health Nursing), State Board of Health (Maternal and Child Health), Mental Health Division (Eastern Oregon Hospital and Training Center, Fairview Hospital and Training Center),

Oregon Society for Crippled Children and Adults (Easter Seal Society), Crippled Children's Division, and United Cerebral Palsy Association.

The Crippled Children's Division of the University of Oregon Medical School conducts a cerebral palsy clinic at the Medical Center and at other locations throughout the state. An interdisciplinary team is used consisting of the pediatrician, neurologist, orthopedist, orthodontist, dentist, social worker, physical therapist, occupational therapist, speech pathologist, audiologist, and psychologist. The Division serves a large percentage of children under 21 that it must other states, but a significant percentage still are unknown even to this Division.

Local services, both public and private, at the county or community level, show a great variation among areas throughout the state. Even Multnomah County, which has perhaps the greatest range of both public and private services available, is a long way from meeting the needs of its cerebral palsied residents.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1973, establish a system of case-finding to insure that all cerebral palsied persons are diagnosed and treated at the earliest possible age.

2. By 1973, identify high-risk groups and improve obstetrical and preventive services to reduce the incidence of cerebral palsy in Oregon.

3. Provide a coordinated array of services and facilities necessary to help the cerebral palsied achieve their maximum potential.

RECOMMENDATIONS AND METHODS

1. EXPAND PROFESSIONAL EDUCATION EFFORTS TO IDENTIFY AND PUBLICIZE THE PROBLEMS AND PREVENTIVE SERVICES RELATED TO CEREBRAL PALSY AND OTHER BRAIN DISFUNCTIONS.

   Method

   Oregon Medical Association and Regional Medical Program include cerebral palsy in the continuing education programs for health professionals.

2. *IDENTIFY HIGH-RISK MOTHERS AND NEWBORN INFANTS IN ORDER TO TAKE PREVENTIVE MEASURES TO MINIMIZE THE CHANCES OF BRAIN DAMAGE.*

Methods

a. *Areawide comprehensive health planning committees, in cooperation with local health departments and community medical personnel: 1) identify high-risk groups in the community, and 2) identify and publicize the preventive services available to them such as pre- and postnatal care clinics, genetic counseling, abortion, etc.*

b. *United Cerebral Palsy Association act as a referral agency for preventive and treatment services for the cerebral palsied.*

3. *DEFINE AND COORDINATE THE ACTIVITIES AND SERVICES OF THE PUBLIC AND PRIVATE AGENCIES CONCERNED WITH CEREBRAL PALSY.*

Methods

a. *United Cerebral Palsy Association survey all concerned agencies to define their current levels of operation, their legal and budgeting restrictions, their plans for the future, and their evaluations of unmet needs.*

b. *United Cerebral Palsy Association establish an inter-agency committee to explore and implement cooperative action among agencies concerned with cerebral palsy to provide a continuum of services for the cerebral palsied.*

4. *EXPAND TRAINING AND TREATMENT PROGRAMS FOR THE DISABLED.*

Methods

a. *United Cerebral Palsy Association encourage the Division of Vocational Rehabilitation to provide community-based vocational rehabilitation, vocational training, and/or sheltered employment including activity centers in those areas of the state with high concentrations of the disabled as determined through casefinding.*

b. *United Cerebral Palsy Association encourage the establishment of regional facilities for the cerebral palsied and other handicapped individuals as an alternative for those who cannot live with their families, but are not so disabled as to require institutional care.*

c. *United Cerebral Palsy Association encourage local school districts and other community organizations to establish life*

enrichment programs for the cerebral palsied, with suitable social and recreational activities for all ages focusing on learning to live with an optimum degree of independence.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

The United Cerebral Palsy Association evaluate programs for the cerebral palsied through a reduction in the incidence of cerebral palsy and expansion of preventive and treatment services for the cerebral palsied.

PRIORITY

To be determined.

CHRONIC BRONCHITIS AND EMPHYSEMA

GOAL PREVENT PREMATURE DEATH AND DISABILITY DUE TO CHRONIC OBSTRUCTIVE PULMONARY DISEASE.

CONDITION

Chronic bronchitis and emphysema are diseases of major importance throughout the United States. They are being reported with increasing frequency as a cause of death and disability. Death rates are doubling every five years. The prevalence with resulting hospitalization and disability make these diseases the most important chronic diseases of the respiratory system in this country, causing severe economic burdens to the individual and to the community. In 1966 alone, the Social Security Administration provided disability benefits to almost 19,000 people with chronic obstructive pulmonary disease under the age of 65 in the United States. (Statistics reflecting the number of discharges from Oregon general hospitals and Social Security disability benefits for Oregonians having chronic bronchitis and emphysema are not available.)

DEATHS FROM SELECTED RESPIRATORY CONDITIONS

	United States			Oregon		
Primary Cause of Death	# of Deaths 1961	1965	Average Annual % Change	# of Deaths 1962	1968	Average Annual % Change
Chronic Bronchitis	2,271	4,022	15	32	94	12
Emphysema	10,269	18,664	16	205	344	9
Total	12,540	22,686	16	237	438	11

It is generally accepted that cigarette smoking is a principle etiological factor with other forms of air pollution playing an important but undefined role. It has been established that genetic abnormalities also play a definite role in the development of chronic obstructive pulmonary disease.

There is no reliable method for the early detection of chronic obstructive pulmonary disease and considerable debate on its clinical management. Smoking cessation and control of respiratory infection are the most common therapeutic recommendations. The benefits of exercise and the

use of mechanical devices for management and rehabilitation are still being investigated. Effective prevention and early detection methods in clinical management and rehabilitation of chronic obstructive pulmonary disease can and must be implemented immediately to prevent continued destruction by chronic bronchitis and emphysema.

CURRENT PROGRAMS AND ACTIVITIES

Oregon Tuberculosis and Respiratory Disease Association - Portland has a current demonstration and research project dealing with the establishment of a research center to develop tools, techniques and referral systems for those people at risk of having and/or developing chronic bronchitis or emphysema. The program is supported entirely by Christmas Seal income, bequests, and grants.

The Emphysema Screening and Research Center of the Oregon Tuberculosis and Respiratory Disease Association is located in the Medical Arts Building, Portland. This Center is designed to screen between 10-12 thousand Oregonians per year for obstructive lung disease. Individual reports are provided to each person screened as well as to his physician. Specific attention is paid to the smoking habits of the participants; they are encouraged to quit smoking or not to start. In the area of research, the Center is investigating new techniques to discover early chronic obstructive pulmonary disease and provides educational services to physicians, nurses, technicians, and other medical support people. The current annual operating budget is $42,000. The program will be placed in mobile units to be made available to all Oregon industries and communities when adequate funds are available for capital investment and operation expenses.

Oregon Thoracic Society (Medical Section of the Oregon Tuberculosis and Respiratory Disease Association - Portland) conducts professional education programs alerting physicians to new techniques in detection, clinical management and rehabilitation of patients with chronic obstructive pulmonary disease. The Society provides travel funds for medical residents to attend scientific symposia related to respiratory diseases, as well as educational movies, medical abstracts, and text books, and conducts scientific meetings to promote knowledge about chronic obstructive pulmonary disease.

Oregon State Board of Health - Occupational Health Section conducts programs to investigate the working environment of certain selected industries where dust or chemical exposure is a known or suspected health hazard. Investigations will involve pulmonary function evaluations and nasal examinations on employees at risk. Histories and re-examinations will be correlated over a 5-year period to determine improvement or deterioration in the functional capacity of the lungs.

Oregon State Board of Health - Tuberculosis and Chest Diseases Section conducts scheduled clinical and chest film evaluation at 26 chest clinics in 24 Oregon counties. Medical consultation with the practicing physician, public health nurse consultation and chest x-ray equipment are also available in each county health department.

Oregon State Board of Health - Chronic Disease Section - Health educators provide classroom presentations and coordinate various educational activities designed to encourage non-smoking and smoking cessation.

Veterans' Administration Hospital - Portland[1] provides care and treatment of patients with chronic bronchitis and emphysema, as well as extensive research programs on exercise tolerance and exercise value in the clinical management of chronic obstructive pulmonary disease. This hospital has the most complete respiratory intensive care unit in the state; it is not only serving patients in the Veterans' Administration Hospital but is making bold contributions in the training of physicians, nurses, and other support people.

University of Oregon Medical School - Portland[2] - The Division of Chest Medicine at the Medical School provides an active service of disability and work evaluation for people with chronic obstructive pulmonary disease. They also operate the chest outpatient clinic at the University of Oregon Medical School and provide consultative support of those managing patients in the Multnomah County Hospital and Medical School hospitals.

Providence Hospital - Portland[3] provides a home rehabilitation program for patients with chronic obstructive pulmonary disease. This is a private service, available on physician referral, designed to develop a flexible patient care program. The program covers evaluation, consultation, treatment, re-evaluation, and follow-up.

Oregon Regional Medical Program conducts the Circuit Course Program of the University of Oregon Medical School presenting courses of 4 1/2 to 5 hours duration to physicians, nurses, and allied health professionals throughout the state of Oregon. Among the diseases that are discussed are those of chronic obstructive pulmonary disease. These courses include concepts in the advancement of treatment and care of these diseases promoting the team effort. Evaluation of the program is

1 & 2. Both the Veterans' Administration and the University of Oregon Medical School have important teaching functions which are not limited to medical students; also included are medical doctors, such as interns, residents, and those who return for post-graduate education. Nurses at all levels including intensive care specialists and inhalation therapists receive a major emphasis of the teaching activity.
3. Other private care units-general hospitals-have similar programs in operation. Providence is listed as being representative.

continual. The Oregon Regional Medical Program budget for chronic obstructive pulmonary disease is $10,000 per year.

The Public Welfare Division, State Accident Insurance Fund, and Division of Vocational Rehabilitation provide assistance.

AUTHORITIES

To be researched.

OBJECTIVES

1. Increase professional and public knowledge of chronic obstructive pulmonary disease.

2. Improve methods to identify those with early airway disease, and identify at an early stage those with chronic obstructive pulmonary disease.

3. Reduce the percentage of Oregonians who smoke.

4. Determine minimum respiratory health standards for at least ten occupations by 1973.

5. Reduce those job-related factors contributing to chronic obstructive pulmonary disease.

6. Provide adequate rehabilitative services for patients with chronic obstructive pulmonary disease.

RECOMMENDATIONS AND METHODS

1. *INTENSIFY EDUCATION PROGRAMS ON CHRONIC OBSTRUCTIVE PULMONARY DISEASE FOR PHYSICIANS, NURSES, PARAMEDICAL PERSONNEL AND THE COMMUNITY INCLUDING THE IMPORTANCE OF EARLY DETECTION, METHODS OF CLINICAL MANAGEMENT, REHABILITATION, CAUSES AND SUSPECTED CAUSES, AND THE HEALTH DANGER OF AIR POLLUTION.*

   Methods

   a. *Oregon Tuberculosis and Respiratory Disease Association and Oregon Regional Medical Program provide seminars on all phases of care for those with chronic obstructive pulmonary disease.*

   b. *Oregon Tuberculosis and Respiratory Disease Association provide speakers to scientific sessions of the Oregon Medical Association, Oregon Academy of General Practice, Occupational*

Medical Society, county medical societies, hospital staff meetings, nursing symposiums and allied technical meetings.

c. *Oregon Tuberculosis and Respiratory Disease Association provide scientific literature to physicians, nurses, and paramedical people.*

d. *Oregon Tuberculosis and Respiratory Disease Association and Oregon Regional Medical Program develop professional education programs for physicians, nurses, and other medical personnel regarding new concepts of detection, diagnosis, clinical management and rehabilitation of chronic obstructive pulmonary disease.*

e. *Oregon Tuberculosis and Respiratory Disease Association conduct intensive community education programs about chronic obstructive pulmonary diseases.*

f. *Oregon Tuberculosis and Respiratory Disease Association assist community air quality control efforts by demonstrating that air pollution damage can be measured.*

2. *EXPLORE NEW METHODS TO IDENTIFY INDIVIDUALS IN WHOM EARLY BRONCHITIS AND EMPHYSEMA IS PRESENT OR LIKELY TO DEVELOP AND ESTABLISH APPROPRIATE REFERRAL MECHANISMS.*

Methods

a. *Oregon Tuberculosis and Respiratory Disease Association utilize the normal measurements developed cooperatively by Oregon State University, Portland Veterans' Administration Hospital, and the Oregon Tuberculosis and Respiratory Disease Association to identify people with changes in their respiratory abilities.*

b. *Oregon Tuberculosis and Respiratory Disease Association investigate the physiological measurement technique of nitrogen washout and other methods of identifying early stages of disease.*

c. *Oregon Tuberculosis and Respiratory Disease Association operate a community screening center in Portland.*

d. *Oregon Tuberculosis and Respiratory Disease Association screen and develop histories on 10,000 persons per year and, when indicated, refer them to medical care.*

e. *Oregon Tuberculosis and Respiratory Disease Association take mobile emphysema screening detection equipment to*

industries where potential hazard exists and to all Oregon communities.

f. Oregon Tuberculosis and Respiratory Disease Association and Occupational Health Section of the Oregon State Board of Health encourage firms to include pre-employment and annual pulmonary function screening in their health programs.

3. *DEVELOP METHODS TO AID THOSE PERSONS WHO WISH TO QUIT SMOKING AND REINFORCE THOSE WHO HAVE QUIT SMOKING.*

4. *OCCUPATIONAL HEALTH SECTION OF THE OREGON STATE BOARD OF HEALTH ESTABLISH A BASELINE FOR THE PRESENT RESPIRATORY HEALTH STATUS OF TEN OCCUPATIONAL GROUPS AND, BY RE-EXAMINING THESE WORKERS PERIODICALLY FOR SEVERAL YEARS, DEVELOP RESPIRATORY HEALTH STANDARDS AND DETERMINE CHANGES IN MORBIDITY AND MORTALITY IN RELATION TO CONTROL GROUPS.*

5. *OFFER CONSULTATION TO THOSE INDUSTRIES WHERE EXPOSURE IS LIKELY TO CAUSE OR AGGRAVATE CHRONIC BRONCHITIS AND EMPHYSEMA.*

Methods

a. Oregon Tuberculosis and Respiratory Disease Association perform pulmonary function tests on various segments of the working population and make results available by phone to physicians.

b. Oregon Tuberculosis and Respiratory Disease Association perform follow-up measurements on as many workers as possible to measure decreases in pulmonary function to determine if a health hazard exists.

6. *EXPAND REHABILITATION PROGRAMS AND SERVICES FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE PATIENTS.*

Methods

a. University of Oregon Medical School establish a model chronic obstructive pulmonary disease rehabilitation unit.

b. Oregon Tuberculosis and Respiratory Disease Association promote the need for multi-disciplinary team effort in the clinical management of chronic obstructive pulmonary disease.

c. Oregon Tuberculosis and Respiratory Disease Association, in cooperation with Oregon State Board of Health, survey all hospitals in Oregon to determine the number of facilities, type of equipment and personnel available to diagnose, manage, and rehabilitate persons with chronic obstructive pulmonary disease.

OPERATIONAL PROBLEMS

There is a need for:

1. Funds to operate and expand the Emphysema Screening and Research Center and develop satellite programs.

2. A technique for early detection of chronic obstructive pulmonary disease i.e., nitrogen washout or Alpha$_1$ anti-trypsin.

3. Research with human sera to determine if deficiency of anti-trypsin is a cause of emphysema.

4. Education techniques to persuade high-risk people to be screened.

5. New concepts for smoking cessation activities.

6. Mobile unit to provide statewide screening for chronic obstructive pulmonary disease.

7. Increased research in the methods of rehabilitation in chronic obstructive pulmonary disease patients.

8. Accurate statistical facts representing morbidity/mortality, Social Security disability, general hospital admissions and discharges for the state of Oregon.

9. Pulmonary function equipment that will reduce operator importance and that will record data for recall with serial studies; results to be available to physicians by telephone.

10. Pulmonary function equipment that will reduce testing time permitting the testing of more people.

11. Rehabilitation programs for severely disabled cardiopulmonary patients.

12. Increased chest faculty and more fellowship opportunities at University of Oregon Medical School.

EVALUATION CRITERIA

1. Oregon Tuberculosis and Respiratory Disease Association to determine effectiveness of screening procedures to detect changes in the respiratory system at the small airway level (first 5-10% loss).

2. Oregon Tuberculosis and Respiratory Disease Association to determine the percentage of people found with abnormal screening results who subsequently went to their physicians.

3. Oregon Tuberculosis and Respiratory Disease Association to determine percentage of abnormal screening results confirmed by diagnosis.

4. Oregon Tuberculosis and Respiratory Disease Association and Occupational Health Section of the Oregon State Board of Health to determine the number of firms which received consultation on the potential hazards to the employee of their work environment and determine the number of firms which have improved or corrected the potential problems.

5. Occupational Health Section of the Oregon State Board of Health determine number of firms which include pre-employment and annual pulmonary function screening in their health programs.

6. Occupational Health Section of the Oregon State Board of Health identify studies which can be used as aids in determining health differences among diverse occupational groups.

PRIORITY

To be determined.

CYSTIC FIBROSIS

GOAL PREVENT AND CONTROL CYSTIC FIBROSIS.

CONDITION

Based on current population figures, it is estimated there are in excess of 600 children in the state of Oregon who have cystic fibrosis. Cystic Fibrosis is the most serious disease affecting children's lungs and digestive systems. The sweat glands of cystic fibrosis patients produce unusually salty sweat, while certain other glands function improperly, and an abnormal, thick gluey mucus is secreted. This mucus clogs the lungs, causing breathing difficulties and infections that may permanently damage the lungs. This mucus also interferes with digestion, preventing the flow of digestive enzymes into the digestive system.

Cystic fibrosis is hereditary and occurs in approximately one out of every thousand live births.

Prognosis varies with the severity of the disease in each individual child. As recently as a dozen years ago, most babies with cystic fibrosis died before reaching school age. Today, although 50% of cystic fibrosis victims still die before age ten, with early diagnosis and improved therapy, more are living into their teens and early twenties.

Current treatment methods consist of the daily administration of drugs (antibiotics, high potency vitamins and digestive enzymes); liquifying and dialating agents through aerosol inhalation; and physical therapy.

There is a great need for basic research into the causes of cystic fibrosis and investigations directed toward better treatment methods. Continuing education programs on cystic fibrosis for physicians, nurses, allied health personnel, and teachers represent another area in need of improvement. Greater public education about the disease is essential for support of the Foundation's programs.

CURRENT PROGRAMS AND ACTIVITIES

Primary resource for diagnosis and treatment of cystic fibrosis in Oregon is the research, patient care, and training center which is located at the University of Oregon Medical School and receives support from the National Cystic Fibrosis Research Foundation. Center

activities include research and training programs and a cystic fibrosis outpatient clinic. Currently about 200 patients are followed in the clinic. The University of Oregon Medical School's Crippled Children's Division finances the hospitalization, treatment, and care of Oregon children whose families are without sufficient funds. When necessary, the Division also provides medication and aerosol equipment for use by cystic fibrosis patients. Social service is provided by Crippled Children's Division to cystic fibrosis families in need of counseling, as is transportation and lodging when out-of-town families without necessary funds must come to the cystic fibrosis center.

Inpatient services are provided at the Medical School's Doernbecher Memorial Hospital for Children. During the period July 1, 1969 to June 30, 1970, 27 cystic fibrosis patients were hospitalized for a total of 551 days and 13 patients with related chronic lung diseases for 135 days making a total of 686 recorded hospital days. In cases when a cystic fibrosis patient is required to be hospitalized in his local community and funds are not available, the Crippled Children's Division assists with such hospitalization.

A research laboratory supported by a grant from the National Cystic Fibrosis Research Foundation is provided in Doernbecher Memorial Hospital by arrangement with the Medical School. Professional personnel in the cystic fibrosis center are on the faculty of the Medical School and have other responsibilities in non-cystic fibrosis programs.

The Oregon Cystic Fibrosis Chapter, founded in 1958, provides non-medical, parent counseling, and special teachers and public education programs. Since medicine costs for a cystic fibrosis patient can exceed $100 a month, the Chapter conducts negotiations for securing drugs at reduced rates. It also makes arrangements for securing necessary equipment for cystic fibrosis children. One of the primary resources for this has been Crippled Children's Division. In addition, the Oregon Cystic Fibrosis Chapter conducts a one-week summer camp for cystic fibrosis youngsters annually. The 1970 camp was attended by 30 cystic fibrosis children throughout the state.

Various fund raising activities are conducted throughout the year including a door-to-door drive. Of the non-exempt funds collected, 75% is sent to the National Cystic Fibrosis Research Foundation for research activities and redistribution in grants to the various cystic fibrosis centers as needed. Since the Center in Oregon was established it has received more than twice as much from National as it has contributed.

AUTHORITIES

Responsibility for operation of the National Cystic Fibrosis Research Foundation Center in Oregon is with the State System of Higher Education through the Medical School.

OBJECTIVES

1. Insure early identification and treatment of cystic fibrosis victims.

2. Achieve greater public awareness and understanding of cystic fibrosis and the problems related to it.

3. Intensify research efforts to determine the causes of cystic fibrosis.

RECOMMENDATIONS AND METHODS

1. *EXPAND COURSES ON THE DIAGNOSIS AND TREATMENT OF CYSTIC FIBROSIS AND OTHER RELATED DISEASES FOR ALL HEALTH PERSONNEL.*

   Method

   University of Oregon Medical School, Oregon Medical Association, and the Oregon Regional Medical Program establish continuing education courses in cystic fibrosis for physicians and other professional health personnel.

2. *ESTABLISH ADDITIONAL TREATMENT SERVICES FOR CYSTIC FIBROSIS IN MAJOR POPULATION AREAS.*

   Method

   Oregon Cystic Fibrosis Research Foundation, in cooperation with the Crippled Children's Division of the University of Oregon Medical School, encourage and support the establishment of cystic fibrosis diagnostic and treatment services as part of a regional center in Southern Oregon and, as population growth demands, in other areas of the state.

3. *EXPAND COMMUNITY EDUCATION PROGRAMS FOR CYSTIC FIBROSIS.*

   Method

   Oregon Cystic Fibrosis Research Foundation establish branch chapters in Southern, Northeastern, Central, and South Central Oregon and in the Salem-Albany area, Clackamas and Washington Counties to promote greater public understanding of cystic fibrosis and assist in acquiring funds.

4. *STIMULATE INTEREST IN RESEARCH RELATING TO CYSTIC FIBROSIS.*

Method

Oregon Cystic Fibrosis Research Foundation develop statewide conferences for physicians and scientists to explore areas of research in cystic fibrosis and related conditions. Genetic research and efforts to isolate a medication to control the disease should be stressed. Oregon Cystic Fibrosis Research Foundation request funds from the National Cystic Fibrosis Research Foundation to support and augment local research efforts.

OPERATIONAL PROBLEMS

The most serious problems are shortage of funds for research, patient care and education together with a lack of health professionals specially trained in the field of cystic fibrosis.

EVALUATION CRITERIA

Primary responsbility for evaluating progress related to medical care, research, and professional training objectives is with the Cystic Fibrosis Center, Director Dr. Robert Campbell.

The Board of Directors of the Oregon Cystic Fibrosis Chapter serves as the evaluating body for non-medical activities.

PRIORITY

To be determined.

DENTAL HEALTH

GOAL OBTAIN OPTIMUM DENTAL HEALTH FOR THE PEOPLE OF OREGON.

CONDITION

Only four states have a higher caries rate than Oregon. It is estimated that 98 out of every 100 adults have been affected by oral disease; this prevalence of disease has not been effectively changed in the past 25 years. Almost every child, before he reaches his 16th birthday, suffers from dental caries or other dental diseases. Gingivitis, or gum inflammation, affects 40% of children 6 to 18 years of age. Arthritis and other systemic diseases have resulted from oral infections in adults. About 27 out of every 100,000 adults are afflicted with cancer in or about the oral cavity.

Oral diseases also affect the mental and social well being of our population. Thousands of children and adults are psychologically and socially handicapped by maloccluded teeth and malformed jaws and faces, due to the results of oral diseases or developmental defects. Over 20% of school-age children suffer malocclusion defects.[1] One child out of every 988 is born crippled by cleft lip or cleft palate or both.

Dental Health by Age

Studies by the Dental Health Section of the Oregon State Board of Health indicate that dental problems (decayed, missing, or filled teeth) appear in from 70 to 99% of the children aged 6 to 16 examined.[2] This range is evident in various geographic areas and similar age groupings. Dental caries are more extensive and numerous in areas where the water supply is fluoride deficient. An example of the differences in average number of permanent decayed, missing, and filled (DMF) teeth by age is indicated in Table 1.

The Oregon Dental Service reports that by age two, 50% of children have decayed teeth; there is an average incidence of one new cavity per year in children ages 6 to 11 and 1-1/2 cavities per year in children ages 12 to 15. (Note that reference is made to caries only and not to periodontal and malocclusion problems.)

The Oregon Dental Service reports that, "Periodontal disease....affects three-fourths of adults by age 50. This disease begins early in life, and, if uncontrolled, will eventually result in loss of teeth. The

1. The American Council on Education, Survey of Dentistry, 1961, page 16.
2. Dental Problems of Portland School Children, August, 1964, Table 8.

accumulated effects of dental disease are demonstrated by the fact that 1% of persons between age 18 and 24 have lost all their teeth while almost 50% of persons aged 65 to 74 have lost all their teeth. It is well known by the dental profession that many people who require dentures could have saved their natural teeth with regular care and preventive measures initiated at an early age."

A 1960 to 1962 U.S. Public Health Service survey showed that "of the 32 permanent teeth of the average American adult, 20 were decayed, missing, and filled. Also, 18 out of every 100 adults had lost all of their teeth and an additional 9 had only a few left in one jaw only."[1]

Table 1

AVERAGE NUMBER OF DMF TEETH PER CHILD

Age	Portland School Children[2]	Oregon Data Baseline[3]
6	.6	.8
7	1.6	1.6
8	2.7	2.6
9	3.1	3.3
10	3.9	4.2
11	4.8	5.3
12	6.0	6.9
13	7.3	8.8
14	9.7	10.7
15	11.8	12.0
16	13.0	12.7

Fluoridation of Public Water Supplies

In Oregon, 75% of the population is served by public water supplies; of that population, only 20% have the advantage of natural or controlled fluoridation. The dental health, manpower, and economic aspects of fluoridation in deficient areas cannot be ignored.

Other positive effects can be noted; elderly residents of Lubbock and Bartlett, Texas, where there are high concentrations of natural fluorides, have been found to have harder bones than people in non-fluoridated areas. Other studies have indicated that residents in low-fluoride areas have more deafness than those in high-fluoride areas.

1. Data from the National Health Survey.
2. Dental Problems of Portland School Children, August, 1964, Table 10.
3. Summary of Studies of Continuous Residence Children in Oregon, by Oregon State Board of Health.

Records of the California Dental Service, which handles dental insurance benefits for over 12 million Californians, disclose that the cost of providing dental care to Head Start children in non-fluoridated Los Angeles is $48; in fluoridated San Francisco, the comparable cost is $26. A controlled study of fluoridation in Grand Rapids, Michigan, showed that the number of DMF permanent teeth had dropped from 14 to 7 for the average 16-year-old child 15 years after the water supply was fluoridated.

Oregon's relatively poor dental health, combined with its low fluoridation rate, will mean higher costs to the taxpayer and further manpower shortages when Title XIX (Medicaid) coverage is extended to cover all indigents, rather than just the categorically needy. Other factors contributing to poor dental health include: limited dental health education programs; lack of awareness by many segments of the population of the available preventive and treatment procedures offered by modern dentistry; and the relatively small number of people with dental insurance. The Oregon Dental Service estimates that there are only about 120,000 people (6% of the population) in Oregon with dental insurance.

Dental Health by Area

A comparison of the similarity of DMF rates of children residing in various fluoride-deficient areas is shown below:

Table 2

A Comparison of the Similarity of DMF Rates of Children Residing In Various Fluoride-Deficient Areas

AGE	Ashland	Grants Pass	Hillsboro	LaGrande	Lebanon	Portland
6	1.0	1.1	0.9	0.5	1.2	0.6
7	1.8	1.6	1.9	1.7	2.0	1.6
8	3.0	2.8	3.4	2.0	3.1	2.7
9	3.2	2.9	3.7	3.0	4.4	3.1
10	4.5	4.6	3.8	3.5	5.0	3.9
11	5.5	4.3	5.7	4.3	6.7	4.8
12	9.1	6.2	7.8	6.2	6.2	6.0
13	-	8.6	9.3	8.7	9.7	7.3
14	-	11.6	-	9.2	11.5	9.7
15	-	11.5	-	11.5	14.0	11.8
16	-	-	-	12.7	15.0	13.0

Table 3

Average Number of DMF Teeth of Children in Communities Having Fluoride-Bearing Water Supplies

AGE	Arlington	Hermiston
6	0.2	0.2
7	0.9	1.0
8	0.6	1.2
9	1.6	0.7
10	1.6	1.3
11	2.0	2.6
12	3.2	1.5
13	2.8	3.6

Source: Oregon State Board of Health, Dental Health Section

Table 4

Comparison of Dental Caries, Average Number of DMF Teeth of Children Before and After Fluoridation

	Astoria		Salem	Salem Heights
AGE	Before	After 7 Years	Before	After 12 Years
6	.92	.20	.42	.04
7	1.56	.90	1.20	.54
8	2.76	1.63	1.57	.53
9	3.88	2.82	2.04	1.59
10	5.57	2.82	2.93	1.61
11	5.58	4.30	4.27	3.00
12	7.62	5.82	5.15	3.76
13	10.85	7.40	7.13	3.54
14	12.73	9.20	8.61	4.93

Source: Oregon State Board of Health, Dental Health Section

Preliminary information from the Head Start dental health programs shows that the average child received over four extractions or restorations. The following table does not reflect needs of these children, only the services received. Such services were in some cases dependent upon funds applied for and received.

Table 5

Average Number of Extractions, Restorations, and Crowns and Average Cost per Child

Summer Programs	Average No. of Restorations & Steel Crowns Per Child	Average Cost Per Child
Baker	3.7	$ 30.46
Clackamas	4.9	62.01
Oregon City	3.9	60.53
Molalla	7.5	77.25
Sandy	2.4	33.78
Milwaukie	5.6	72.40
Clatsop	4.6	75.71
Columbia	N/A[2]	63.24
Coos	3.8	54.14
Douglas	1.6	28.01
Lane	4.9	69.81
Marion-Polk	4.9	62.45
Dallas	4.0	53.63
Mt. Angel	6.3	97.27
North Marion	1.8	31.40
Silverton	3.6	40.27
Stayton	6.5	61.38
Woodburn	5.9	74.60
Salem	6.4	82.64
Umatilla	1.3	24.47
Hermiston	2.6	28.54
Pendleton	1.8	19.22
Milton-Freewater	0.4	25.00
Wasco	N/A	18.00
Washington	6.7	39.42
Yamhill	3.7	55.00
All Centers	3.8	54.92
Year-long Programs		
Jackson	4.5	53.03
Medford	3.6	46.43
White City	5.5	69.98
Ashland	4.5	43.10
Warm Springs Indian Reservation	0.9	N/A
Portland	4.9	73.78
Salem	6.2	74.49
All Centers	4.5	66.45

1. Dental Problems Among Children Enrolled in the Head Start Program
2. N/A = Not Available.

Socio-Economic Influences

Studies have shown that there is a definite incidence rate of dental caries for children residing in non-fluoride areas and a definite but different incidence rate for those residing in a fluoridated area.[1] However, in both areas the levels of care may vary dependent upon socio-economic factors. National statistics indicate that the relationship between dental problems and socio-economic status is valid for other age groups.[2] Assuming that there were no socio-economic influences, that all newly decayed teeth could be restored on an annual basis, and using present rates of decay and estimated (minimum) costs, the total amount of money needed to be expended annually for Oregon children can be estimated.

In Oregon, there are 567,632 children who live in non-fluoridated areas;[3] the 319,425 who are between 2-11 years will have approximately one new decayed tooth each year. The remaining 248,207 children aged 12-18 years will have 1.5 new decayed teeth each year. Using these figures and an average cost of $11.28 per silver amalgam filling,[4] the annual cost of restoring the newly decayed teeth would be $7,802,770 or $13.72 per child.

In the fluoridated areas of the state there are 116,263 children. The 65,425 children in the 2-11 age group will each have 0.5 new carious teeth per year. The 50,838 children in the 12-18 age group will each have 0.6 new decayed teeth per year. Using the same cost factor ($11.28) per carious tooth, the annual cost would be $770,412 or $6.63 per child.

If all 683,895 Oregon children aged 2-18 years[5] had the same benefits of fluorides and using the latter cost factor of $6.63, the total cost for newly decayed teeth would be $3,763,400 instead of $7,802,770 - a saving of over $4 million annually. A greater cost benefit than noted above can be expected as the cost per tooth restored in fluoridated areas is markedly less as there are fewer surfaces per tooth affected.

Approximately 70% of Oregon children have experienced caries by the time they start to school,[6] and 99% by the time they reach high school. Based on the Portland study,[7] if the same incidence of dental caries applies with reasonable accuracy to all children in fluoride-deficient areas, the percent of permanent and primary teeth with caries would be as shown in Table 6.

1. Studies of Dental Health Section, State Board of Health, of Ainsworth, 1964 and Riverdale Schools, 1968, and Census Tracts 2 and 3, Washington County.
2. Health Statistics, U.S. National Health Survey, Dental Care Volume Series B, #15, April, 1960.
3. 83% of the population is not on fluoridated water.
4. Oregon Dental Service reports that a study of approximately 3,500 claims in a recent (1970) 2-month period showed an average cost of $11.28 per restoration.
5. Statistical Report, Oregon State Board of Health and Population Estimates.
6. Dental Problems of Portland School Children, August 1964, Table 8.
7. Dental Problems of Portland School Children, August 1964.

Table 6[1]

Age	Percent of Carious Teeth
5	21.0
6	18.8
7	23.3
8	33.8
9	31.7
10	30.1
11	20.0
12	21.4
13	26.1
14	34.6
15	42.1
16	46.4
17	47.1

Dental Manpower

On January 1, 1970, there were 1,400 dentists in Oregon. Based on a 1965 survey of the dental profession in Oregon, tabulated by the American Association of Dental Examiners, approximately 94% of all dentists located in the state were active in their profession. As we believe this ratio is still valid, there are now about 1,316 active dentists in Oregon or approximately one dentist for every 1,558 people, as compared with a national ratio of one dentist for every 2,248 people.

Dentists are unevenly distributed among the population. In 1968, the four-county Portland Metropolitan area (State Administrative District 2) had 53% of the state's dentists and 43% of the population. Conversely, the remaining state administrative districts (32 counties) had only 47% of the dentists with 57% of the population.

The 1965 Dental Profession Survey showed that almost 95% of the professionally active dentists were primarily in private practice. Of the remaining active dentists, about one-half were on the staff at the University of Oregon Dental School. One in every ten practitioners limits his practice to a dental specialty, primarily orthodontics or oral surgery. Almost one-half of the self-employed practitioners devote at least 48 weeks of the year to their practice and work 40 hours or more a week.

1. Dental Problems of Portland School Children, August, 1964, Table 13.

Seventy-three percent of the practicing dentists employ dental hygienists and/or assistants; utilization varied according to the age of the dentist and was most frequent among dentists between the ages of 35 and 54 (80% of which employ at least one auxiliary). Almost 70% of all the practitioners employ dental assistants, usually on a full-time basis. Dental hygienists on the other hand, are employed by only about 15% of the practicing dentists, usually on a part-time basis.

Although Oregon has one of the highest ratios of dentists to population, the present facilities and available dental manpower are inadequate to meet even current needs (it has been estimated that over 70% of Oregonians are in need of dental care). Furthermore, Oregon's population is expanding due to natural increase and immigration at a rate of 2% a year.

Although an unmet need for dental service exists, there are very few areas where present dentists are encouraging new men to locate. The primary causes of the existing need are the public's inability to pay for care and their consideration of dental care as a low-priority item.

As public funds are made available for dental care, an increasing shortage of dental manpower and a need for greater utilization of dental auxiliaries will develop.

CURRENT PROGRAMS AND ACTIVITIES

Dental Clinics

There are 18 dental clinics in the state treating low-income patients. Generally, they are staffed by volunteer and/or paid dentists.

District 2
- Buckman Dental Clinic, Portland
- Clackamas County Children's Dental Clinic, Oregon City
- Creston Dental Clinic, Portland
- Dental School Clinic, Portland
- Maternal-Infant Care Project Dental Clinic, Portland
- Portland Community College Dental Clinic, Portland
- Washington County Children's Dental Clinic, Beaverton

District 3
- Children's Community Dental Clinic, Salem
- Community Dental Center, Dallas

District 5
- Cottage Grove Hospital, Cottage Grove
- Elks Dental Clinic, Eugene
- Lane Community College, Eugene

District 7
- Lions Dental Clinic, Coos Bay

District 8
- Kiwanis Indigent Child Dental Clinic, Grants Pass
- Rogue Valley Memorial Hospital, Medford

District 10
- Junior Chamber of Commerce, Bend

District 11
- Oregon Technical Institute, Klamath Falls

The Dental Health Section of the Oregon State Board of Health provides consultant assistance and services in dental health education, prevention and dental care programs, studies, and activities.

Accredited Dental Education Programs

Dentistry

University of Oregon Dental School, Portland

Dental Hygiene

Lane Community College, Eugene
University of Oregon Dental School, Portland

Dental Assisting

Blue Mountain Community College, Pendleton
Lane Community College, Eugene
Oregon Technical Institute, Klamath Falls
Portland Community College, Portland
Chemeketa Community College, Salem

Dental Laboratory Technology

Portland Community College, Portland

The Board of Dental Examiners examines and licenses dentists and dental hygienists, and supervises the work of auxiliary personnel.

Local Health Departments provide clinic care in some areas (see Dental Clinics above). Public health nurses are involved in educational programs in schools and homes and provide screening and referral services to dental clinics and offices.

The State Board of Education provides information on dental and oral diseases to school boards and teachers.

The Women's Auxiliary of the Oregon Dental Society provides assistance in dental health education programs.

AUTHORITIES

Dental Health Program, Oregon State Board of Health - Statute
Local Boards of Health - Statute
Board of Dental Examiners - Statute
Dental School, University of Oregon - Statute
Community Colleges - Statute

OBJECTIVES

1. By 1975, expand fluoridation to include 90% of the population served by public water supplies.

2. By 1975, expand preventive dental health programs to reach all school-age Oregonians.

3. By 1977, provide dental care for all dentally indigent Oregon school-age children.

4. Provide dental health education programs for adults and children.

RECOMMENDATIONS AND METHODS

1. *OBTAIN LEGISLATION REQUIRING, PUBLIC EDUCATION EXPLAINING, AND ADMINISTRATIVE DIRECTION AND PROFESSIONAL ADVICE ENCOURAGING FLUORIDATION.*

   Methods

   a. *Governor's Comprehensive Health Planning Committee submit legislation requiring fluoridation of deficient public water supplies.*

   b. *City officials, through the League of Oregon Cities, and other public officials support fluoridation legislation.*

   c. *State Public Welfare Division actively support fluoridation and dental health education.*

   d. *Dental professionals continue to encourage people on private water systems and those not served by fluoridated water systems to use topical and prescribed fluorides.*

   e. *Pediatricians, family physicians, and dentists prescribe fluorides and topical applications and encourage the use of fluoridated drinking water by very young children.*

   f. *Oregon Board of Education and State Board of Health educate students and teachers to the advantages of fluoridation and encourage and assist schools not served by public water supplies to install their own fluoridation systems.*

   g. *Head Start Dental Services counsel parents regarding the advantages of fluoridation.*

   h. *Dental professionals educate the public through speeches and other means.*

2. *INCREASE PREVENTIVE DENTAL HEALTH PROGRAMS FOR ALL AGES.*

Methods

a. *Public assistance program, Community Action Program (CAP) agencies, and other community programs for low-income groups provide dental health education and prescribed fluorides and topical applications to children.*

b. *Oregon State Board of Health Dental Health Section, in cooperation with the Oregon Dental Association, increase education and examination of pre-school and school-age children; and hold programs in self-application of topical fluorides.*

c. *Cooperative Extension Service provide increased education regarding the dental health aspects of nutrition.*

d. *Oregon Dental Association provide informational public relations through newspapers, periodicals, radio, TV, etc. In addition, there should be a program working through the Parent Teachers Association for parents of school children which would include encouragement to give greater priority to dental care.*

e. *Care facilities such as state institutions, nursing homes, homes for the aged, etc., establish or expand their preventive dental health programs.*

3. *IMPROVE THE DENTAL HEALTH CARE DELIVERY SYSTEM THROUGH CONTINUING EDUCATION, GREATER USE OF DENTAL AUXILIARIES, AND MORE DENTAL HEALTH SERVICES FOR THE POOR.*

Methods

a. *Dental and allied professions make greater use of continuing education programs offered by the Dental School and study clubs.*

b. *Dental professions make greater use of latest techniques and accepted procedures.*

c. *Dentists make greater use of dental auxiliaries for those procedures not requiring the expertise of licensed dentists pursuant to rules and regulations of the Oregon State Board of Dental Examiners.*

d. *Communities assist existing clinic programs to extend their service areas, upgrade their facilities and equipment, improve their scheduling, and obtain necessary additional personnel.*

Areawide comprehensive health planning committees to request additional funds necessary from the counties involved.

e. *Oregon State Board of Health allocate more funds for expansion of dental clinic operations, develop referral programs and materials for programs in self-application of topical fluorides.*

f. *Public Welfare assist in the funding of dental clinics.*

g. *Public Welfare request additional funds to provide broader dental care services to the needy.*

h. *Oregon Dental Service increase percent of population with insured dental care.*

i. *State Board of Dental Examiners explore possibility of expanding the scope and responsibility of trained dental auxiliaries.*

4. *EXPAND ACCREDITED PROGRAMS AND INCREASE THE PRODUCTION OF DENTISTS AND DENTAL AUXILIARY PERSONNEL.*

Method

See Health Manpower Section of the Plan.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

1. Dental Health Section of the Oregon State Board of Health, in cooperation with the Oregon Dental Association and others, to provide periodic evaluations:

Prevalence of Oral and Associated Diseases and/or Conditions

a. Caries prevention and control.

1) Percentage of people served by fluoridated public water supplies.

2) Number of schools and children (not on a public water supply) that are served by a school fluoridation program.

3) Status of school children involved in other fluoride programs, i.e., topical self-applied, fluoride mouth-rinse, and prescribed fluorides.

b. Interceptive orthodontic procedures and correction of other handicapping oral conditions.

c. Oral cancer detection.

d. Preventive periodontia.

e. Primary prevention of rheumatic fever.

Services

a. Evaluate the dental services as they meet the community's needs:

1) Dental indigent
2) Public assistance recipients
3) Chronically ill
4) Aged
5) Migrants
6) Mentally retarded
7) Handicapped
8) Maternal high-risk group

b. Evaluation of community and/or county dental health program:

1) Level of dental care services
2) Educational program activities
3) Coverage of preventive programs

c. Evaluation of public's attitudes toward dental health and dental care services.

Dental Manpower

a. Distribution

b. Utilization of ancillary personnel

c. Training program needs

PRIORITY

To be determined.

DIABETES MELLITUS

GOAL THE REDUCTION OF MORBIDITY AND MORTALITY RESULTING FROM DIABETES.

CONDITION

Diabetes mellitus is a complicated disease related to the metabolic process and occurs when the pancreas secretes an insufficient amount of insulin. Symptoms are an excessive thirst or appetite, frequent urination, general weakness, itching of the skin, drowsiness, and difficulty in focusing the eyes. The obese, the elderly, and females are especially susceptible. Heredity and obesity are contributing factors.

With proper guidance, diet, and treatment with insulin and other drugs, control can be good to excellent; however, once diabetes is present it is a lifetime problem and may lead to complications including arteriosclerosis, neuropathy, nephropathy, and retinopathy.

It has been estimated that 40% of diabetes are unknown and that 40,000 Oregonians are afflicted. The United States ranks first among the nations in reported cases. Diabetes mellitus was the eighth ranking cause of death in Oregon in 1969 and was the primary cause of 310 deaths with an average age at death of 72 years.

Available statistics[1] indicate that Oregon's mortality rate compares favorably with the national rate as seen on the table below.

	Oregon		United States	
	Mortality		Mortality	
Year	Number	Rate	Number	Rate
1965	270	13.7	33,174	17.1
1966	279	14.0	34,597	17.7
1967	255	12.7	35,049	17.7
1969	310	14.9		

There is a correlation between proper diet control and the management of diabetes. Most early cases of diabetes can be controlled by diet alone. In 1967, a survey of the Diabetes and Arthritis Control Program

1. Oregon State Board of Health, Vital Statistics Report, 1969; Statistical Abstract of the United States, 1968, 1969.

of the United States Public Health Service was conducted by the National Center for Health Statistics to study diabetes. The major problem identified was "the patient does not possess a basic knowledge of dietary principles or motivation to follow a diet." The patient must understand why he needs insulin, why he needs to take care of his feet, and why he needs to be cognizant of abnormal signs and symptoms if he is to avoid complications. Such knowledge coupled with better medical management of the disease can lead to decreasing frequency and severity of complications and resultant preventable hospitalization.

CURRENT PROGRAMS AND ACTIVITIES

Oregon Regional Medical Program funds projects related to diabetes:

Mid-Willamette Valley Diabetic Patient Training Project - Salem

Training Programs for Medical and Paramedical Personnel to Promote Better Care of the Diabetic Patient - Portland (provides 6 programs per year at Good Samaritan Hospital)

Southern Oregon Diabetic Instruction and Evaluation Project - Medford

Oregon State Board of Health, Chronic Disease Section provides diabetes mellitus assistance and advice, assistance on diabetic screening programs and surveys, nurse education, and patient education.

Local health departments assist in diabetic screening programs.

Voluntary Services

Oregon Diabetes Center, Good Samaritan Hospital, has been in continuous operation since 1934.

Gales Creek Camp, Glenwood, Oregon, a diabetic children's camp established in 1952, is operated by the Diabetic Children's Camp Foundation, c/o Trust Department, United States National Bank of Portland. It is located on a 36-acre site and serves boys and girls ages 7 through 16 years. Scholarships are available for those unable to pay. Camp physician and nurses supervise and care for all children. Over 100 children from Oregon, Washington, Montana, Idaho, and Northern California are enrolled each year.

Oregon Medical Association and county medical societies assist in diabetic screening programs.

AUTHORITIES

To be researched.

OBJECTIVES

1. By 1973, reduce the diabetes death rate to less than 14/100,000 population and attain a minimum average age at death of 73 years.

2. By 1975, reduce diabetes morbidity by 10%.

RECOMMENDATIONS AND METHODS

1. *PROMOTE PROGRAMS FOR THE EARLY DETECTION OF DIABETES.*

   Methods

   a. *Local public health offices, in cooperation with the Oregon Medical Association and local medical societies, provide diabetes screening clinics to employers, citizen groups, and individuals. (Oregon State Board of Health has established procedures and standards for screening 40,000 people per year concentrating on high-risk groups such as: 1) over age 40, 2) overweight, 3) blood relatives of diabetics, and 4) mothers of babies over nine pounds at birth.*

   b. *University of Oregon Medical School sponsor research to find an inexpensive fast test for diabetes (as an improvement over the glucose challenge blood test).*

2. *EDUCATE DIAGNOSED DIABETICS AND FAMILY MEMBERS REGARDING THE DISEASE, ITS CONTROL AND PREVENTION OF COMPLICATIONS.*

   Methods

   a. *Oregon State Board of Health, in cooperation with selected hospitals, establish diabetic education courses on a continuing basis in five regional centers.*

   b. *Local public health offices provide detection programs and surveillance through diabetes clinics, educating patients and their families about proper disease management, the use of prescribed diets, the techniques of urine tests for glucose and ketones, and insulin use.*

   c. *Cooperative Extension Service, with assistance from Oregon Diabetes Association and Oregon State Board of Health, provide educational programs regarding proper diabetic diets, adaptation of special diets to dovetail with family eating patterns, meal planning to make the diet more interesting, and food preparation.*

   d. *Gales Creek Camp expand its camping program for diabetic children.*

3. *EDUCATE THE PUBLIC ABOUT THE DANGERS AND PREVENTION OF DIABETES.*

Methods

a. *Oregon State Board of Health expand its genetic counseling service.*

b. *Oregon State Board of Health and Cooperative Extension Service prepare materials regarding the prevention and dangers of diabetes, proper dietary practices, and specific emphasis on the strong relationship between diabetes mellitus and obesity; these materials to be disseminated by television, radio, newspapers, and agencies which conduct nutritional education programs.*

4. *ASSURE ADEQUATE TRAINING FOR HEALTH PROFESSIONALS ON THE TREATMENT OF DIABETES.*

Method

University of Oregon Medical School, Oregon Regional Medical Program, Oregon State Board of Health, and community colleges improve education of medical and allied health students and post-graduate training of professionals in diabetes.

5. *ASSIST ELDERLY DIABETICS, PARTICULARLY SINGLE PERSONS, TO OBTAIN PROPER FOODS TO MAINTAIN DIETARY CONTROL OF THEIR CONDITION.*

Methods

a. *Local health offices, in cooperation with medical societies, dieticians and service organizations, establish hot lunch programs for diabetic and other elderly persons.*

b. *Oregon State Board of Health investigate the possibilities of furnishing freeze-dried, dietetically acceptable foods through personal deliveries or mail for diabetic and other elderly persons.*

6. *REACTIVATE THE OREGON DIABETES ASSOCIATION BY 1973.*

Method

Oregon Medical Association, encourage the reactivation of the Oregon Diabetes Association.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages

of manpower, money and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Oregon State Board of Health to: 1) determine diabetes mellitus death rate and average age of death, 2) determine numbers and/or percentage of people served by screening programs, diabetic clinics, and informational programs, and 3) estimate trend of diabetes morbidity.

PRIORITY

To be determined.

EPILEPSY

GOAL PREVENT EPILEPSY AND ASSURE DIAGNOSIS, TREATMENT, AND REHABILITATION FOR ALL WHO HAVE CONVULSIVE DISORDERS.

CONDITION

Epilepsy affects an estimated 2% of the population, and totals more than cancer, tuberculosis, cerebral palsy, muscular dystrophy and multiple sclerosis combined. In Oregon, there are over 40,000 epileptics.

The cost of care for epilepsy is the highest of all the neurological disorders. The Surgeon General's Advisory Committee on the Epilepsies has estimated the annual cost of the nation to be $1 billion....including state and local welfare payments. Oregon's share of this cost, on a population basis would be $10,000,000 per year.

Epilepsy is not a disease; it is a symptom only. "Epileptic attacks" may be present in many different medical conditions ranging from earlier brain injury and strokes, to infection and deranged chemical functions. These conditions are known as convulsive disorders, (the term "convulsive" or "convulsion" being used interchangeable with "epileptic," "seizure," "spell," etc.). However termed, the epileptic attack consists of involuntary and unpredictable electrical discharge of some or all of the normal functions of the brain, resulting in temporary alteration or cessation of brain activity. Depending on which part of the brain's function is disturbed, the seizure results in a variety of symptoms: movements of parts of the body, sensation, altered behavior, and generally, partial to complete loss of consciousness. In the vast majority of affected individuals, there is no other abnormality or deficiency of brain function. Epilepsy in individuals under the age of 20 usually is the after-effect of birth or childhood injury to the nervous system or from other illness. Heredity plays virtually no role. The onset of seizures in adults more often accompanies diseases such as stroke, diabetes, heart disease, etc., or occur as a result of accidental brain injury. If the attacks become chronic, despite treatment of the originating cause, then epilepsy is present.

The trend of the incidence of epilepsy is not clear at this time. Insofar as more infants survive, as the lifespan of adults increases, and as military, automobile and industrial head injuries increase, the overall incidence of epilepsy can be expected to show some upward trend. It is also suspected that drug abuse (particularly relative to the hallucinogens) may lead to the development of epilepsy in some patients. Among neurological disorders epilepsy is the lowest cause of death (about 1%).

The detection and treatment of underlying disease, as well as the treatment of continuing epileptic attacks, requires a high degree of medical

sophistication. Physicians trained in neurological medicine and the highly technical diagnostic tests are not easily available in most localities.

In ideal situations, epilepsy responds well to treatment. Removal or elimination of identifiable physical causes (tumors, blood clots, abnormal body chemistry, etc.) can effect complete recovery. More commonly, treatment is based on utilization of anti-convulsant medication. An estimated 60% of patients receiving specific individualized care may expect to have their seizures completely controlled. Another 25% can expect satisfactory reduction in the frequency and severity of seizures. The remaining 15% can obtain no significant relief with treatment currently available. These persons are the first targets of research.

These figures paint a misleading optimistic picture. As is often the case in health care, treatment is not equally available to all and individualized care is the exception. The National Health Education Committee has stated that fewer than half of the epilepsy patients in this country receive adequate care and treatment. For Oregon, this would represent more than 20,000 persons.

Another reason is a dearth of qualified neurological diagnosticians. Nationally, there is only one neurologist for every 2,220 people; in Oregon, the ratio is one for every 2,670 people. The problem is even more acute in rural areas. An additional problem is that if, by accident or misadventure, an epileptic patient runs out of medication and is without money, he can find relief only in some police departments and hospital emergency rooms.

The attitude of some of the epileptics themselves tends to discourage counselors and caseworkers from dealing with them. It must be stressed that these individuals are few in number, but are a serious problem. These are the long-term epileptics, whose seizures are not under good control (possibly because they fail to take medication) or whose mental attitude is deteriorating. These people are poor in inter-personal reactions both on and off the job.

As important as the usual inadequacies of personnel and facilities, however, are the obstacles to proper detection and treatment caused by public attitudes. To the extent that the person with epilepsy (either due to his own belief or to the beliefs of those around him) will not voluntarily seek treatment or is not brought to it, the availability of facilities or personnel is meaningless. Such fears must be overcome through programs of public and professional education.

The Gallup Poll reported that in 1949, only 45% of American adults believed persons with epilepsy should be employed in jobs like other people; today, 76% hold this view. It is currently estimated, however, that the unemployment among those identified as having epilepsy, even

though completely controlled, is 25% (five times the national average). Gallup also identified a large segment of the population holding the erroneous views that epilepsy prohibited schooling and was equated with insanity. These attitudes have serious repercussions on employment, education, and rehabilitation of an otherwise entirely useful and productive individual.

Fewer than 1,300 people in Oregon are being served by sheltered workshops; present estimates indicate that 20,000 Oregonians could benefit from such services. Outside of the Portland area, there are few comprehensive workshop facilities.

This spectrum of attitude, treatment, control, acceptance, and rehabilitation creates very special problems for a substantial portion of the epileptic population.

The University of Oregon Medical School cites cases where the school has diagnosed and treated patients, sent them to rehabilitation agencies only to have those agencies request medical examinations by a private practitioner.

Since 1947, all epileptics have had to be reported to the State Board of Health (ORS 482.140); the information is used to determine the qualifications of persons to operate motor vehicles.

CURRENT PROGRAMS AND ACTIVITIES

The University of Oregon Medical School in Portland provides a weekly diagnostic and treatment clinic for adult epileptic patients. In addition to medical care, health services by allied personnel including psychologists, social workers, and Epilepsy League representatives provide comprehensive care to each patient. Approximately 475 patients are receiving services.

The University's pediatric neurology clinic, staffed by pediatric neurologists, has approximately 1,300 patient visits annually; approximately 60% of these visits are related to seizure disorders.

The Clinic for Children with Epilepsy, Learning and Behavior Problems, a diagnostic clinic at Good Samaritan Hospital, Portland, operates two mornings a week. Referral is necessary through a mental health agency or physician. (This clinic is in imminent danger of being discontinued because of difficulty in obtaining financial support).

General neurology clinics at both the University of Oregon Medical School and Good Samaritan Hospital provide service to patients with convulsive disorders.

Although no child with epilepsy has been excluded, the Crippled Children's Program in Oregon does not include epilepsy as it has not been funded. There are only 7 states, to our knowledge, that do not include epilepsy under Crippled Children's Division.

Electroencephalograms (EEG), the principal laboratory test used in the differential diagnosis of epilepsy, may be obtained from private physicians and from 23 hospitals throughout the state. Approximately 20,000 EEG's are performed yearly at these hospitals. The number of EEG's performed by private physicians in their offices is not known. Fourteen hospitals have facilities for special x-ray procedures such as carotid arteriography. Facilities for special surgical and electroencephalographic recordings from the depth of the brain are available at the University of Oregon Medical School and at Good Samaritan Hospital.

Five year approved training programs in neurosurgery are presented at the University of Oregon Medical School and at Good Samaritan Hospital. These two institutions also offer a combined three year neurology residency program.

Other post graduate courses in epilepsy are periodically offered in Oregon to physicians, nurses, allied health personnel, social workers, rehabilitation specialists, police, etc.

The Public Welfare Division provides counseling services and training to persons having disabilities which prevent them from obtaining and continuing suitable employment.

State Industrial Accident Commission provides assistance to injured workmen and also offers protection to employers and their epileptic workers in case of work incurred injuries.

Epilepsy League of Oregon is a non-profit voluntary health agency approved by the Oregon Medical Association. The League became a member of United Good Neighbors in 1953, from which it receives its major support. Volunteers from various professions contribute valuable assistance in presenting medical and educational programs, staff exhibits, etc. The League serves as a center of information for anyone seeking services, provides interviews and acts in a referral capacity to guide persons with specific needs to reliable resources for medical treatment, counseling, employment, rehabilitation, job motivation, and other related problems. The League also distributes literature, identification cards, and publishes a bulletin, "Epilepsy Speaks". It supplies films, speakers, educational exhibits, and tape recordings; a lending library at the League office offers a variety of reliable books and current literature on epilepsy. Special emphasis is given to programs in the schools of higher education and to potential teachers, counselors, school nurses, et al. A Medical Advisory Committee assists in presenting educational programs which are regularly provided for schools, colleges, and public groups.

The Epilepsy Foundation of America, Washington D.C., promotes, conducts and supports research, information, education and treatment services and programs.

AUTHORITIES

To be researched.

OBJECTIVES

1. Broaden research efforts into the causes and treatment of epilepsy.
2. Expand the availability of trained neurologists and other appropriate specialists to treat epilepsy.
3. Improve services and increase the availability of clinics, schools, camps, and other facilities for treating, educating, training, counseling, or otherwise assisting epilepsy patients.
4. Eliminate legal, educational, social, or economic discrimination towards persons with epilepsy solely on the basis of their medical history.

RECOMMENDATIONS AND METHODS

1. *ASSURE BETTER DIAGNOSIS AND TREATMENT OF EPILEPSY THROUGH PROFESSIONAL EDUCATION.*

   Method

   University of Oregon Medical School and Oregon Medical Association establish continuing medical education programs in epilepsy to include the varied nature of seizure states, criteria for diagnosis, proper classification of the patient, individualizing medical management of recurring epileptic seizures, proper use of the electroencephalogram (EEG) and its interpretations and techniques for helping the patient with the social/economic aspects of his illness.

2. *EDUCATE PUBLIC AGENCY PERSONNEL AND OTHER EMPLOYERS ABOUT EPILEPSY.*

   Methods

   a. *Departments of Employment, State Police, Vocational Rehabilitation, Board of Education, local police and sheriffs improve in-service training/education programs to better recognize, understand, and serve those with epilepsy. The Epilepsy League of Oregon to provide leadership and coordination, and to provide films, literature, and professional speakers.*

b. *Epilepsy League of Oregon continue its program to educate employers, personnel managers, etc., regarding the work potential of the epileptic.*

3. *STATE BOARD OF HIGHER EDUCATION EXPAND PROGRAMS FOR HEALTH EDUCATORS, UNDERGRADUATE TEACHERS, SCHOOL COUNSELORS, SOCIAL WORKERS, AND OTHERS WHO WILL COME IN CONTACT WITH EPILEPTICS TO INCLUDE CURRENT KNOWLEDGE OF THE CHRONIC ILLNESSES OF CHILDHOOD AND ADOLESCENCE, INCLUDING EPILEPSY.*

4. *IMPROVE COORDINATION OF SERVICE AGENCIES, ORGANIZATIONS, AND COMMUNITY RESOURCES IN DELIVERING SERVICES TO THE EPILEPTIC.*

Method

Information on epileptic patients be included in a total human resources information registry showing when and how a client was referred and served by public agencies to assure comprehensive care and prevent duplication.

5. *COORDINATE SPECIAL EDUCATION ACTIVITIES FOR EPILEPTICS.*

Method

State Board of Education and Oregon State Board of Health establish a joint committee including physicians and educators to make recommendations about assigning students to programs in special education to insure both optimal medical benefits and educational progress.

6. *ESTABLISH EMERGENCY MEDICAL SUPPLY CENTERS.*

Method

Oregon State Board of Health study the development of a program to provide emergency supplies of anti-convulsant medications free to the needy, dispensed through hospitals.

7. *ESTABLISH SHELTERED WORKSHOPS.*

Method

Epilepsy League of Oregon, in cooperation with Division of Vocational Rehabilitation and voluntary agencies, explore the possibility of establishing more sheltered workshops serving a wide variety of disabled people, including the epileptic.

8. *EPILEPSY LEAGUE OF OREGON SUBMIT LEGISLATION TO REVISE O.R.S. 482.140 TO REMOVE SPECIFIC REFERENCE TO THE REPORTING OF DIAGNOSED*

EPILEPSY WHILE RETAINING THE REQUIREMENTS FOR REPORTING THOSE WITH DISEASES AND DISORDERS CHARACTERIZED BY MOMENTARY OR PROLONGED LAPSES OF CONSCIOUSNESS WHICH ARE, OR MAY BECOME, CHRONIC.

9. *UNIVERSITY OF OREGON MEDICAL SCHOOL AND OREGON MEDICAL ASSOCIATION STUDY THE DESIRABILITY AND FEASIBILITY OF ESTABLISHING ITINERANT CLINICS STAFFED BY MEDICAL SCHOOL PERSONNEL, PRIVATE NEUROLOGISTS, AND/OR SENIOR NEUROLOGY STUDENTS TO PROVIDE BETTER NEUROLOGICAL SERVICES TO REMOTE AREAS.*

10. *LOCAL MENTAL HEALTH CLINICS ASSIST THE NEUROLOGICALLY IMPAIRED TO COPE WITH THEIR PSYCHO-SOCIAL PROBLEMS.*

OPERATIONAL PROBLEMS

1. Difficulty in properly categorizing and managing seizure disorders by physicians, nurses, counselors, etc.
2. Misuse of electroencephalogram as a diagnostic tool.
3. Lack of qualified personnel to assist the patient to cope with the social and economic facets of his illness.
4. Lack of coordination among agencies.

EVALUATION CRITERIA

Epilepsy League of Oregon to measure improved patient care, betterment of employment, reduction of patients' and publics' misconceptions and better rehabilitation. They may also measure time elapsed between doctors' diagnosis of epilepsy and adequate services being rendered to those afflicted; and determine: number of research programs supported by state and national organizations; increase in number and availability of trained neurologists and other specialists available for the treatment of epilepsy; number of people reached through various educational programs; increase in number of clinics, schools, camps and other facilities which assist epilepsy patients; general changes eliminating legal, educational, social, and economic discriminations towards persons with epilepsy.

PRIORITY

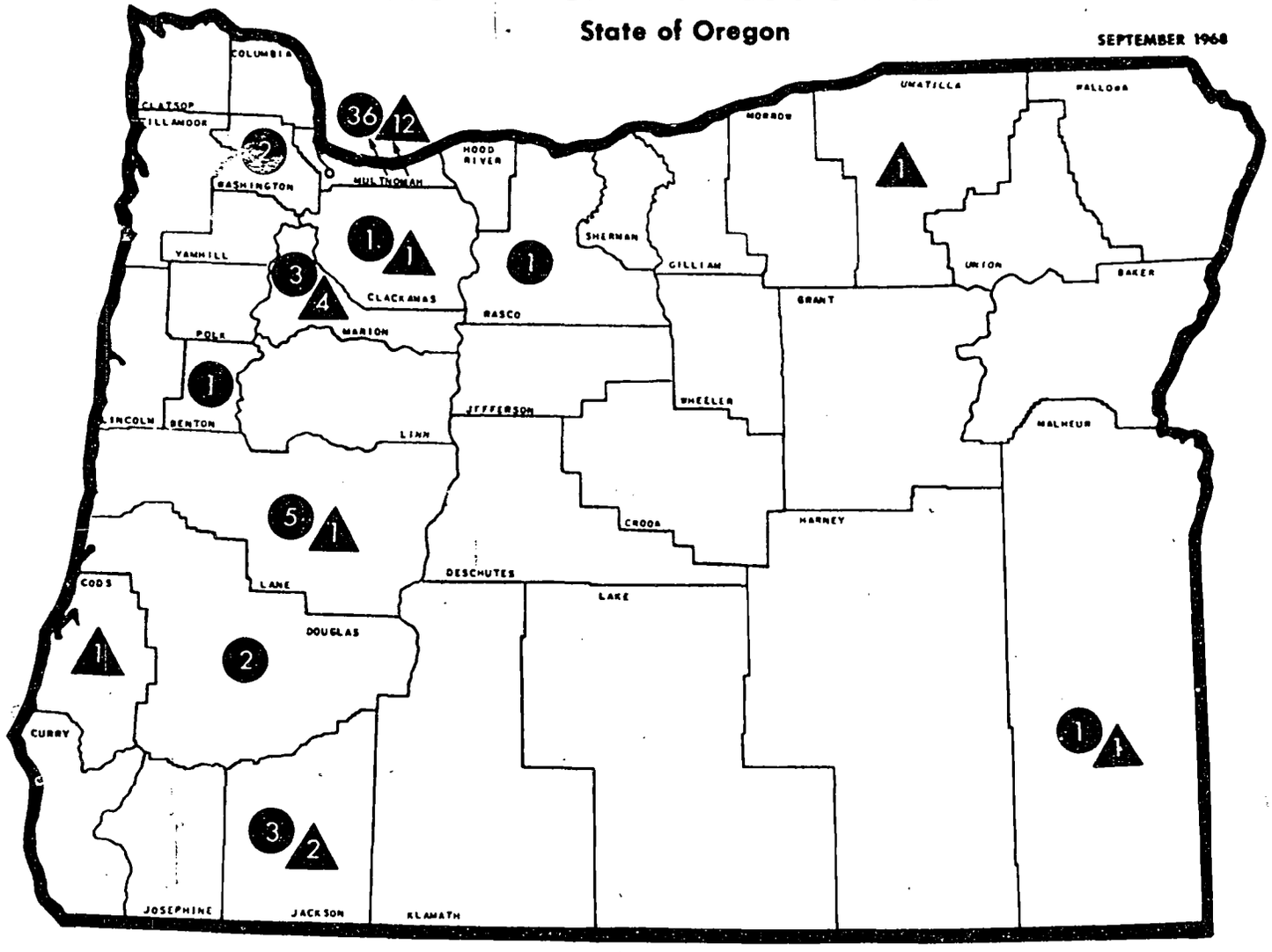
To be determined.

EXHIBIT 1

DISTRIBUTION OF NEUROLOGICAL SERVICES

State of Oregon

SEPTEMBER 1968



● NUMBER OF PHYSICIANS WITH INTEREST IN NEUROLOGICAL SCIENCES.

▲ NUMBER OF EEG FACILITIES AT MEDICARE APPROVED HOSPITALS

MULTIPLE SCLEROSIS

GOAL DETERMINATION OF THE CAUSE, EFFECTIVE DIAGNOSTIC PROCEDURES, AND TREATMENT FOR MULTIPLE SCLEROSIS.

CONDITION

Multiple sclerosis, commonly called "MS" means "many scars." Scattered throughout the nervous system myelin (fatty protective nerve sheaths which may be likened to insulation on electric wire, without which short circuits or loss of power may result) disintegrate partially or completely. The cause is not known. The destroyed myelin is replaced by scars which, at first, are soft, but in time become more dense or destructive. Initially, the scar may only impair the transmission of messages from nerve center to muscle. Later the formation of other scars resulting from subsequent attacks leads to greater disability and frequently to total incapacity. The disease affects approximately 4,000 Oregonians; it has an early onset (during one's productive period). About one-half of the multiple sclerosis victims have severe disabilities.

CURRENT PROGRAMS AND ACTIVITIES

The Multiple Sclerosis Society of Portland, Oregon, Inc., (a United Good Neighbors agency) serves Multnomah, Washington, Clackamas, and Clark Counties. It is a voluntary participation group with a Board of Directors, a Medical Advisory Board, and interested and involved citizens who provide, through regular meetings, opportunities for social intercourse and entertainment for afflicted members.

The Society was aware of the physical needs of many multiple sclerosis patients which could not be filled in the home because of lack of money, because hospitals were not set up to care for chronic cases, or because rehabilitation agencies could not take cases with an unfavorable prognosis. The staff (a Director and four home health aides) give direct patient services and maintain and distribute equipment for any patient in need. The group publishes a newsletter and funds a small number of research projects. Patients may become members of the Society without cost.

The National Multiple Sclerosis Society (Oregon Central Chapter) serves the needs of the multiple sclerosis patient, his family, and his community. The Chapter is involved in lay and professional educational programs through a speakers' bureau, films, and literature.

Equipment, including talking-book machines, wheelchairs, walkers, lifts, and hospital beds are loaned to qualified patients. A newsletter is published quarterly.

An information and referral service is maintained to utilize existing services within the community. Realizing that patient needs vary, the Chapter considers all requests for help on an individual basis.

The National Multiple Sclerosis Society is currently funding 71 active research grants, 14 fellowships, and 69 clinics (none in Oregon).

The International Federation of Multiple Sclerosis Societies was formed in 1967 to broaden the scope of multiple sclerosis research and education. Currently 19 countries are members of the International Federation.

Local health departments provide limited nursing care to multiple sclerosis victims.

The University of Oregon Medical School conducts research on multiple sclerosis under the supervision of Dr. Roy Swank, Department of Neurology. (see: Multiple Sclerosis: Twenty Years on Low-Fat Diet).

Public Welfare Division provides assistance to multiple sclerosis victims.

AUTHORITIES

To be researched.

OBJECTIVES

1. Increase research efforts to determine the cause, effective diagnostic procedures, and treatment of multiple sclerosis.

2. Improve early diagnosis and treatment capabilities for multiple sclerosis.

RECOMMENDATIONS AND METHODS

1. *STIMULATE RESEARCH ACTIVITIES IN THE AREAS OF IMMUNOLOGY, NEUROLOGY, PHARMACOLOGY, AND OTHER RESEARCH AREAS TO IDENTIFY CAUSES AND MORE EFFECTIVE DIAGNOSTIC AND TREATMENT PROCEDURES FOR MULTIPLE SCLEROSIS.*

   Methods

   a. *Multiple Sclerosis Society of Portland encourage legislative and federal financial support for intensified research into multiple sclerosis and related conditions at the University of Oregon Medical School and other institutions of higher learning in Oregon.*

b. Oregon Medical Association, in cooperation with Multiple Sclerosis Society of Portland, establish an effective mechanism for dissemination of research findings to practicing physicians throughout the state.

2. *ENSURE CONTINUING PROFESSIONAL EDUCATION AND INFORMATION PROGRAMS FOR PERSONNEL INVOLVED IN THE DELIVERY OF HEALTH CARE TO PATIENTS WITH MULTIPLE SCLEROSIS.*

Methods

a. University of Oregon Medical School, with financial support from the Oregon Regional Medical Program, include a program of professional education through its "circuit course" relating to diagnosis and treatment of multiple sclerosis.

b. Multiple Sclerosis Society of Portland, with support by Oregon Medical Association, encourage publication of information relating to diagnosis and treatment of multiple sclerosis in local professional journals and other professional communications media.

3. *PROVIDE BETTER HOME CARE FOR MULTIPLE SCLEROSIS VICTIMS.*

Methods

Multiple Sclerosis Society of Portland, together with recognized home health agencies, develop a program providing home care, home health, and homemaker services to multiple sclerosis patients.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, materiel, and adequate rehabilitative services, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

To be determined.

PRIORITY

To be determined.

MYASTHENIA GRAVIS

GOAL DETERMINATION OF THE CAUSE, EFFECTIVE DIAGNOSTIC PROCEDURES, AND TREATMENT FOR MYASTHENIA GRAVIS.

CONDITION

Myasthenia gravis (grave muscle weakness) is a nerve-muscle illness which strikes men, women, and children of all ages. The illness causes an interference in the normal transmission of nerve impulses to the muscles of the body, and can be fatal without early diagnosis and treatment. Common symptoms are double vision; drooping eyelids; inability to chew, swallow, breathe, or walk; and the illness is characterized by a general rapid exhaustion. With proper medication and treatment, some patients are able to attain as high as 80% of normal activity, while others may be completely bedridden. Unfortunately, diagnosis is difficult during the early stages of the illness, because of a lack of an easily available diagnostic procedure, as well as a significant variance in the severity of the illness from patient to patient.

At the present time, neither a cure nor the cause of myasthenia gravis has been discovered. It is generally regarded as a rare disease by physicians, and even when considered in patient examination, difficult to diagnose. The public is generally unaware of this mysterious disease. It is estimated that there are between 400 and 800 Oregon residents with either diagnosed or non-diagnosed myasthenia gravis.

CURRENT PROGRAMS AND ACTIVITIES

Myasthenia Gravis Association is a United Good Neighbors voluntary, non-profit agency which operates a diagnostic and treatment clinic at the Good Samaritan Hospital in Portland, where patients are seen on referral by the attending physician. The Association also has undertaken a myasthenia gravis educational program for Oregon physicians, as well as a patient information center.

University of Oregon Medical School conducts myasthenia gravis research funded to a limited degree by the myasthenia gravis association.

AUTHORITIES

To be researched.

OBJECTIVES

1. Increase research efforts to determine the cause, effective diagnostic procedures, and treatment of myasthenia gravis.

2. Improve early diagnosis and treatment capabilities through expanded professional education and information programs.

RECOMMENDATIONS AND METHODS

1. *STIMULATE RESEARCH ACTIVITIES IN THE AREAS OF IMMUNOLOGY, NEUROLOGY, PHARMACOLOGY, AND OTHER RESEARCH AREAS TO IDENTIFY CAUSES AND MORE EFFECTIVE DIAGNOSTIC AND TREATMENT PROCEDURES FOR MYASTHENIA GRAVIS.*

   Methods

   a. *Myasthenia Gravis Association encourage legislative and federal financial support for intensified research into myasthenia gravis and related conditions at the University of Oregon Medical School and other institutions of higher learning in Oregon.*

   b. *Oregon Medical Association, in cooperation with Myasthenia Gravis Association, establish an effective mechanism for dissemination of research findings to practicing physicians throughout the state.*

2. *INSURE CONTINUING PROFESSIONAL EDUCATION AND INFORMATION PROGRAMS FOR PERSONNEL INVOLVED IN THE DELIVERY OF HEALTH CARE TO PATIENTS WITH MYASTHENIA GRAVIS.*

   Methods

   a. *University of Oregon Medical School, with financial support from the Oregon Regional Medical Program, include a program of professional education through its "circuit course" relating to diagnosis and treatment of myasthenia gravis.*

   b. *Myasthenia Gravis Association, with support by Oregon Medical Association, encourage publication of information relating to diagnosis and treatment of myasthenia gravis in local professional journals and other professional communications media.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

The Myasthenia Gravis Association, in cooperation with the applicable medical resource agencies, will be responsible for making evaluation of progress toward objectives. Criteria of success to be determined by:

a. Expanded research efforts and progress in determining the cause and cure of myasthenia gravis.

b. Reduction in the incidence of myasthenia gravis.

c. Increased productive life of patients with myasthenia gravis.

PRIORITY

To be determined.

SERIOUS RENAL DISEASE

GOAL REDUCE THE INCIDENCE OF CHRONIC RENAL FAILURE AND CONTROL END-STAGE RENAL DISEASE.

CONDITION

The common characteristic of almost all kidney diseases is their tendency to progress eventually to a common end-stage, the clinical syndrome of uremia. Unlike most other chronic diseases, kidney diseases are particularly prone to cause death in patients in the middle and most productive years. This serves to vividly point out that the social and economic impact of kidney diseases greatly exceeds the normal expectations revealed through analysis of the bare statistical data available.

In considering the impact of kidney diseases, available statistics indicate that between July, 1964 and June, 1965, kidney diseases were responsible for the death of 58,783 Americans. During the same period, an additional 7,847,000 persons in this country suffered from kidney diseases and from diseases related to the kidney, resulting in approximately 16 million lost workdays. The cost of kidney disease and its associated diseases amounted to a total of 1,210 million dollars, or 5.4% of our total estimated national health expenditure. In terms of cost to this Nation, kidney disease was ranked fifth among all diseases in 1965.

Since 1961, significant medical advances have been made in controlling mortality due to end-stage renal disease. Home and center-based hemodialysis as well as human renal homotransplantation have proven to be successful techniques for rehabilitating the end-stage renal disease patient. Need dictates that greater efforts be made to extend this type of therapy to a greater number of individuals.

Based on two studies completed in 1967 for the Bureau of the Budget and the U.S. Public Health Service, there are between 58 and 73 new patients per year (in a population area the size of Oregon) who could benefit from dialysis or transplantation. It is estimated that about two-thirds of this number are now benefiting from the three available dialysis and/or transplantation programs conducted by the Kidney Association of Oregon, the University of Oregon Medical School, and the Veterans' Administration Hospital. There is, therefore, a great need to increase programs including development of:

1. a dialysis in-center program for those who do not qualify for existing transplantation or home dialysis but who could benefit from in-center dialysis; as well as,

2. a statewide program of organ procurement for transplantation programs.

Although dramatic progress has been made in the evolution of end-stage therapy in the past several years, this provides only a temporary solution. Considerable future emphasis must be placed on earlier identification and treatment of the underlying disease processes. Ultimately, balanced renal disease control programs incorporating early identification, prompt treatment and comprehensive patient follow-up, as well as continued end-stage treatment programs, must be realized.

CURRENT PROGRAMS AND ACTIVITIES

Hemodialysis Programs and Activities

1. Chronic Dialysis Facilities

   Good Samaritan Hospital, Portland (training for home-based hemodialysis only).

   University of Oregon Medical School Hospital, Portland (hemodialysis preparative to renal transplantation only).

   Veterans' Administration Hospital, Portland (both in-patient dialysis and dialysis preparative to renal transplantation...Limited to veterans).

2. Acute Dialysis Facilities

   Emanuel Hospital, Portland

   Good Samaritan Hospital, Portland

   Providence Hospital, Portland

   University of Oregon Medical School Hospital, Portland

   Veterans' Administration Hospital, Portland

3. Training Programs

   The Good Samaritan Hospital conducts the only home hemodialysis patient training program in Oregon. The staff from this center will travel to other hospitals for training local nurses, technicians, and physicians in the use of hemodialysis equipment. The training center is also available for onsite familiarization with equipment and scheduled lectures.

The home dialysis patient training center is financed jointly by the Good Samaritan Hospital and the Kidney Association of Oregon (KAO). KAO provides financial support for patient training and follow-up care in those cases where patient personal resources are inadequate. KAO also operates a patient supply center for monthly medical supplies located at the KAO office, separate from Good Samaritan Hospital. The Kidney Association of Oregon Medical Screening Committee sponsored by the Oregon Medical Association processes applications for patients who are proposed as candidates by the patients' personal physician. Candidates are processed by the Committee according to their needs and referred back to their personal physician after either home dialysis training, referral for consideration for transplantation; or with appropriate recommendations for conservative medical management.

The Oregon Division of Vocational Rehabilitation provides financial support for Kidney Association of Oregon patients who qualify for the Vocational Rehabilitation program. Funds thus provided help to defray training, equipment and supply costs while the patient is being trained (rehabilitated). During the first year of this operation (1969), the Kidney Association of Oregon referred nine patients to the Division of Vocational Rehabilitation of which four cases have been closed as rehabilitated and two have returned to work, but have not yet been closed.

The University of Oregon Medical School in Portland has facilities for teaching medical students, resident interns, and post-residency fellows dialysis and transplant methods and techniques, including administration of a National Institute of Health post-doctoral training grant for renal transplantation. The School also offers, under sponsorship by the National Kidney Foundation, a post-doctoral fellowship in pediatric nephrology with emphasis on transplantation.

The Regional Medical Program provides financial support for the University of Oregon Medical School circuit course that provides physician education in chronic renal disease. Authority for regional medical programs was recently expanded to cover kidney disease and other related diseases, as well as heart disease, cancer, and stroke. On a national scale, a maximum of $15,000,000 will be available in 1971 for kidney disease.

The Veterans' Administration Hospital in Portland operates a center-based hemodialysis program for veterans from Oregon and Southwest Washington. The Veterans' Administration Hospital currently has a limited home dialysis training program which, it is anticipated, will be expanded during the summer of 1971. The nephrology service of the hospital, which is responsible for the chronic inpatient facility, is an integral component of the University of Oregon Medical School teaching program for medical students, interns, and fellows.

Kidney Transplant Programs and Activities

1. Kidney Transplantation Facilities

   University of Oregon Medical School, Portland

   Veterans' Administration Hospital, Portland

   (An organ transplant program is under serious consideration by the Board of Trustees and the medical staff of the Good Samaritan Hospital in Portland.)

2. Tissue Typing Laboratories

   Both the University of Oregon Medical School and the Veterans' Administration Hospital have facilities for tissue typing for their transplantation programs.

3. Transplant Programs

   The University of Oregon Medical School Transplantation Program currently is financed with funds provided by the Oregon Legislature through House Bill 1256. Financing of the school's dialysis program is provided for in the school's budget. The University of Oregon Medical School is a member of the North American Network for Kidney Sharing.

   The Veterans' Administration Hospital has a small but active renal transplantation program. It also has a substantial research grant for the study of transplantation and tissue preservation.

AUTHORITIES

To be researched.

OBJECTIVES

1. Make available to all Oregonians suffering from chronic renal disease a comprehensive program of medical care to include detection, treatment, training, follow-up care, and rehabilitation.

2. Improve utilization of existing medical resources for treatment of renal disease through increased public and professional education and information programs.

RECOMMENDATIONS AND METHODS

1. *PROVIDE HOME-BASED HEMODIALYSIS AND TRANSPLANTATION FOR ALL OREGONIANS SUFFERING FROM CHRONIC RENAL DISEASE WHO ARE*

MEDICALLY AND PSYCHOLOGICALLY QUALIFIED (i.e., WHO CAN BENEFIT FROM THIS TYPE TREATMENT).

Methods

a. *Kidney Association of Oregon maintain financing of direct costs of the Good Samaritan Hospital home hemodialysis training center in Portland through funds obtained from private contributions.*

b. *Good Samaritan Hospital and Kidney Association of Oregon seek federal funding assistance for the Good Samaritan Hospital home hemodialysis training center.*

c. *Oregon Division of Vocational Rehabilitation maintain provision of rehabilitative services and financial support for equipment, training, and home supplies for qualified patients referred from the Kidney Association of Oregon.*

d. *State Board of Higher Education provide financial support for the University of Oregon Medical School transplantation program.*

e. *Kidney Association of Oregon encourage cooperation between existing renal disease programs, including sharing agreements with the Veterans' Administration program, to achieve maximum utilization of existing resources.*

2. *EXPAND CENTER-BASED PROGRAMS OF TREATMENT, FOLLOW-UP CARE AND REHABILITATION FOR ALL OREGONIANS SUFFERING FROM CHRONIC RENAL DISEASE WHO CANNOT QUALIFY FOR EITHER TRANSPLANTATION OR HOME-BASED HEMODIALYSIS.*

Methods

a. *Kidney Association of Oregon, together with the Oregon Medical Association and the Oregon Association of Hospitals, encourage the establishment of additional centers to provide hemodialysis for persons not qualified for transplantation or home-based hemodialysis, as well as for those persons faced with prolonged waiting periods prior to transplantation.*

b. *University of Oregon Medical School establish a central facility to provide hemodialysis for small children.*

3. *EXPAND COMMUNITY LEVEL EFFORTS AIMED AT PREVENTION, EARLY IDENTIFICATION, TREATMENT CAPABILITIES, AND REFERRAL PROGRAMS THROUGHOUT THE STATE.*

Methods

a. *Comprehensive Health Planning, together with the State Board of Health, continue efforts to establish good school and occupational health education programs aimed at preventing serious renal disease.*

b. *Kidney Association of Oregon, together with cooperating Oregon medical institutions and the Oregon Medical Association through its charitable research foundation (Oregon Medical Education Foundation), actively seek credit or project funds to augment private and state resources to support and sustain a comprehensive program of renal disease detection, medical care, and rehabilitation.*

c. *University of Oregon Medical School request state financial assistance for expansion of the Medical School tissue typing center facilities and program, and support of the processing of antilymphocyte serum for investigation of the rejection problem. Services of the center should be made available to all Oregon transplantation facilities.*

d. *University of Oregon Medical School, with financial assistance from Oregon Regional Medical Program, provide a Lipid Dialysis machine for cooperative use in the Portland Metropolitan Area.*

e. *Comprehensive Health Planning, together with the Kidney Association of Oregon, Oregon Medical Association, and Oregon Association of Hospitals, encourage expansion of existing acute hemodialysis programs in selected hospitals throughout Oregon, according to priorities based on community need.*

f. *University of Oregon Medical School, Veterans' Administration Hospital in Portland, Kidney Association of Oregon, and the Oregon Medical Association cooperate in developing an organ procurement program sufficient to meet current and projected needs for kidney transplantation requirements. An element of this program would be the development of a statewide communications network for organ procurement.*

g. *University of Oregon Medical School, Department of Pediatrics, in cooperation with local medical societies, develop and implement a community-based program for the detection, referral, and early treatment of school-age children with bacteriuria and proteinuria (early signs of potential kidney failure).*

h. *Kidney Association of Oregon establish a statewide referral program for persons who have entered into hemodialysis or transplantation programs to appropriate state or local agencies to insure optimal utilization of available psychological and physiological rehabilitative services.*

4. *STIMULATE RESEARCH ACTIVITIES IN THE FIELD OF RENAL DISEASE WITH EMPHASIS ON PREVENTION, EARLY DETECTION, AND TREATMENT TECHNIQUES.*

Method

Kidney Association of Oregon encourage legislative financial support for on-going and expanded research projects conducted by the University of Oregon Medical School, as well as encouraging research activities at other institutions within the state in the field of renal disease.

5. *INSURE CONTINUING PROFESSIONAL EDUCATION AND INFORMATION EXCHANGE FOR PERSONNEL INVOLVED IN THE DELIVERY OF HEALTH CARE TO PATIENTS WITH KIDNEY DISEASE.*

Methods

a. *University of Oregon Medical School, with financial support from the Regional Medical Program, develop and coordinate a program of professional education relating to kidney disease and its treatment (i.e., through the "circuit course", post-graduate seminars, and other programs).*

b. *Kidney Association of Oregon develop plans for establishment of a continuing forum for the exchange of technical information between the various medical and para-medical agencies, institutions, and personnel involved in the detection and management of patients with chronic renal disease. (e.g., cooperative sharing of expertise in care and management of end-stage renal disease as provided by the Kidney Association of Oregon Medical Screening Committee.)*

c. *Kidney Association of Oregon, together with cooperating medical institutions, develop and implement a program for the collection of demographic data relating to the prevalence of inherited and acquired renal disease in Oregon.*

6. *INSURE ADEQUATE PUBLIC EDUCATION AND INFORMATION OF KIDNEY DISEASE INCIDENCE, SYMPTOMS, AND AVAILABLE MEDICAL RESOURCES.*

Method

Kidney Association of Oregon seek financial support through the Oregon Regional Medical Program to develop and sponsor a program of public education regarding the warning signs of kidney disease, treatment, and available medical resources.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages

of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

The Kidney Association of Oregon in cooperation with the applicable medical resource agencies will be responsible for making evaluation of progress toward stated objectives.

Criteria of success to be determined by:

1. Reduction in mortality rates due to chronic renal disease.

2. Reduction in the morbidity rate for chronic renal disease.

3. Improvement in community-related management of patients with renal disease.

PRIORITY

The priority designation that renal diseases will have relative to other reported health problems has not been determined; however, within the problem area of renal disease, the highest priority has been assigned to Recommendation 4 calling for increased emphasis on research into the causes, methods of identification and treatment.

The second priority is assigned to the continuation of support of the existing transplantation and home dialysis programs, increased physician education, and expansion of organ procurement programs.

Of next highest priority is establishment of a center-based hemodialysis program for those persons who do not qualify for transplantation or home-based hemodialysis and for those persons faced with prolonged waiting periods prior to transplantation.

SPEECH AND HEARING

GOAL PROVIDE EASY ACCESS TO QUALITY SPEECH AND HEARING SERVICES FOR ALL CITIZENS OF OREGON REGARDLESS OF GEOGRAPHIC LOCATION, ECONOMIC STATUS, OR AGE.

CONDITION

Speech and hearing disorders which interfere with communication or call unfavorable attention to the speaker, embarrass the speaker, or interfere with speech acquisition or with education, need the special attention of speech pathologists, audiologists, teachers of the deaf and allied professionals.

Disorders of verbal expression may take the form of impaired articulation, voice, rhythm (e.g., stuttering), and language (e.g., dysphasia). The causes for such disorders may be singular or multiple. The common causes are neuromuscular disorders (e.g., cerebral palsy), structural anomalies (e.g., cleft palate), emotional aberrations (e.g., stuttering), cerebral vascular accident (e.g., dysphasia), disease processes (e.g., cancer of larynx -- laryngectomy), heredity (e.g., deafness), environmental deprivation (e.g., lack of stimulation), and developmental failure (e.g., mental retardation).

It is estimated that 8% of all preschool and elementary school children and 4% of high school and adult-age persons in Oregon have speech or language disorders of handicapping proportion (excluding the deaf and mentally retarded). In 1960, 9,000 mental retardates under the age of 21 had speech and language defects.[1] In addition, there were 2,974 deaf persons from preschool through age 54 identified in Oregon in 1969-70.

Table 1

Estimates of Speech Disorders by Age Group and/or School-Status

Group	Speech Disorder[2]
Preschool	15 to 20%
Elementary School	8%
High School	5%
Adult (and/or college age)	4%
Geriatric	5 to 10%

1. Public Health Reports, Vol 81, No. 4, April, 1966, Page 313.
2. Human Communications and its Disorders-An Overview, NINDS, National Institutes of Health, PHS, HEW.

Table 2

Type of Speech Disorders of Children and Adults

Type of Speech Disorder	Percent of Total Children Ages 5-21	Percent of Total Adults[1] Ages 18-65
Articulation	76%	50%
Voice	5%	15%
Rhythm (stuttering, etc.)	14%	25%
Language	5%	1%
Miscellaneous	---	9%

The apparent discrepancy in the figures in Table 2 showing greater percentages of stuttering and voice disorders in adults is a reflection of the total percentage of disorders and since articulation disorders decrease markedly in adults, other disorder percentages reflect the less marked decrease with age.

Table 3 on the following page does not reflect the whole hearing handicapped population in Oregon, since a conservative estimate of that population would be approximately 20,000 people. It should be further pointed out that there is a discrepancy in the figures associated with the term "school age". In Salem, and at some other centers, the term refers to children starting school at age 3.8 years. In some centers the term refers to any child under 6 or 7 years of age who has not yet started school.

In 1969-70 approximately 28,647 persons in Oregon received speech and hearing services (including the deaf). Another 199,453 children received hearing screening (21,600 were infants). It is estimated that in Oregon, 51,353 did not receive speech and hearing services but were in need of these services. The principal reason appears to be that a service was not available in their community. The most frequently available service is speech assistance for elementary age public school children (except the hard of hearing). Speech service is generally not provided for preschoolers, junior high and high school children, and private and parochial school children. Service for the deaf is generally provided for these groups.

1. Morley, D. E., JSHD, Vol. 17, No. I, March, 1952, Page 25.

Table 3

Number and Distribution of the Deaf During 1969-70
(These persons, except adults, received speech and hearing services)

Age	No.	Sex	Location
Preschool Children	18	both	Eugene Hearing and Speech Center
	61	both	Oregon State School for the Deaf
	59	both	Portland Center for Hearing and Speech
	10	both	Regional Facilities (Eugene)
	14	both	Regional Facilities (Medford)
	35	F.	Regional Facilities (Portland)
	24	M.	Regional Facilities (Portland)
	15	both	Tucker-Maxon (Portland)
	87	both	no school
Elementary School	61	both	Portland Public Schools Education Program
Deaf-Blind Children	20	both	Oregon
	5	both	Washington School for the Deaf and Blind (Vancouver)
School Age	531	both	Total for the State of Oregon
	6	both	Beaverton Resource Room for the Deaf
	234	both	Oregon State School for the Deaf
	6	both	Oregon College of Education
	169	both	Regional Facilities
High School	19	both	Portland Public Schools Education Program
Adults (24-54 yrs.)	870	M.	-----
	730	F.	-----
TOTALS			
Children	1374	both	all locations
Adults	1600	both	all locations
All Ages	2974	both	all locations

Disability Days

It is difficult to predict the number of disability days which may result from speech and hearing disorders. Those most dramatic examples of loss of work and/or school days would be for cases of laryngectomy and stroke. In Oregon, 108 new laryngectomies were recorded for the calendar year 1969 (114 and 100 for 1968 and 1967, respectively[1]); a survey of the literature[2] suggests that some 12,000 persons have linguistic impairment as a residual from strokes. Individuals suffering from either of these two disorders may be unable to function in the same work setting after the loss, or significant impairment, of speech and language.

Loss of speech is the primary disability of the laryngectomee. His ultimate

1. American Cancer Society, Portland Office.
2. Wepman, J., in Fields, W. S., and Spencer, W. A., Stroke Rehabilitation, Warren H. Green, Inc., St. Louis, 1967.

rehabilitation will depend on his subsequent success in communication. Responsibility for the speech rehabilitation of the laryngectomized falls primarily on the speech pathologist. Most laryngectomees (from 50 to 90 percent), depending on the population and age levels sampled, learn with guidance from the speech pathologist to use esophageal speech, and the duration of esophageal speech training ranges from three to six months.[1]

Those individuals who do not or cannot, for some physical or psychological reason, learn esophageal speech are taught to communicate with electronic devices such as the electrolarynx.

Several studies indicate that a high percentage of laryngectomees (approximately 75%) are employable and many will return to their former jobs.[2] The time it takes a laryngectomee to return to gainful employment will depend on factors such as age, extent of surgery and/or any resulting complications, the degree of communicative efficiency required to resume a job, and individual motivation. A safe estimate is that the laryngectomee will be off the job from two to six months.

The major communication problems of stroke victims are aphasia or, more appropriately, dysphasia and dysarthria. Dysphasia is a general language disturbance which impairs the individual's ability to manipulate linguistic symbols in all language modes (reading, writing, gesturing, etc.). Dysarthria is a neurogenic motor speech disturbance which affects the individual's ability to initiate, coordinate, and time movements of the speech musculature. Individuals manifesting these communication problems ordinarily require a substantial amount of speech and language therapy. Responsibility for the communicative rehabilitation of these patients falls upon the speech pathologist.

Almost two-thirds of those individuals suffering a cerebrovascular accident (stroke) have neared or passed retirement age. Those individuals who are employed at the time of their stroke (approximately one-third) may or may not return to work in some capacity. Employability will depend on successful physical, vocational, and speech rehabilitation of the individual. Precise figures are not available in the crucial area.

An excellent study of employment of the deaf as it relates to their training is now in final report preparation by Mr. Theodore Holdt. It is entitled "Oregon Vocational Research Project for the Deaf" and may soon be obtained through the office of Mr. John E. Taylor, Coordinator, Handicapped Child Program, State Department of Education.

Target Groups

Groups of speech and hearing impaired which are in most urgent need of professional assistance are the very young, the severely impaired, the school age hard of hearing child, and the aged.

1. Webb, M.W., and Irving, R.W., Journal of American Geriatric Society, 12, 303-322 (1964).
2. Gardner, W.H., Archives of Environmental Health, 9,777-789 (1964); and American Cancer Society.

Although the law (ORS 343, specifically 343.212, 243.221 and 343.227) specifies that any child under 21 years of age requiring special education shall be provided with this service through his school, many school districts do not provide speech assistance to preschool children nor encourage such assistance for high school and post high school children. Many will provide preschool service upon proper referral when it is demonstrated that the disorder can best be ameliorated by providing early service.

The older citizen is more frequently in need of hearing evaluation, hearing aid use, lip reading and auditory training. However, stroke patients suffering from language and speech loss (dysphasia) are in need of speech and language rehabilitation, also. These individuals who are over 65 are eligible for Medicare and may receive speech assistance and hearing evaluation (when connected with medical diagnosis) but are not eligible for aural rehabilitation services (lip reading instruction, auditory training, hearing aids). The economic burden and/or the lack of knowledge about the availability of speech and hearing services frequently result in the patient going without this help.

Noise Pollution and Control

In Oregon, potentially damaging noise levels are present in the lumber and canning industries, airports, shipyards construction work and other settings where high-speed, high-powered equipment is used regularly. The Walsh-Healey Act of the U.S. Department of Labor, Part 50-204, specifies the intensity levels and exposure times beyond which noise control measures are required. Modifications of the existing laws in Oregon (Sections 22-114 - 22-022 of the Administrative Rules for Occupational Health) are under consideration to make them compatible with the Walsh-Healey Act. The controls specified are: reduction of noise at its source and a requirement for employees to wear ear protection devices and to have regular audiometric evaluations. While the Walsh-Healey Act pertains to those industries with federal contracts in excess of $10,000, it is expected to be the prototype for protection of employees in most high noise level environments.

Laws pertaining to nonindustrial noise appear to vary from one community to the next. Automobile mufflers are required statewide. Beyond this, there is only the broad category of "disturbing the peace" under which citizens can register complaints about environmental noise conditions.

Where hearing rehabilitation in the form of amplification or training is needed, state law provides only for those under 21 years of age of those eligible for vocational rehabilitation. Federal programs cover veterans only. Thus, hearing-impaired adults retired from high-noise employment have no provision for rehabilitation, even under Medicare.

Need

The number of employment settings in which permissible noise exposure levels are exceeded in Oregon is estimated at 12,000, with some 200,000 employees

affected. The settings range from the large lumber corporations to small manufacturing plants. If one includes the independent farm machine operator, auto mechanic, rock musician, et al, it is apparent that there are many people being subjected to damaging noise levels without any provision for measurement or control. Where ear protectors are required or suggested, they are often rejected by the workers because they find them uncomfortable, they do not believe that noise will damage their hearing, or they cannot hear signals which they say they need to hear through the background noise.

Perhaps the greatest present need is for increased public education regarding the effects and control of noise. Legislation and industrial controls can provide a model, but the individual must accept the responsibility for wearing the protection provided on-the-job, and in his noisy avocational activities as well. Since damaging noise levels are often below the pain threshold, he has no built-in warning system and must be taught.

Needs Met Now

Few industries are known to have implemented controls compatible with the Walsh-Healey Act, but the majority are approaching the task. Large corporations with sizable federal contracts, many employees and considerable operating capital, are moving to comply with the law; some are challenging it. Smaller companies face a different set of problems, in that the cost of modifying equipment or providing ear defenders, audiometric technicians and their equipment can be formidable. For the self-employed and the average citizen, there is probably no control at present, short of cotton plugs in the ear canals of those who find noise annoying and can reduce it without penalty.

CURRENT PROGRAMS AND ACTIVITIES

Most habilitation and rehabilitation for speech and hearing disorders takes place in public schools.

From its beginning in 1943, the speech, hearing, and deaf program has undergone continuous growth. During the 1969-70 school year, special education services for speech handicapped, hard of hearing, and deaf children were provided by 39 school districts and 26 intermediate education districts. The number of children served was:

Area	Number of Children Served by Grade									Total P-K-8	Total 9-12	EMR	Total Served
	P+K	1	2	3	4	5	6	7	8				
Deaf	103	29	22	21	25	7	5	10	6	228	72		300
Hard of Hearing	22	31	23	21	28	19	10	19	13	186	12	7	205
Speech	201	2716	2471	2941	2419	935	575	375	283	10,916	146	335	11,397
Totals	326	2776	2516	1983	1472	961	590	404	302	11,330	230	342	11,902

The figures reported under EMR represent educable mentally retarded children who received speech and/or hearing instruction.[1]

1. Figures are from the records of the State Department of Education.

Remedial instruction to the above children was provided by 35 teachers of the deaf and 187 speech and hearing clinicians. There are no known private or parochial school speech and hearing programs.

In terms of the number of children who needed help but did not receive it, the Oregon Board of Health through its hearing-testing program in the public, parochial, and private schools for the 1969-70 school year located 1,888 preschool and school-age children with hearing losses signigicant enough to require medical and/or special education service.

In addition to the survey figures reported by the Board of Health, school districts that operated speech and hearing programs were requested to provide on their 1969-70 annual reports an estimated number of children who have speech problems but received no help. Their figures indicate that 1,229 school-age children and 660 preschool children could have benefited from remedial speech instruction.

It should be noted that both sets of figures are somewhat incomplete and therefore probably do not reflect the total need for speech and hearing services.

There are a number of agencies and resources for obtaining assistance with speech and hearing disorders, other than schools. The following is a list of these resources in speech and hearing:

Speech and Hearing Training Clinics. These exist for the purpose of training students and are not specifically set up as diagnostic and treatment centers. All are minimal or no charge.

	Persons receiving speech and hearing evaluation and/or treatment 1969-70 school year.
University of Oregon	120
Oregon State University	284
Oregon College of Education (deaf education also)	427
Eastern Oregon College	55
Southern Oregon College	?
Portland State University	230
Pacific University	61
Lewis and Clark College (deaf education only)	0

Diagnostic and Treatment Centers in Speech and Hearing

	Persons receiving speech and hearing evaluation and/or treatment in 1969.
Eugene Hearing and Speech Center UGN agency; fee, according to ability to pay; includes pre-school deaf and infant hearing screening.	627

Portland Center for Hearing and Speech UGN agency; fee, according to ability to pay; includes pre-school deaf, stroke, and laryngectomy programs.	1,609

	Persons receiving speech and hearing evaluation and/or treatment in 1969.
University of Oregon Medical School, Crippled Children's Division Includes placement of hearing aids. Maintains a Ph.D training program in cooperation with the University of Oregon. Birth to 21, no charge.	627
Oregon State Board of Health Portland Includes statewide hearing screening, hearing evaluation, provision and orientation for hearing aids, program for stroke patients, speech and hearing evaluation through Child Development Clinics. No charge.	
Bess Kaiser Hospital Hearing evaluation only; minimal charge to members	580
Veterans Administration Hospital Portland No charge, veterans only.	150

State Training Schools Providing Services in Speech and Hearing

State School for the Deaf Fairview Hospital and Training Center	1,100	1969

Day Schools for the Deaf

Eugene Regional Facility for the Deaf
Portland Regional Facility for the Deaf
Tucker-Maxon Oral School
Private - tuition
Jackson County Intermediate Education District

Schools for Cerebral Palsy and Like Disorders

Holladay School - Portland Public Schools
Children's Hospital School - Eugene Public Schools

Public School Speech and Hearing Services. Includes staff of Special Education Division of State Board of Education. (There are no private school programs.)

See Directory of Personnel Engaged in the Education of Handicapped Children in Public Schools in Oregon, 1969-70. Issued by Special Services Division, Oregon Board of Education.

Summer Speech Camp

Camp Meadowood Springs, Weston Financed by donations and tuition.	115	1969

Private Practice in Speech and Hearing

Only one full-time person known in state.

A large number of people practice a few hours per week.

Child Development Clinics. Provide speech and hearing evaluation without charge.

	Children receiving speech and hearing evaluation in 1969.
Clackamas County	176
Polk County	20
Washington County	84
Yamhill County	40
Total	320

Other

National Society for Crippled Children and Adults. Eugene, Grants Pass.	87	1969-70
Federal Regional Facility for Deaf-Blind, Vancouver, Washington.	25	1969-70 children
University Affiliated Centers for Mental Retardation. Portland, Eugene.		
Industrial Audiometry Provided by many companies for employes to establish baseline hearing at pre-employment.		

Hearing Conservation Program - Oregon State Board of Health

Total number of audiometric tests	199,506
Total number of children tested (20,057 are preschool)	181,475
Total number referred audiometrically	10,628
Percentage incidence hearing impairment	5.85%
Total number referred for diagnostic otologic evaluation	6,934
Percentage referred for diagnostic otologic evaluation	3.82%
Number of counties participating in screening	36
Number of counties participating in otologic clinics	28
Number of otologic clinics	72
Number of children examined in otologic clinics	3,622
Number of children referred to family physician for medical care	1,888
Referral rate from otologic clinic for medical care	52%
Number of otologists participating (16 otologists + 8 ENT resident physicians)	24

College and university students with needs for speech and hearing services can usually obtain evaluation of their problem through the speech and hearing clinic at their particular institution (not community colleges). However, only a few receive speech or hearing treatment (habilitative and rehabilitation) services. Since 4% of college students have speech problems requiring treatment, a large number go without care.

Speech and hearing services for adults not in college are mainly limited to the Portland Center for Hearing and Speech, the Eugene Hearing and Speech Center, a handful of part-time private practitioners, and the Veterans Hospital in Portland (veterans only). Thus, most adults with speech needs are going without. Many adults receive marginal "over-the-counter" hearing evaluation while purchasing hearing aids from hearing aid dealers.

Hearing aid use is most adequately determined by audiological assessment, otological evaluation, and hearing aid trial with instruction. Nevertheless, most hearing aid users have had none of these services, but have had minimal audiometric testing by a hearing aid dealer (regulated for protection of the public under ORS 694) and then have been sold a hearing aid without benefit of professional counseling. Approximately 1% of the population use hearing aids.[1]

1. Anders, L.D., Journal of Oregon Speech and Hearing Association, Vol. 9, No. 1, 1970, p45.

Oregon Speech and Hearing Association

The Oregon Speech and Hearing Association (OSHA) is the local affiliate of the (ASHA) and has 187 members (1970). The OSHA maintains the same minimum requirements and the same code of ethics as the ASHA and provides guidance, professional cohesiveness, professional programs, short courses and a professional journal for its members and for others working in the field who are not members.

None of the speech and hearing specialists working in the State of Oregon are members of either the ASHA or the OSHA. There are approximately 342 people working with the speech and hearing handicapped (this does not include teachers of the deaf) in Oregon. Eighty-four of these do not belong to either OSHA or ASHA. Whether or not they could qualify is not certain; many could not.

Teachers of the Deaf

Teachers of the deaf take their professional direction from either or both of the following organizations: American Instructors of the Deaf, and The Council of Organizations for the Deaf. The professional journals of these organizations are The American Annals of the Deaf and the Volta Review. Approved certification for teachers of the deaf in Oregon is Certificate A (or eligibility therefore) from the Council of Organizations for the Deaf. The Oregon State Department of Education has the same requirement for certification.

Teacher training in Oregon for teachers of the deaf is obtainable at Oregon College of Education and Lewis and Clark College. These are programs approved by the Council of Organizations for the Deaf and qualify graduates for Certificate A.

A unique and helpful forum in this State is the Oregon Cooperative Council for the Deaf. This group meets monthly to discuss problems of a general nature involving the deaf in Oregon and is composed of representatives from all organizations in Oregon which deal with the hearing impaired and deaf.

The State Board of Education maintains a minimum standard of certification for "speech correctionists" which is below that required by the ASHA. If the minimum standards required by the State are met, a person may be hired by public schools as a "speech correctionist" and the particular school district will be reimbursed approximately 50 percent of the salary of this worker. Thus, standards set earlier by professionals and presently maintained by the State Board of Education encourage students in training to terminate training in order to seek professional employment at a level considerably below what the ASHA and the OSHA presently consider minimal allowable training, practicum, and supervised professional experience. If the training institutions, which

carry major responsibility for specifying standards, do not require the higher standard (i.e., ASHA - OSHA standard), then many new graduates are permitted to work with speech and hearing handicapped children at levels now considered to be inappropriate (based on the majority view of practicing speech pathologists and audiologists.

AUTHORITIES

Oregon Statute

All of the public colleges and universities, through authority of the State Board of Higher Education.

Crippled Children's Division, University of Oregon Medical School

Maternal and Child Health and Chronic Disease Sections of the Oregon State Board of Health

Oregon State School for the Deaf

Fairview Hospital and Training School

Children's Hospital School, Eugene - through authority of the Superintendent of Public Instruction

Holladay School, Portland - through authority of the Superintendent of Public Instruction

All Public School Programs - through authority of the Superintendent of Public Instruction

All State Regional Facilities for the Deaf and the Day Schools (except Tucker-Maxon)

Lewis and Clark College - private, non-profit corporation

Private, Non-Profit Corporations

Bess Kaiser Hospital, Portland

Camp Meadowood Springs

Eugene Hearing and Speech Center

National Society for Crippled Children and Adults

Portland Center for Hearing and Speech

Tucker-Maxon Oral School

Pacific University - by act of Territorial Government, Document No. 5327, 1854.

Federal Statute

Veterans Administration Hospital, Portland

Federal Regional Facility for Deaf-Blind, Vancouver, Washington

OBJECTIVES

1. By 1975 assure evaluative, habilitative, and rehabilitative services in speech and hearing within the local community of the handicapped individual.

2. By 1973 establish public and professional education programs relating to the nature of speech and hearing disorders and the availability of services.

3. By 1975 assure the reduction of noise pollution in industry, the community, and the home to levels safe for the human ear.

4. By 1973 assure professional competence of speech pathology and audiology personnel.

RECOMMENDATIONS AND METHODS

1. *DEVELOP COMMUNITY-BASED SPEECH AND HEARING SERVICES AS PART OF REGIONAL CENTERS IN KEY LOCATIONS TO ASSURE EVALUATIVE SERVICES IN SPEECH AND HEARING.*

   Methods

   a. *University of Oregon Medical School, in cooperation with the Oregon State Board of Health and the Oregon Medical Association, establish speech and hearing centers in selected areas throughout the state. Consideration should be given to providing space for community-sponsored speech and hearing clinics in community college buildings such as those at Astoria, Bend, Coos Bay, Ontario, and Roseburg.*

   b. *University of Oregon Medical School expand the speech and hearing evaluative and consultative services of the Crippled Children's Division on a statewide basis to include major* population centers throughout the state.

2. *REAFFIRM THE RESPONSIBILITY OF SCHOOL DISTRICTS UNDER ORS 343.221, PARTICULARLY FOR PRESCHOOL, HIGH SCHOOL, AND POST HIGH SCHOOL PERSONS UP TO 21 YEARS OF AGE, SO THAT HABILITATIVE AND REHABILITATIVE SERVICES IN SPEECH AND HEARING ARE ASSURED WITHIN THE LOCAL COMMUNITY.*

Method

Superintendent of Public Instruction issue a formal directive to superintendents of schools reminding them of the obligation which schools have to provide speech and hearing services when needed, or to contract for these services from a school district maintaining such services. These are to be made available to all children who can profit therefrom, particularly those with severe handicaps, e.g., hard of hearing, cerebral palsy, and language disorders.

3. *ESTABLISH EDUCATIONAL PROGRAMS ON THE NATURE OF SPEECH AND HEARING DISORDERS FOR PROFESSIONALS AND THE PUBLIC.*

Methods

a. *Oregon Medical Association, in cooperation with the University of Oregon Medical School and Oregon Regional Medical Program, include topics on hearing and speech disorders in continuing education programs for physicians and other related health professionals.*

b. *Oregon Speech and Hearing Association encourage Board of Higher Education to include topics on hearing and speech disorders and their recognition in the curriculum of Oregon teacher-training programs.*

c. *Oregon Speech and Hearing Association, in cooperation with the Oregon State Board of Health, establish community education programs regarding the nature of speech and hearing disorders and the availability of services. The public should also be made aware of the dangers of high intensity noise and be informed of the protective measures that can be taken. Adult education to be an extension of the present Board of Health hearing conservation activities, with provision of funds for pamphlets and informative features via the mass media.*

d. *Board of Education require inclusion in appropriate courses of the science curriculum of all Oregon schools, the physiology of the auditory system and the relationship of noise to hearing disorders.*

4. *REDUCE NOISE POLLUTION TO SAFE LEVELS FOR THE HUMAN EAR.*

Methods

a. *Oregon Speech and Hearing Association, in cooperation with the Association of Oregon Industries, sponsor legislation*

which is compatible with noise controls provided by the Walsh-Healy Act. Revise Sections 22-114 through 22-022 of the Administrative Rules for Occupational Health to be compatible with the Walsh-Healy Act.

b. *Workman's Compensation Board and Oregon State Board of Health include in their Rules and Regulations, language requiring that workmen take preventive measures when within auditory range of equipment and machinery producing noises of potentially damaging intensity.*

c. *Oregon State Board of Health develop an educational program aimed at students to inform them of the potential dangers to hearing created by high amplification of sound.*

5. *ESTABLISH LEGISLATION REQUIRING MINIMAL LEVELS OF COMPETENCE AS DESIGNATED BY THE AMERICAN SPEECH AND HEARING ASSOCIATION, IN THE PRIVATE PRACTICE OF SPEECH PATHOLOGY AND AUDIOLOGY.*

Methods

a. *The Health Marpower Committee of the Governor's Health Planning Committee, in cooperation with the Oregon Speech and Hearing Association, initiate a study of present Oregon certification requirements for clinicians to determine how these compare with the requirements established by the American Speech and Hearing Association.*

b. *Board of Education, in cooperation with the Governor's Health Planning Committee, determine the feasibility of adopting the standards required by the American Speech and Hearing Association. A special ad hoc committee of the Oregon Speech and Hearing Association work with the Health Manpower Committee of the Governor's Health Planning Committee to introduce appropriate legislation.*

6. *ENCOURAGE SPEECH AND HEARING CLINICS, SCHOOL SERVICE PROGRAMS, AND PRIVATE PRACTITIONERS, TO MEET MINIMAL REQUIREMENTS FOR STANDARDS OF SERVICE SET FORTH BY THE PROFESSIONAL SERVICES BOARD OF THE AMERICAN SPEECH AND HEARING ASSOCIATION.*

Method

All public and private speech and hearing service units be encouraged to seek certification through the Professional Services Board of the American Speech and Hearing Association. (The President of the Oregon Speech and Hearing Association, with the support of the Board of Education, should write a letter to all service units encouraging certification.)

OPERATIONAL PROBLEMS

1. "Giving" space in a community college for a community speech and hearing clinic will undoubtedly present priority problems in each community. An alternative plan would be to rent space wherever it can be found, or to use temporary space in the community college.

   Alternate: If the State Board of Health staffed regional speech and hearing clinics, budget would have to be provided for up to six speech pathologist-audiologists (dual American Speech and Hearing Association Certification) and appropriate test facilities for hearing evaluation.

2. To expand statewide speech and hearing services of the Crippled Children's Division would require additional budgeting for at least one full-time staff member. A mobile unit could be considered as a way of meeting the space and equipment requirements for extension of evaluative services in speech and hearing. However, this would be a significant expenditure (approximately $10,000) and would require additional budgeting.

3. Many school districts have not provided, or at least not encouraged, speech and hearing services for preschool, high school and post high school children and, therefore, may require additional staff. In a reimbursed program (ORS 343.281), this would require additional budget allotment to the Department of Special Education, State Board of Education.

4. The expansion of regional speech and hearing services through school districts would require additional budgeting for reimbursement through the Department of Special Education, State Department of Education.

5. If a licensure law for speech pathology-audiology were passed, administration of the advisory board would have to be assigned to an appropriate agency -- probably the State Board of Health. Administrative Costs would be met by the licensing fees.

6. It is anticipated that Oregon industries would oppose legislation for noise control based on the expense they might incur.

7. Additional budget would be required to extend education regarding noise pollution and regarding speech and hearing disorders.

EVALUATION CRITERIA

Responsibility for the evaluation of progress toward all objectives could be invested in the State Board of Education, Special Education Division, and the Oregon Speech and Hearing Association, and more specifically the semi-annual Retreat -- a planning and problem-solving group comprised of the major officers of the Association, its State Council, and its past presidents. The State Council includes, ex-officio, two members of the staff of the State Board of Education, Special Education Division, and a staff member of the State Board of Health, Maternal and Child Health Section. Among the past presidents are staff members from the Medical School, the University of Oregon, Oregon State University, Portland Public Schools, etc.

The efficiency of regional speech and hearing centers should be formally invested in the agency made responsible for the centers, but could be studied further by the Oregon Council for the Deaf and the Oregon Speech and Hearing Association.

Criteria for success would be that no significant number of speech and hearing handicapped persons, who seek help, go without professional evaluation and treatment (as indicated) of their problem.

PRIORITY

To be determined.

ENVIRONMENTAL HEALTH PROBLEMS

AIR QUALITY

GOAL RESTORE AND MAINTAIN THE QUALITY OF THE STATE'S AIR RESOURCES.

CONDITION

The pollution of Oregon's air resources is a matter of increasing public concern. Emissions from industrial, agricultural, and domestic sources - including motor vehicles - reduce air quality below acceptable standards.

The major air pollution problems in Oregon include health risks, reduced visibility, high particle fallout, excessive suspended particulate concentrations and objectionable odors. The primary causes include the many types of industrial operations such as inadequately controlled wigwam waste wood burners, motor vehicle emissions, open burning (forest slash, agricultural field straw and stubble, land clearing debris), incinerators, and power boilers.

In general, the concentrations of most gaseous contaminants are within acceptable limits although those associated with motor vehicle emissions are of concern, particularly in the downtown Portland area.

Although it is difficult to prove that air pollution is a health problem, it is easily inferred from the mounting research evidence from epidemiological surveys, clinical studies, industrial research, laboratory experiments, and accidents.

CURRENT PROGRAMS AND ACTIVITIES

Comprehensive programs for the control of air quality are conducted by the State Department of Environmental Quality; the Columbia-Willamette Air Pollution Authority in Clackamas, Columbia, Multnomah, and Washington Counties; the Lane Regional Air Pollution Authority in Lane County; and the Mid-Willamette Valley Air Pollution Authority in Benton, Linn, Marion, Polk, and Yamhill Counties.

The state program has been in operation since 1951, and the three regional programs since 1967 and 1968.

The existing regional programs cover 14% of the state's area and serve 63% of the total state population. The regional authorities have complete jurisdiction within their areas except for control over aluminum reduction plants, pulp and paper mills, nuclear power

plants, and motor vehicles which are retained by the State under the Department of Environmental Quality because of the complexity of the technology involved.

The activities of the state and regional programs are to: develop and coordinate plans and requirements for controlling air pollution; promote voluntary cooperation by all persons concerned with air pollution; conduct areawide studies and surveys; develop and adopt ambient air quality and emission standards and general rules for control of air pollution; monitor ambient air quality and atmospheric emissions; review and approve plans for installation of air pollution control devices; cooperate with all levels of government and interested agencies; investigate complaints; hold public hearings and enforce laws and administrative rules; provide advisory technical consultative services; process applications for tax relief for pollution-control facilities; prepare reports and educational material for the information of the public.

The funds and staffs for the regional and state programs for the 1970-1971 fiscal year are:

	Total Budget	Authorized Positions Full-time	Part-time
Columbia-Willamette Air Pollution Authority	$ 448,243	27	2
Lane Regional Air Pollution Authority	160,046	10	1
Mid-Willamette Air Pollution Authority	154,112	10	0
Oregon Department of Environmental Quality*	307,739	17	2

AUTHORITIES

The state and regional air pollution control programs are conducted under specific authority granted by the Legislature and set forth in Chapter 449 of the Oregon Revised Statutes (Sections 449.702 to 449.992).

All agricultural operations are exempt from the general requirements of the state air pollution statutes and administrative rules of the state and regional authorities with the exception that some control is exercised by the state agency over field burning under special legislation enacted in 1967 and 1969.

*Excludes budget and staff for administration and certain other special services.

OBJECTIVE

By 1973, develop necessary regulations to prevent potentially hazardous emissions into the atmosphere and insure total compliance with established ambient air quality and emission regulations.

RECOMMENDATIONS AND METHODS

1. *DEVELOP AND PUBLICIZE A STATEWIDE POLLUTION AND EMISSIONS INVENTORY WITH NECESSARY METEOROLOGICAL INFORMATION.*

   Methods

   a. *Department of Environmental Quality and regional authorities extend and improve air monitoring network for gathering visible and non-visible air contaminant and meteorological information.*

   b. *Department of Environmental Quality and regional authorities develop a registry of air contaminant sources.*

2. *REGULATE OPEN FIELD, OPEN DOMESTIC BURNING AND PHASE OUT INADEQUATELY CONTROLLED WIGWAM WASTE WOOD BURNERS TO MINIMIZE AIR POLLUTION.*

3. *ESTABLISH AMBIENT AIR QUALITY AND EMISSION PROGRAMS AND ENFORCE REGULATIONS.*

   Methods

   a. *Department of Environmental Quality and regional authorities develop and enforce ambient air quality standards, and emission standards where applicable, pertaining to fluorides, oxides of nitrogen, sulfur dioxide, oxidant, and hydrocarbons.*

   b. *Department of Environmental Quality submit legislation granting them control over emissions into the atmosphere.*

   c. *Department of Environmental Quality submit legislation removing agricultural exemption from general air pollution statutes.*

   d. *Department of Environmental Quality to develop programs to meet ambient air standards such as particle fallout, suspended particulates, and carbon monoxide.*

4. *REDUCE TOTAL AMOUNT OF EMISSIONS CAUSED BY TRANSPORT VEHICLES.*

   Methods

   a. *Transportation Department and cities to promote adequate inter- and intra-city mass transportation service and usage.*

b. Regional authorities to submit legislation granting them authority for regulating motor vehicle traffic in congested areas.

c. Department of Motor Vehicles develop legislative proposals to require all motor vehicles in Oregon to have an approved smog control device.

5. *PROVIDE CIVIL PENALTIES FOR AIR POLLUTERS.*

Methods

a. Department of Environmental Quality and regional authorities submit legislation providing civil penalties for violation of air pollution control statutes or rules.

b. Department of Environmental Quality and regional authorities enforce regulations pertaining to motor vehicle visible emissions, particulate matter emissions, raft mills, aluminum reduction plants, rendering plants, and hot mix asphalt plants.

6. *ENCOURAGE EXPERIMENTS WITH DEVICES AND OTHER TECHNIQUES TO ELIMINATE AIR POLLUTION.*

7. *PREPARE PLANS FOR EMERGENCY AIR QUALITY CONDITIONS.*

Method

Department of Environmental Quality and regional authorities develop an alert system for emergency air quality conditions.

OPERATIONAL PROBLEMS

1. Shortages of staff and money.
2. Inadequate information regarding dangers to health caused by air pollution.

EVALUATION CRITERIA

Department of Environmental Quality and regional authorities to analyze ambient air quality, chemical content of selected emissions, and visibility levels.

PRIORITY

To be determined.

DRINKING WATER SUPPLIES

GOAL INSURE THAT ALL DOMESTIC WATER SUPPLIES IN OREGON ARE SUFFICIENT AND MEET THE QUALITY STANDARDS OF THE STATE BOARD OF HEALTH.

CONDITION

In 1969, 46% of the approximately 500 community water supplies in Oregon did not fully meet the bacteriological standards for safe drinking water. These supplies served 31% of the state's population and 11% of the population served by community water systems. There is a need for better supervision and enforcement of these supplies. Approximately 26% of the people are served by individual water systems or systems serving less than 25 families. Many of these supplies are of poor quality as they receive little supervision. There are other potential problems in that the approximately 2,500 parks and recreation areas (which serve 66 million visitor days per year) usually have their own water supplies. Many of these supplies along with other water supplies serving industries, motels, mobile home courts, farm labor camps, private camps, and restaurants receive little supervision; some have never been sampled; often the water samples for these supplies are collected by untrained people.

CURRENT PROGRAMS AND ACTIVITIES

The Oregon State Board of Health Office of Public Health Engineering supervises community water systems serving over 10 families or fifty people; and reviews all plans for new water systems and improvements to existing systems serving more than 10 families. With the cooperation of county health departments they supervise the collection of samples of water from all water supplies serving over 25 families, collect samples of water for compliance with standards of chemical quality, make surveys of water systems, and follow-up on unsatisfactory reports to obtain correction of water problems.

Oregon State Board of Health and local health department sanitarians conduct sanitary surveys, provide sampling and consultative service to families and private camps having private water supplies and small community water supply systems (10 services or less). Such activities, however, are not clearly defined in the state statutes. Because of the demand for sampling from private water supplies or small community supplies, local health departments sometimes dispense sample bottles to individuals for taking their own water samples; these are then sent to the Oregon State Board of Health laboratory for bacteriological analysis; however, no chemical examinations are provided.

Oregon State Board of Health and local health department sanitarians also provide limited supervision of water supplies, sampling, test evaluations, enforcement procedures at tourist facilities and restaurants which are licensable.

The Occupational Health Section of the State Board of Health supervises industrial and farm labor camp water supplies.

Oregon State Board of Health sanitarians provide direct services for water supply surveillance, sampling, test evaluation, and assistance to owners in seeking corrective action in seven state counties having a population of less than 10,000 and in two counties under contractual agreement with the Oregon State Board of Health.

Oregon State Board of Health sanitarians in cooperation with the State, Federal, Public Utilities, timber companies and private recreational areas provide consultation and assistance in those areas concerning water supply sources serving the public.

AUTHORITIES

The State Board of Health, ORS 449.215, 449.220, 449.225, 449.232, 449.235, 624.090, 446.062, 446.520, 447.130.

Local health departments, ORS 446.002, relating to tourist facilities, and following sections. ORS 624.060, relating to restaurants. ORS 449.225, relating to water samples from community water supplies.

Anyone selling water, ORS 210.

Cities, ORS 449.305 through 449.340.

Public Utilities Commissioner, ORS Chapter 757.

State Engineer, Water Resources Board, ORS Chapters 536 through 542.

OBJECTIVE

Assure that the 500 community water systems, 2,500 public parks and recreation areas, 1,500 licensable facilities having their own sources of water, and the 15,000 private water systems serve sufficient amounts of safe drinking water.

RECOMMENDATIONS AND METHODS

COMMUNITY WATER SUPPLIES

1. *IMPROVE SUPERVISION OF MUNICIPAL WATER SUPPLIES.*

2. *PROVIDE SPECIFIC AUTHORITY FOR STATE AND LOCAL HEALTH OFFICERS TO REGULARLY TEST AND TO ENFORCE DOMESTIC WATER QUALITY AND QUANTITY STANDARDS OF WATERS PURVEYED TO SMALL WATER SYSTEMS.*

3. *REQUIRE CHEMICAL ANALYSIS ANNUALLY FOR SURFACE SUPPLIES AND EVERY THREE YEARS FOR UNDERGROUND SUPPLIES.*

Methods

a. Oregon State Board of Health:

1) Require monthly collection and bacteriological examination of all water samples serving communities and require compliance with standards of those found to be unsatisfactory.

2) Survey systems reported to be unsatisfactory and make recommendations and requirements to correct defects.

3) Require reports of deviations from normal treatment procedures.

4) Review plans for new water systems and additions to existing water systems of all sizes.

5) Regularly check chemical analyses of water produced.

b. Local health offices explore the feasibility of using trained aides to perform laboratory sample screening using the Millipore methods.

PRIVATE OR INDIVIDUAL WATER SUPPLIES

1. *OREGON STATE BOARD OF HEALTH COLLECT SAMPLES AND CONDUCT SANITARY SURVEYS FOR NEW SYSTEMS. SURVEYS ARE NOW REQUIRED BY LOANING AGENCIES (FHA, VETERANS', AND PRIVATE LOANS) AND FOR THOSE SUPPLIES WHICH HAVE A PUBLIC HEALTH IMPACT.*

2. *OREGON STATE BOARD OF HEALTH STUDY FEASIBILITY OF COLLECTING FEES FOR THE BACTERIOLOGICAL EXAMINATIONS OF PRIVATE WATER SUPPLIES.*

3. *OREGON STATE BOARD OF HEALTH AND LOCAL SANITARIANS ESTABLISH PRIORITY FOR SAMPLE COLLECTION AND SANITARY SURVEYS BASED ON PUBLIC HEALTH IMPACT; INCLUDE FOSTER HOMES, GROUP CARE HOMES, INDUSTRIAL USERS, DOMESTIC PURPOSES, ETC.*

OTHER WATER SUPPLIES

1. *CORRECT NON-CONFORMING WATER SUPPLIES.*

2. *PROVIDE SANITARY SURVEYS OF WATER SUPPLIES AND DEVELOP AN ALTERNATE METHOD FOR EVALUATING THE CURRENT PROCEDURE OF COLLECTING AND EXAMINING WATER SUPPLY SAMPLES.*

3. *AUTOMATE WATER SUPPLY REPORTING.*

4. *DETERMINE THE FEASIBILITY OF REQUIRING CERTIFICATION OF WATER SYSTEM OPERATORS.*

Methods

a. Oregon State Board of Health, in cooperation with counties, require submission of plans for review prior to construction or installation of water supplies.

health departments, other state and federal agencies; and monitor status of regional water table in conjunction with State Engineer and Department of Geology and Mineral Industries.

PRIORITY

To be determined.

SEWERS AND SUBSURFACE SEWAGE DISPOSAL SYSTEMS

GOAL PRESERVATION OF HEALTH THROUGH PROVISION OF EFFECTIVE AND STANDARD CONFORMING SEWERAGE AND SUBSURFACE SEWAGE DISPOSAL SYSTEMS.

CONDITION

The lack of approved public sewerage and effective individual subsurface sewage disposal systems in many urban and suburban areas throughout the state has for many years been a problem source of major concern to the state and local health authorities. Serious diseases, including typhoid fever, infectious hepatitis, and gastrointestinal disorders may be transmitted through water supplies, or sewage effluents may break out onto the surface of the ground or into roadside ditches or nearby streams that are frequently utilized by people.

Impervious subsoil formations, high ground water tables (which are potential sources of domestic water supplies), geology, topography, annual rainfall, and poor surface drainage often make it impractical, if not impossible, to dispose of sewage in a safe and sanitary manner by means of adequate sewage collection, treatment, or an effective subsurface disposal system. The over-flow of inadequately treated sewage into ground waters and domestic water wells and onto the surface of the ground, or into ditches or drainage ways creates potential health hazards, water pollution, and nuisance situations. The disposal of sludge or sewage solids accumulated by such systems has also become a serious environmental problem.

Only 65% of Oregon's population receives the services of a sewage collection and treatment system; of these people, only 62% are served by secondary treatment facilities. Rapid improvement is being made, and by July, 1972, all of the state's sewage collection and treatment systems will be served by secondary treatment.

The solution to sewage disposal problems where they occur may best be developed through the installation of public or community-wide sewerage systems, or effective subsurface sewage disposal systems which provide the required degree and type of treatment and disposal.

There are still many small cities, communities, and portions of suburban areas adjacent to the larger municipalities that do not have public or community-wide sewerage; they are in urgent need of them.

Frequently plans for new subdivisions or platted lands are submitted to city or county authorities (planning commissions, boards of county commissioners) and are approved without regard for plans for the orderly development of water supply and sewage disposal systems; because of this, they create needless and serious environmental problems.

CURRENT PROGRAMS AND ACTIVITIES

The county health departments, sanitary districts and authorities, the State Board of Health, and the Department of Environmental Quality are promoting the installation of effective subsurface sewage disposal systems as well as public or community-wide sewerage systems throughout the state.

The State Board of Health regulations include minimum standards for the design, construction, and use of subsurface sewage disposal systems. To provide for variations in local conditions, the county health departments may establish standards that exceed state minimums.

Limited inter-agency coordination is being carried on by State Board of Health staff and to a more limited degree by the local health departments. Such coordination definitely upgrades the reliability of decisions made on subsurface sewage disposal when such agencies as the Soil Conservation Service and the State Engineer's Office are called in as consultants.

The Department of Environmental Quality regulations govern the use of waste disposal wells. Such disposal systems have been used extensively in the Central Oregon area (Bend, Redmond, Madras), but are to be phased out of operation by 1980 or earlier as community-wide sewerage systems become available and suitable land is found for subsurface sewage disposal systems. The sewage disposal wells constitute a potential threat to the quality of the underground water resource.

The State Board of Health and the Department of Environmental Quality have recently placed specific limitations on the use of subsurface sewage disposal systems in the north Clatsop County plains area because of the potential of contaminating ground water resources. Enforcement is through the prohibition of high density land development utilizing subsurface disposal sewage in the Clatsop Plains area by the Department of Environmental Quality, the endorsement of the ban by the State Board of Health, the issuance by cities and counties of building permits for limited construction, and the review and approval of plans and specifications for sewage treatment plants or subsurface sewage disposal systems by local, regional, and state agencies.

AUTHORITIES

The local and state programs for control of sewage collection and disposal are conducted under general authority granted by the Legislature to local government and under specific authority granted to the State Board of Health in ORS Chapters 183, 431, 446, 447, and 449, to the Department of Environmental Quality in ORS Chapter 449, and to Sanitary Districts and Authorities in ORS Chapter 450.

OBJECTIVES

1. Install effective subsurface sewage disposal systems or community-wide sewerage systems with approved treatment in all communities where warranted, to prevent health hazards and water or ground water pollution by 1973.

2. Attain optimum inter-agency coordination at national, state, regional, and local levels to improve decision-making pertinent to effective sewage disposal and protection of surface and ground waters by 1972.

RECOMMENDATIONS AND METHODS

1. *CLARIFY AGENCY JURISDICTION OVER SEWAGE DISPOSAL PROBLEMS AND FACILITIES, INCLUDING SEWERAGE SYSTEMS, SUBSURFACE SEWAGE DISPOSAL, AND SEWAGE TREATMENT PLANTS.*

   Methods

   a. *Department of Environmental Quality and Oregon State Board of Health cooperatively develop and introduce proposed revisions to the Oregon Revised Statutes, clarifying the jurisdiction of the two agencies relative to sewage matters.*

   b. *Department of Environmental Quality and Oregon State Board of Health promulgate, adopt, and enforce sewage collection, disposal, and treatment regulations in accordance with their respective regulatory and programming functions, as dictated by statute.*

2. *FULLY UTILIZE APPROPRIATE FINANCING MECHANISMS TO PLAN AND CONSTRUCT NEEDED SEWAGE DISPOSAL AND TREATMENT FACILITIES IN HIGH PRIORITY AREAS.*

   Method

   Department of Environmental Quality and Oregon State Board of Health, in cooperation with Program Planning (New Resources), provide consultation and guidance to local governments as to sources and requirements for funding projects, including regional sewerage trunks and treatment services.

3. *IDENTIFY AREAS WHERE THERE IS A LIKELIHOOD OF DEVELOPING A RESIDENTIAL COMMUNITY OF SUFFICIENT DENSITY AND WHERE SOIL AND OTHER TOPOGRAPHIC CONDITIONS PRECLUDE THE EFFECTIVE HANDLING OF SEWAGE.*

   Method

   Department of Environmental Quality define and inventory present and potential hazardous areas, which, based on applicable criteria, cannot support septic tank systems.

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Department of Environmental Quality evaluate program progress by monitoring percentage of population not served by approved sewerage systems.

PRIORITY

To be determined.

SOLID WASTE

GOAL OPTIMAL PROTECTION OF PEOPLE AND ENVIRONMENT THROUGH PREVENTION, PROPER COLLECTION, TRANSPORTATION, AND DISPOSAL, REUSE, OR RECYCLING OF ALL TYPES OF SOLID WASTE THROUGH A COORDINATED STATE, LOCAL, AND PRIVATE INDUSTRY PROGRAM.

CONDITION

The responsibility for control over solid waste matters is presently divided between the Oregon State Board of Health and the Department of Environmental Quality. This division of responsibility has complicated procedures and cooperative efforts with other levels of government and private industry. There are no comprehensive programs for solid waste prevention or reuse.

Storage Many cities and counties have inadequate and/or poorly enforced rules and regulations regarding garbage cans or containers and other solid waste storage problems. Fifty-eight percent of the communities do not have regulations covering solid waste storage. Despite present regulations, there is a prevalence of backyard burning of refuse. Burning barrels create air pollution, odor, vector, and fire problems.

Collection There are 106 communities (comprising 15% of Oregon's population) that do not have collection services; an additional 15% of the population do not use the collection service available to them. It has also been noted that individuals make more trips to the disposal sites than commercial trucks and often cause litter by spillage. Many city and commercial garbage collection services do not pick up, nor do public and private disposal sites always accept, all kinds of solid waste; often excluded items include oils, chemicals, septic tank pumpings, tires, auto bodies, large appliances, building demolition debris, and dead animals. This results in unauthorized dumping.

Disposal "Open burning" dumps at 162 of the 231 (70%) muncipal sites create pollution, vector, fire safety, and nuisance problems. Sixty-four percent of the authorized disposal sites are open dumps rather than the preferable land-fill type. Forty percent of the authorized disposal sites have existing or potential drainage problems. Many others lack effective vector controls and/or fire protection. Some cities and counties are running out of land-fill sites. Individuals dump at more than 640 unauthorized disposal sites, which receive no control or maintenance. Unauthorized dumps exceed authorized ones by a ratio of 3 to 1.

CURRENT PROGRAMS AND ACTIVITIES

Oregon State Board of Health, Solid Waste Section gives consultation to cities, counties, state government, private industry, and individuals about solid waste planning and operations. New and old disposal sites are evaluated (about ten new sites per month are evaluated). Two training courses a year are conducted for disposal site operators, consulting engineers, and enforcement agencies. The section continually searches for new and improved methods of solid waste disposal and develops grants for these purposes.

Department of Environmental Quality reviews plans and has approval authority for solid waste disposal sites. They are responsible for air and water pollution aspects of solid waste disposal. They have authority to regulate most aspects of solid waste disposal.

Local Governments dispose of solid waste or license or franchise private operators. (Eighteen counties and four cities have accepted site operation and maintenance responsibilities; 10 counties are planning to accept these responsibilities; 8 counties have yet to accept any responsibility for disposal sites.)

Private Industry provides more than 95% of regular garbage and refuse collection service.

AUTHORITIES

Department of Agriculture - Statutory
Oregon State Board of Health - Statutory
Department of Environmental Quality - Statutory
State Police - Statutory
State Game Commission - Statutory
County Government - Statutory and County Orders
Sanitary Districts - Statutory
State Engineer - Statutory
Cities - Ordinances
Department of Geology and Mineral Industries - By Request
Regional Air Pollution Authorities - Statutory and Rules and Regulations of Columbia-Willamette, Mid Willamette, and Lane Regional Air Pollution Authorities

OBJECTIVES

1. Effect a merger of solid waste program activities into a single State agency during 1971.

2. Attain proper solid waste storage, collection, and disposal by 1973.

3. Develop improved methods for solid waste prevention, storage, collection, recycling, reuse, and disposal by 1973.

4. Revise solid waste laws and regulations to clearly define roles of State and local government and private industry.

RECOMMENDATIONS AND METHODS

1. *DEPARTMENT OF ENVIRONMENTAL QUALITY BE GIVEN AUTHORITY FOR ALL SOLID WASTE MANAGEMENT IN OREGON.*

2. *REQUIRE AND ENFORCE PROPER SOLID WASTE STORAGE PRACTICES.*

   Method

   Cities and counties enact and enforce regulations regarding proper solid waste storage.

3. *ENFORCE PROHIBITION AGAINST OPEN BURNING OF PUTRESCIBLE SOLID WASTES.*

   Method

   State and local governments enact and enforce regulations prohibiting open burning of putrescible solid wastes.

4. *COLLECTION SERVICES PICK UP AND DISPOSAL SITES ACCEPT ALL BUT HAZARDOUS WASTES.*

   Method

   Cities, counties, and private industry provide for collection and disposal of all types of household solid wastes.

5. *OBTAIN, DEVELOP, EQUIP, AND MAINTAIN AUTHORIZED DISPOSAL SITES IN ALL COUNTIES.*

   Methods

   a. *Cities and counties close, clean up, and post unauthorized disposal sites.*

   b. *Governments sanction the use of short-term (under five years) sanitary land-fill sites for areas which would not qualify for such use on either a permanent or long-term basis.*

   c. *Department of Environmental Quality:*

      1) *Submit legislation making each county or region responsible for providing adequate disposal sites.*

2) *Advise and/or assist cities, counties, and private industry in locating, acquiring, and financing approved solid waste disposal sites and necessary compacting, covering, and equipment-washing facilities.*

3) *Submit legislation for a solid waste disposal site permit program requiring agency, city, and county approval for the establishment or operation of disposal sites under adequate environmental quality control regulations.*

6. *ENCOURAGE PLANNING RESEARCH AND MANAGEMENT OF SOLID WASTE PROBLEMS.*

Methods

a. *Department of Environmental Quality:*

1) *Obtain improved legislation, rules, and regulations regarding solid waste management practices.*

2) *Promote the formation of solid waste utility management groups to operate as regional, county, state, or private enterprises; these groups may encourage the establishment of franchised utility services.*

3) *Cooperate with local health departments, public works departments, and county governments to develop solid waste management guidelines and criteria and achieve adequate supervision and control of solid waste disposal sites.*

4) *Complete the industrial solid waste survey.*

5) *Provide information to the public and technical assistance to government and industry regarding solid waste management.*

6) *Cooperate with the State Engineer and the Department of Geology and Mineral Industries to collect, compile, and appraise surface and subsurface geological surveys to delineate areas suitable for the disposal of nuclear, toxic chemical, and other hazardous wastes, as well as other solid wastes.*

7) *Encourage research leading to new processes (including prevention, reuse, closed-system incinerators, etc.) of reduction, handling, or disposal of solid wastes.*

8) *Prepare legislation to control litter, such as requiring a deposit fee on all beverage bottles.*

9) *Encourage the development of organic (bio-degradable) material containers.*

b. State Local Government Relations Division promote regional planning for solid waste management.

c. Department of Transportation encourage mass transit facilities on both an inter- and intra-city basis to reduce the number of vehicles on the road and thereby reduce the quantity of waste tires, oil, etc.

7. *DEVELOP ALTERNATE FINANCING MECHANISMS TO PROVIDE STATE OR FEDERAL FINANCIAL AID TO REGIONAL OR LOCAL AREAS FOR SOLID WASTE MANAGEMENT.*

Method

Department of Environmental Quality support legislative enactment of a container or other appropriate tax.

OPERATIONAL PROBLEMS

1. Lack of correlation of the solid waste activities of state, federal, and county governments.
2. Lack of specific state programs for solid waste prevention, reuse, recycling, or disposal.
3. Lack of money and trained personnel.

EVALUATION CRITERIA

The single state agency with authority for solid waste management measure: (1) reduction of illicit disposal sites; (2) number and percent of the properly operated disposal sites; (3) percent of population without adequate solid waste collection services; (4) adequacy of solid waste land disposal practices; and (5) promotion of progressive and long-range disposal techniques.

PRIORITY

To be determined.

VECTOR CONTROL

GOAL PROTECT THE HEALTH OF THE PUBLIC FROM VECTOR-BORNE AND ARTHROPOD-BORNE DISEASES AND ZOONOSES (ANIMAL DISEASES TRANSMITTABLE TO MAN), AND FROM HARMFUL EFFECTS DUE TO THE MISUSE OF INSECTICIDES, PESTICIDES, RODENTICIDES, AND OTHER SYNTHETIC CHEMICAL KILLING AGENTS USED TO CONTROL VECTORS.

CONDITION

The extent and prevalence of vectors and causative zoonosis agents in these vectors is unknown, although several are endemic in Oregon. The control of many diseases involves control of animal hosts, vectors, arthropods, and other insects such as mosquitoes, fleas, and mites. No monies are currently available for the control of vectors in case of vector-borne epidemic.

As many as 850 cases of psittacosis have occurred in the past ten years and resulted in three deaths. Five counties have had outbreaks of encephalitis as recently as 1968. In 1959, 80 cases of human tularemia occurred from consumption of polluted water. From 1965 through 1969, there were 28 cases of Colorado tick fever, five cases of Rocky Mountain spotted fever, two cases of arthropod-borne encephalitis, and six cases of tick paralysis reported in Oregon. Sylvan plague has been found in animal populations in eleven eastern and southern Oregon counties. Many major recreational areas are without adequate surveillance of vectors for sylvan plague, tularemia, and tick-borne diseases. This has serious implications due to heavy tourism, especially of campers, in the state of Oregon.

Many areas of the state support populations of anopheles mosquitoes, raising a potential threat of malaria. Eighteen imported cases (mainly returning veterans) were reported in 1969. Arthropod-borne encephalitis has been found in 20 of the 36 counties. Irrigation and multiple use water projects are planned in many parts of the state, and unless mosquito control is considered in the basic design, severe encephalitis control problems will result. Approximately 50% of the state's population is now given a minor degree of protection from mosquitoes through local control programs.

There is a lack of data on prevalence of leprospirosis, rat bite fever, and other organisms in domestic and sylvan rodents; the transmission rates of these diseases to humans and domestic animals is unknown. The danger of disease and a lessened quality of life is indicated by the fact that in the city of Portland alone, there were 14 reported occurrences of rat bites to children and others during 1969.

Although there have been no recent cases of rabies in humans, it is known that local dog and other pet controls have not been generally effective. Other health risks include ringworm infections (often related to cats) and tick and flea problems.

CURRENT PROGRAMS AND ACTIVITIES

1. Oregon State Board of Health, Vector Control Section, is establishing a baseline evaluation for all zoonosis, vector, and arthropod-borne diseases. Vector species are being collected and routine testing is being done on selected vector samples. Mosquitoes are being collected and tested for the encephalitis virus in certain high-risk areas throughout the state. Sampling of selected rodent populations, especially in recreational areas, is performed to determine the prevalence of zoonosis. Plans for irrigation and multiple use water projects are reviewed as to their relationship to vector control. Recommendations are given to the Oregon State Department of Agriculture on labeling and uses of pesticides to protect the public health. Technical aspects of a given pesticide are reviewed carefully before specific uses are recommended by Oregon State Board of Health and/or approved by the Department of Agriculture. Technical assistance and recommendations are provided to all local, state, and federal agencies involved in mosquito and vector control. Assistance is also provided local governmental units in establishing new vector control programs.

   The Vector Control Section activities and annual expenditures are: mosquito control consultation and overall coordination - $18,000; zoonosis surveillance - $7,000; commensal rodent control - $3,500; public health pesticide activities - $3,500; and laboratory and educational activities - $7,000.

   Mosquito control is conducted principally by eight Vector Control Districts, eight local health departments, four cities, and incidentally by miscellaneous state and federal agencies, private groups, and individuals. Organized mosquito control programs expend about $600,000 per year.

2. Oregon State University Extension Service has mosquito and plague surveillance programs, publishes the Insect Control Handbook, and, in cooperation with the Oregon State Board of Health, Vector Control Program, offers a vector control training course.

3. Oregon Veterinary Association, in cooperation with the Oregon State Board of Health, public health veterinarians, and local health departments, holds rabies clinics in many areas of the state.

AUTHORITIES

The activities of the Vector Control Section of the Oregon State Board of Health were sanctioned by legislative mandate in the 1956 Legislative Session. Vector Control Districts operate under the provisions of ORS 452.010 to ORS 452.590. Local health departments conduct mosquito and rodent control under traditional duties of the health department.

OBJECTIVES

1. Reduce vector-borne diseases and control the vectors, arthropods, and animal populations so that all persons are protected from the danger of disease.

2. Reduce the hazards of pesticides and synthetic chemicals used to control vectors.

RECOMMENDATIONS AND METHODS

1. *OREGON STATE BOARD OF HEALTH PROVIDE FULL SURVEILLANCE OF ALL ZOONOSIS AND VECTOR-BORNE DISEASE ENTITIES THROUGHOUT THE STATE.*

   Method

   Vector Control Section of the Oregon State Board of Health increase surveillance activities of all types of zoonoses.

2. *PROVIDE EFFECTIVE VECTOR CONTROL THROUGH DISTRICT AND LOCAL PROGRAMS WITH OVERALL SUPERVISION AND COORDINATION BY THE OREGON STATE BOARD OF HEALTH.*

   Methods

   a. *Oregon State Board of Health submit legislation providing State matching funds to local districts or agencies so that effective vector control programs can be established in all populated areas and in major recreational areas, statewide.*

   b. *Oregon State Board of Health, Vector Control Section, enlarge its current technical consultation program to local agencies and the general public.*

   c. *Oregon State Board of Health request amendment of ORS 452.010 so that Vector Control District functions include domestic rodents and other arthropods, as well as mosquitoes and flies.*

3. *PROVIDE EFFECTIVE PROTECTION FROM VECTORS AND VECTOR-BORNE DISEASES IN MAJOR RECREATIONAL AREAS THROUGH FEDERAL, STATE, AND LOCAL PROGRAMS WITH OVERALL ASSISTANCE AND COORDINATION BY THE OREGON STATE BOARD OF HEALTH.*

4. *PROVIDE BETTER EDUCATIONAL PROGRAMS REGARDING VECTORS, THEIR DANGERS, AND CONTROL.*

Methods

a. *State System of Higher Education provide information regarding vector control in curricula of those majoring in recreation and forestry.*

b. *Oregon State Board of Health implement a public information program so that Oregonians are made aware of zoonosis, vector, and arthropod problems and their implications.*

OPERATIONAL PROBLEMS

1. Routine testing for causative agents of vector-borne diseases is restricted, due to manpower limitation, with testing concentrated in areas where epidemics occur.

2. The lack of trained personnel in dealing with the problems in zoonosis, vector, and arthropod control on the local level, results in sporadic outbreaks of epidemics. Maintaining the technical knowledge of vector control personnel on scientific aspects of control is difficult, due to lack of funds for such activity and due to the heavy work load of state and local employees.

3. The public is usually unaware of the need for vector control unless there is a disease outbreak. Sound informational programs are hindered by lack of personnel and funds on the state level to provide this information. This lack of personnel makes it difficult to respond to all requests for technical recommendations and advice from local vector control programs and from local governmental units wishing to implement new programs.

EVALUATION CRITERIA

The Vector Control Section of the Oregon State Board of Health:

1. Measure the level and dangers of morbidity due to vector-borne and arthropod-borne diseases and zoonoses from vital statistics reports;

2. Measure the level and dangers in nuisance complaints to public health departments and other local agencies relating to vector, arthropod, and zoonoses problems;

3. Determine the change in morbidity in areas where vector programs have been put into effect;

4. Annually review staff surveys of major recreational areas to determine the prevalence of vector-borne disease organisms;

5. Evaluate the number of programs carried out as a result of consultation from the Vector Control Section staff;

6. Measure the competency of local vector control personnel by reviews of their survey records, work reports, and complaints.

PRIORITY

To be determined.

WATER QUALITY

GOAL CONSERVE THE WATERS OF THE STATE AND PROTECT, MAINTAIN, AND IMPROVE THEIR QUALITY.

CONDITION

Increased public demand, population growth, economic development, and domestic, agricultural and industrial discharges adversely affect water quality. Pollutants and effluents create additional problems for water systems serving communities and individuals. There is, at present, a recognized need for new and improved treatment services to serve more people and to assure that sewage treatment plants offer secondary treatment. Present plans and construction indicate that by July 1972, the state's general water quality standards will be fulfilled. The task thereafter will be to maintain the standards for the benefit of future generations.

The general water quality standards set numerical equivalents for pH, temperature, disolved oxygen, turbidity, coliform bacteria, and certain chemical ions. Specific treatment requirements and effluent standards have been established where conventional secondary treatment is not adequate.

Although all point discharges are now being treated, dispersed pollution sources such as land run-offs from logging, mining, animal feed lot and agricultural operations require better control.

CURRENT PROGRAMS AND ACTIVITIES

Oregon had the first water quality control program in the United States; it has since been expanded and strengthened. Since July 1969, the program has been conducted by the Department of Environmental Quality.

Its activities are to:

1. Conduct independent and cooperative special studies, surveys, and programs pertaining to water quality and treatment and disposal of wastes;

2. Monitor quality of effluents and public waters;

3. Develop and adopt water quality standards;

4. Investigate complaints, hold public hearings, and enforce laws and administrative rules pertaining to water quality control;

5. Provide advisory technical consultative services and review and approve plans for all sewage and waste collection, treatment, and disposal facilities;

6. Process applications for tax relief for pollution control facilities;

7. Administer the waste discharge permit program;

8. Process applications for state and federal grants for sewage treatment works construction;

9. Supervise operation of waste water treatment works and training the operators of such facilities;

10. Prepare reports and educational material for the information of the public, and promote voluntary cooperation among agencies and people concerned with water quality.

For the 1970-71 fiscal year, the program had a total budget of $565,733 ($96,900 federal and $468,833 state funds) and a staff equivalent to 41.8 man years.

AUTHORITIES

ORS Chapter 449 provides specific authority for the state water quality control program conducted by the Department of Environmental Quality.

OBJECTIVES

1. Require all point waste water sources to meet general water quality standards by July, 1972.

2. Improve the quality of marine and estuarine waters.

3. Develop, adopt, and implement special basin-wide water quality control plans throughout the state.

4. Protect waters from pollution.

RECOMMENDATIONS AND METHODS

1. *PROVIDE CONTROL OVER WASTE WATER SOURCES.*

Methods

a. *Department of Environmental Quality issue discharge permits to approximately 750 waste water sources and enforce a minimum of secondary treatment.*

b. *Department of Environmental Quality adopt and enforce special water quality and waste treatment standards for marine and estuarine waters.*

c. *Department of Environmental Quality develop and implement six coordinated basin-wide water quality control plans by 1974.*

d. *Department of Environmental Quality request legislation:*

1) *To clarify jurisdiction over sewage disposal requirements.*

2) *To provide authority for levying civil penalties for violation of water pollution control statutes and rules.*

e. *Department of Environmental Quality, in cooperation with other state agencies, develop and enforce regulations to protect waters from contamination by logging, animal feed lot, and mining operations.*

2. *PROVIDE ADMINISTRATIVE, LABORATORY, PLANNING, AND TECHNICAL SERVICES TO LOCAL GOVERNMENTS.*

Methods

a. *Department of Environmental Quality and Program Planning - New Resources assist communities in obtaining financial assistance for sewage treatment construction projects.*

b. *Department of Environmental Quality train 200 waste water treatment works operators annually.*

c. *State Local Government Relations Division provide planning assistance to local governments.*

OPERATIONAL PROBLEMS

There are no significant operational problems identified relative to this section other than the usual constraints revolving around shortages of manpower, money, and materiel, as well as policy and procedural changes inherent in any realignment of programs and responsibilities.

EVALUATION CRITERIA

Department of Environmental Quality to determine: number of waste water sources without adequate treatment facilities; and quality of stream, river, estuarine, and marine waters.

PRIORITY

To be determined.

APPENDIX

EXECUTIVE ORDER NO. 67-14

GOVERNOR'S HEALTH PLANNING COMMITTEE

(Amended 12-18-67 Supersedes Order Issued 5-24-67)
(Amended 6-10-68 Supersedes Order Issued 12-18-67)

IT IS HEREBY ORDERED AND DIRECTED that the Governor's Health Planning Committee is created to develop a comprehensive, state-wide health plan.

IT IS FURTHER ORDERED AND DIRECTED that this Committee is designated to supervise and/or coordinate all health planning activities within the State and to implement participation in Public Law 89-749.

IT IS FURTHER ORDERED AND DIRECTED that the goal of this Committee shall be the preservation of life and health achieved with the best use of personnel, facilities, and monies, and with the teamwork of government, private agencies, professions, institutions, and all other concerned citizens.

IT IS FURTHER ORDERED AND DIRECTED that the Committee shall act in an advisory and resource capacity to the Governor on all matters related to the field of health, and in so doing to:

1. Prepare a state plan to facilitate comprehensive and regular assessment of health needs and of the resources available to meet these needs. This plan should be reviewed annually and submitted to the Governor prior to the end of each fiscal year, with recommended modifications.

2. Make recommendations relating to the administration, supervision, and direction of programs pertaining to the field of health.

3. Make recommendations for legislation to strengthen or clarify questions related to the field of health.

4. Encourage cooperative planning and implementation of plans between public and private groups, agencies, organizations, and institutions, engaged in the field of health.

IT IS FURTHER ORDERED AND DIRECTED that the members of the Committee shall be appointed by the Governor and shall serve at his pleasure. The Committee shall consist of 17 members, as follows:

	Term
*Governor's Office	By Position
*State Department of Finance	By Position
State Health Officer	By Position
State Mental Health Administrator	By Position
State Public Welfare Administrator	By Position
University of Oregon Medical School Dean	By Position
- - - - -	
*County Government	1 Sept. 69
- - - - -	
Dental Profession	1 Sept. 70
Health Insurance	1 Sept. 71
Hospital Administration	1 Sept. 69
Medical Profession	1 Sept. 70
- - - - -	
*1st Congressional District	1 Sept. 71
*2nd Congressional District	1 Sept. 69
*3rd Congressional District	1 Sept. 70
*4th Congressional District	1 Sept. 71
*At Large - Underprivileged	1 Sept. 69
*At Large - Agricultural	1 Sept. 70

* Consumer Members

Following the initial term, the term of office shall be three years.

IT IS FURTHER ORDERED AND DIRECTED that the officers of the Committee shall consist of a Chairman and a Vice Chairman, to be designated by the Governor.

IT IS FURTHER ORDERED AND DIRECTED that the Governor's Health Planning Committee may establish ad hoc committees to study specific areas and to make periodic reports to the Planning Committee. The chairmen of such ad hoc committees shall be appointed by the Chairman of the Governor's Health Planning Committee. The tenure of the ad hoc committees will be determined by the nature of study or project undertaken.

IT IS FURTHER ORDERED AND DIRECTED that staff services shall be provided by a Planning Director, whose responsibilities will be defined by the Committee. The Planning Director and such other employees as may be necessary, will be provided from the Governor's planning staff.

IT IS FURTHER ORDERED AND DIRECTED that all expenses incurred by members of the Governor's Health Planning Committee shall be reimbursed by the Governor's Office to the extent that funds are available and that certain expenses of members of the ad hoc committees may be reimbursed as provided through any grants received under Public Law 89-749.

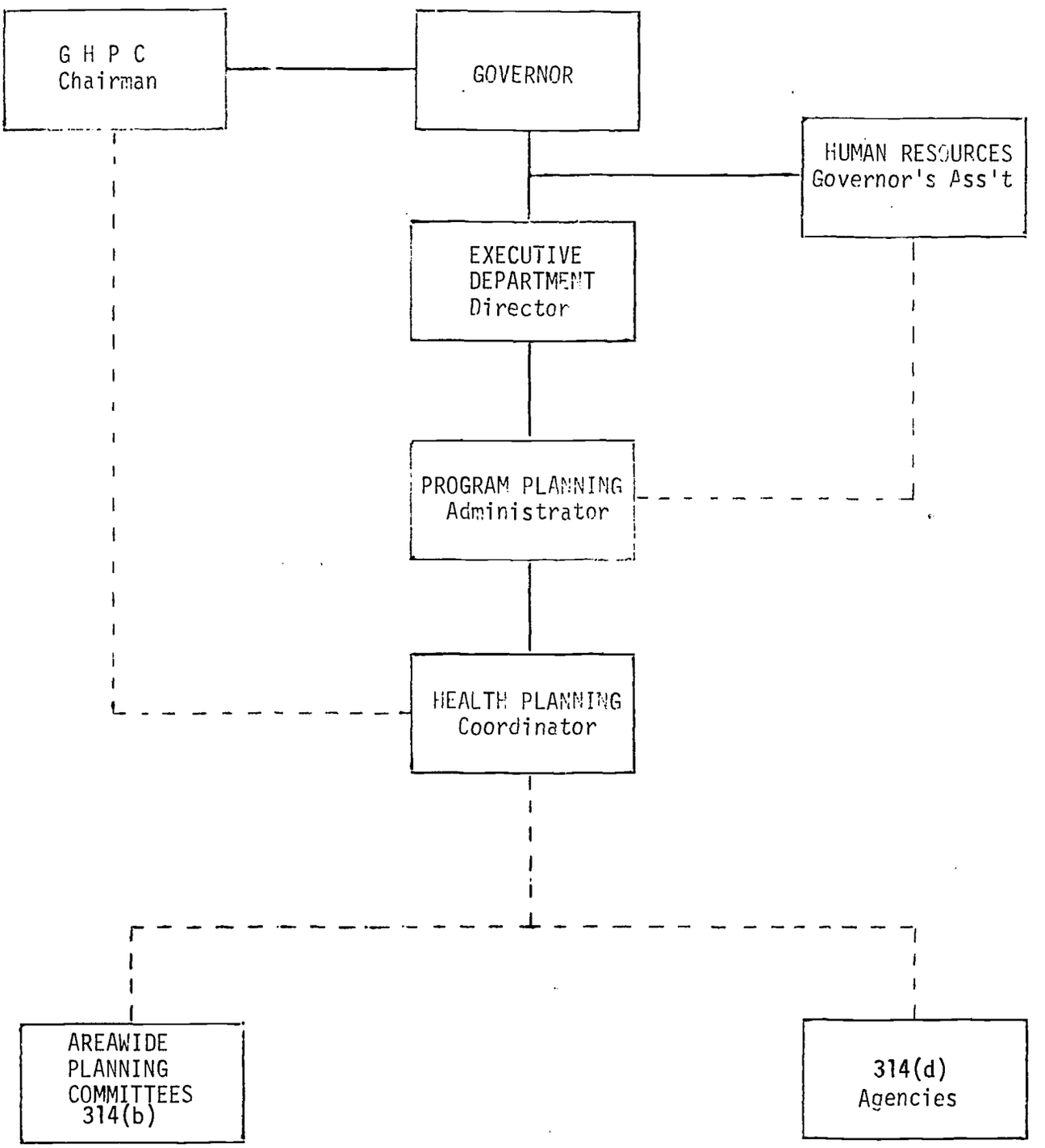
IN TESTIMONY WHEREOF, I have hereunto subscribed my name and caused to be affixed the great seal of the State of Oregon. Done at Salem, the Capital, this 10th day of June, A. D., 1968.

Governor

By the Governor:

Secretary of State

COMPREHENSIVE HEALTH PLANNING
ORGANIZATIONAL RELATIONSHIPS



GOALS AND OBJECTIVES OF OREGON'S COMPREHENSIVE HEALTH PLANNING

GOAL ACHIEVE IMPROVED HEALTH FOR ALL OREGONIANS.

CONDITION

Health programs and health planning lack coordination. Health programs are fragmented among the State Board of Health, State Mental Health Division, Vocational Rehabilitation Division, University of Oregon Medical School, Public Welfare Division, Department of Environmental Quality, Commission for the Blind, County Health Offices, Community Mental Health Clinics, Voluntary Agencies, the Private Practice of Medicine and probably a number of other agencies and organizations not readily identifiable.

Much can be done through the continued efforts of Comprehensive Health Planning. Still more can be accomplished through the realignment under one coordinating authority (wherever feasible) of those state departments who have responsibility for health programs.

There are significant multi-faceted problems of health care that need to be assessed and priorities to be determined for the purpose of allocating limited resources for their solution.

Some health related data and information is collected by many organizations, but no place is this information collated and analyzed as an integrated data base. Unfortunately, the richest source of data is relatively untapped in any formal sense--that is, the private practice of medicine. Other sources of health information such as hospitals and clinics need to be more fully utilized.

The purpose of the Comprehensive Health Planning Program is to establish a process to achieve comprehensive health planning on a statewide basis which:

1. Identifies health problems and defines total health needs of all people and communities in the state.

2. Establishes state and areawide health objectives directed toward improving the availability of health services.

3. Identifies existing resources and resource needs.

4. Inventory and identify relationships among varied local, state, national governmental and voluntary programs (regional medical program, mental health, health facilities, manpower, medicare, education, rehabilitation, and public health) in order to assist these programs in making a more effective impact with their resources.

5. Provides assistance to state and local officials to private voluntary health organizations and institutions, and to other programs supported by U. S. Public Health Service grant funds toward more effectively allocating resources in accomplishing the objectives.

6. Provide information, analysis, and recommendations which can serve as the basis for the Governor, the Legislature, and other decision makers to make more effective allocations of resources in meeting health goals.

7. Support the initiation and integration of pilot projects for better delivery of health services; develop plans for targeting flexible formula and project grants at problems and gaps.

CURRENT PROGRAMS AND ACTIVITIES

The Governor's Health Planning Committee and the Comprehensive Health Planning staff have been charged by the Governor through Executive Order 67-14 to prepare a state health plan, make recommendations on the administration and supervision of health programs, make recommendations to the Legislature, and encourage cooperative planning and implementations of health programs among private, voluntary, and public sectors of health care.

Oregon Regional Medical Program conducts and supports planning, continuing education, and demonstration projects in the areas of heart diseases, cancer and stroke, and related diseases including renal.

State Board of Health conducts a planning program as part of their responsibility in administering the Hill-Burton grant funds for the construction of care facilities. General health planning responsibility within the department is assigned to a planning section within the Administrative Services Division.

AUTHORITIES

Comprehensive Health Planning derives its authority from Executive Order 67-14.

State Board of Health, Hill-Burton Section, authority is found in ORS 441.105 through 441.150.

OBJECTIVES

1. A coordinated health planning effort throughout the state at state, county, and city levels.

2. Achieve optimum communication and working relationships among the various public and private health agencies in Oregon.

3. Develop a statewide comprehensive health plan which identifies the health problems in Oregon, designates priorities as determined by the Comprehensive Health Planning Committee, and recommends a system or rationale for allocating resources to the solving of these problems.

4. Establish goals, objectives, and evaluation procedures for measuring the progress toward their attainment.

RECOMMENDATIONS AND METHODS

1. *DEVELOP COUNTY AND REGIONAL PROFILES BY COMPILING DATA FROM VARIOUS PUBLICATIONS AND FILES FOR A LIST OF DISEASES, ILLNESSES, AND ACCIDENTAL DEATHS FOR THE PURPOSE OF COMPARING COUNTIES AND REGIONS WITH EACH OTHER FOR SUCH THINGS AS THE PREVALENCE OF HEPATITIS, GONORRHEA, SYPHILIS, ILLEGITIMACY, INFANT MORTALITY, AND OTHER HEALTH-RELATED INDICES.*

   THE PROFILES WILL INCLUDE THE LOCATION OF HEALTH CARE FACILITIES, HEALTH MANPOWER, AND OTHER COMPONENTS OF THE HEALTH CARE DELIVERY SYSTEM.

   IN ADDITION, HEALTH AGENCIES, BOTH PUBLIC AND PRIVATE, WILL BE ASKED TO PROVIDE INFORMATION ON MAJOR HEALTH PROBLEMS THEY HAVE ENCOUNTERED IN THESE VARIOUS COUNTIES AND REGIONS. ADDITIONAL INFORMATION THAT WILL BE INTEGRATED INTO THE HEALTH PROFILE OF THE COUNTY AND REGION WILL BE SOLICITED FROM PRIVATE PRACTITIONERS.

2. *INVENTORY HEALTH AGENCIES WHICH HAVE HEALTH OR HEALTH-RELATED FUNCTIONS FOR THE PURPOSE OF ASSESSING THE EXTENT OF HEALTH PROGRAMS AND/OR ACTIVITIES IN OREGON, AND IDENTIFY THE HEALTH PLANNING EFFORTS IN THESE AGENCIES AND THROUGHOUT THE STATE. ESTABLISH WORKING RELATIONSHIP AND SUBSEQUENTLY FUNCTION IN A COORDINATING ROLE RELATIVE TO THESE VARIOUS GROUPS AND AGENCIES.*

3. *DEVELOP FURTHER CRITERIA FOR RANKING SPECIAL PROJECT APPLICATIONS FOR FEDERAL SUPPORT FUNDS SUBMITTED TO THE COMPREHENSIVE HEALTH PLANNING COMMITTEE FOR THEIR REVIEW.*

4. *FUNCTION AS A CENTRAL REVIEW AND APPROVAL OFFICE IN THE STATE FOR ALL FEDERAL GRANTS REQUESTED UNDER THE PROVISIONS OF PUBLIC LAW 89-749, SECTIONS (b), (d), and (e).*

5. *WORK WITH HEALTH AGENCIES TO IDENTIFY THE PROBLEMS, OBJECTIVES, AND METHODS RELATED TO THEIR VARIOUS PROGRAM AREAS AND IMPROVE CURRENT TECHNIQUES FOR EVALUATING PROGRAM EFFECTIVENESS.*

6. *REVIEW STATE BUDGET REQUESTS FOR CONFORMANCE TO HEALTH PROBLEM PRIORITY.*

7. *REFINE THE STATE HEALTH PLAN TO PROVIDE AN INVENTORY OF HEALTH PROGRAMS, HEALTH PROBLEMS, AND HEALTH RESOURCES ON A COUNTY-BY-COUNTY BASIS AND ESTABLISH PRIORITY AREAS FOR CONSIDERATION BY THE GOVERNOR AND THE LEGISLATURE IN THEIR BUDGET DELIBERATIONS.*

8. *DEVELOP A NEWSLETTER PROVIDING INFORMATION ON CURRENT AND PROPOSED HEALTH ACTIVITIES AND SERVICES IN OREGON.*

9. *BRING TOGETHER APPROPRIATE AGENCIES FOR PROBLEM ANALYSIS AND DECISION MAKING AND FOR ANALYZING PROPOSED PROGRAMS, SERVICES, AND ACTIVITIES TO DETERMINE FEASIBILITY, EFFECTIVENESS, AND EFFICIENCY.*

10. *ASSIST THE CHIEF EXECUTIVE IN THE DEVELOPMENT OF NEW GOALS IN THE FIELD OF HEALTH CONSISTENT WITH THE STATE'S NEEDS AND RESOURCES.*

11. *OREGON MEDICAL ASSOCIATION AND THE GOVERNOR'S HEALTH PLANNING COMMITTEE COOPERATIVELY INTRODUCE LEGISLATION GIVING COMPREHENSIVE HEALTH PLANNING A STATUTORY BASE AND AUTHORITY TO ACQUIRE HEALTH INFORMATION AND DATA.*

OPERATIONAL PROBLEMS

The lack of authority to assure the implementation of changes and insufficient staff and budget to effectively deal with the broad scope of comprehensive health planning.

EVALUATION CRITERIA

The effectiveness of comprehensive health planning can best be determined by observing the changes effected in the health care system including improved resource utilization and service levels.

PRIORITY

To be determined.

PLANNING PROCESS

APPROACHES TO PLANNING

Problem Solving

Trial and Error

Imitation

Systematic

Although the generalized health needs of Oregon are too important for a hit or miss approach, it would not be wise to completely exclude some trial attempts. While it is anticipated that Oregon will be able to follow models which have proven successful in other jurisdictions, it is most likely that success in improving the health system will occur as a result of systematic planning tailored to, by and for Oregonians.

The essence of planning is to set a definite goal. The planning should also result in a predetermined course of action and a series of objectives. When these have been established, they will give a focus and pattern to decisions of managers at all levels. Planning must be understood as being a process and not an end unto itself. It is important that the goals and objectives are not constrained by any single segment. It is the expectation of the Governor's Health Planning Committee that the goals and objectives which follow will assist those people with health management functions to take positive and worthwhile actions.

Determine

Health Goals -- What

Action Needed -- How

Agency -- Who

The Governor's Health Planning Committee has noted two generalized approaches to planning.

The "problem solving" approach takes cognizance of a problem and then systematically plans for its solution and evaluates progress toward the solution.

Problem Solving Approach to Planning

Steps

1. Identify Problem
2. Analyze Components Comprehensively
3. Develop Alternate Solutions
4. Evaluate Methods
5. Organize and Implement Programs
6. Evaluate Progress

Goal Setting Approach to Planning

Steps

1. Establish Goal
2. Identify Impediments
3. Establish Objectives
4. Designate Appropriate Organizations
5. Identify Operational Problems
6. Implement Activities
7. Evaluate Progress

The other approach is that of "goal setting". This process visualizes a goal to be attained and systematically determines which steps are to be taken by organizations, establishes a timeframe for the attainment of specified objectives so that all actions are properly timed, and establishes specific evaluative measures.

The Committee has used elements from both of these approaches in this document for the Comprehensive Health Plan for Oregon.

Planning Principles and Practices

1. The health status of people is the main concern of health planning.

   This principle requires that measures be developed for assessing the health of persons and that problems, optimal goals, objectives and recommendations for action be phrased in terms that reflect these measures. Thus, a health problem would be defined as a situation or condition which has a current or potentially adverse effect on people's health. The situation might be existence of an environmental health hazard, or lack of home health services, or a dangerously low level of diphtheria immunization in a vulnerable population. A health objective would be to improve the health status of individuals through eliminating, alleviating, or preventing such adverse conditions or situations.

   Although it is not always possible to anticipate or trace the effect of all suspected adverse conditions or of all health programs upon measurable indices of health status, judgments and values based upon experience and probable relationships are useful and necessary. Continued attention to and improvement of health status measurement will assure that these judgments and probable relationships are valid.

2. Health planning must consider a large number of different kinds of factors that influence health status.

   The factors that influence health status include socio-economic conditions, education, housing, and a host of other social and environmental factors; many of these have not traditionally been the concern of health agencies. Thus, the participation of a variety of non-health agencies and organizations is essential in the comprehensive health planning process.

3. Problems, goals, objectives, and recommendations for action should be stated in quantifiable terms. Such quantification provides not only for refined problem analysis but also for effective evaluation of accomplishments. Wherever possible, such quantification should relate to effects upon health status rather than to activities.

4. The development of criteria for evaluating the effectiveness of plans must be an aspect of planning.

   In many cases, such criteria will be implicit in the objectives stated in the plan, particularly if objectives are quantified and related to specific time periods. In other cases, criteria must be developed using other bases of judgment. Evaluation is not complete merely with the determination of whether objectives have been attained; the objectives must be repeatedly examined for their validity and the optimal goal kept in sight. The attainment of an objective may simply mean that a new objective toward the optimal goal must be set.

5. The completion of a comprehensive plan requires the selection of recommendations for action from among a large number of alternatives.

   The distinction between comprehensive and specialized planning rests particularly on the wider scope of problems that are considered by the Comprehensive Health Planning Committee and staff and, consequently, on the wider range of alternatives that should be examined in the selection of objectives and recommendations for action. In dealing with problems of physical, mental, and environmental health and the services, facilities, and manpower to deal with these problems, as well as with a variety of non-health factors that influence health status, numerous combinations of strategies for effectively serving the health needs of the people of a state should be developed. The Committee should select and recommend that combination of actions which it judges will be most effective.

6. Comprehensive health planning requires the input of skills from a variety of health and other disciplines.

   The Comprehensive Health Planning Committees and their staffs should draw upon other agencies and organizations, both public and voluntary, and upon universities and other sources of consultation to supplement their skills.

7. Comprehensive Health Planning Committees and their staffs should benefit from the experience of other public and voluntary planning and operating agencies and organizations.

   Much of the information that health planning committee requires is already being collected and analyzed by other agencies. Moreover, these other agencies will continue such activities in fulfilling their own missions. Committees should seek out and arrange for cooperative effort with other planning resources. For example, they should employ social, economic, demographic, and similar base data consistent with those to be employed for other comprehensive planning activities in the state, such as planning for education, economic and community development, and transportation.

8. The potential for successful implementation is increased by involving in the development of plans those who will have a role in their implementation.

CLASSIFICATION OF HEALTH PROBLEMS

Health problems can be addressed in several different ways. Some authorities have suggested focusing on so-called "target populations", others have approached planning from the standpoint of optimizing available resources, and some have advocated a systems analysis approach. All of these techniques are quite valid and should produce the desired results.

The Committee focused on several population groups, addressed several system problems, and dealt with other State health problems through the more traditional approach of considering specific disease entities.

In order to array the facts and data, the Committee considered several facets of the Health Delivery System. This approach resulted in the development of a graphic presentation in the form of a cube displayed on a background representing the various population groups particularly identified with health problems (see page 623).

It is to be noted that a health problem can be approached through resources (manpower, facilities, etc.), diseases (tuberculosis, syphilis, etc.), function or process (prevention, treatment, etc.), or target population groups (poor, aged, etc.).

As the Governor's Health Planning Committee determines the priority problems which they will address, each problem will need to be analyzed from each of its several facets.

A sample outline of an approach to an analysis of a specific health problem could be:

I. Prevention (Disease, Illness, Accidents)

II. Diagnosis and Treatment, or Containment

III. Rehabilitation (Accidents, Diseases, Emotional Disorders)

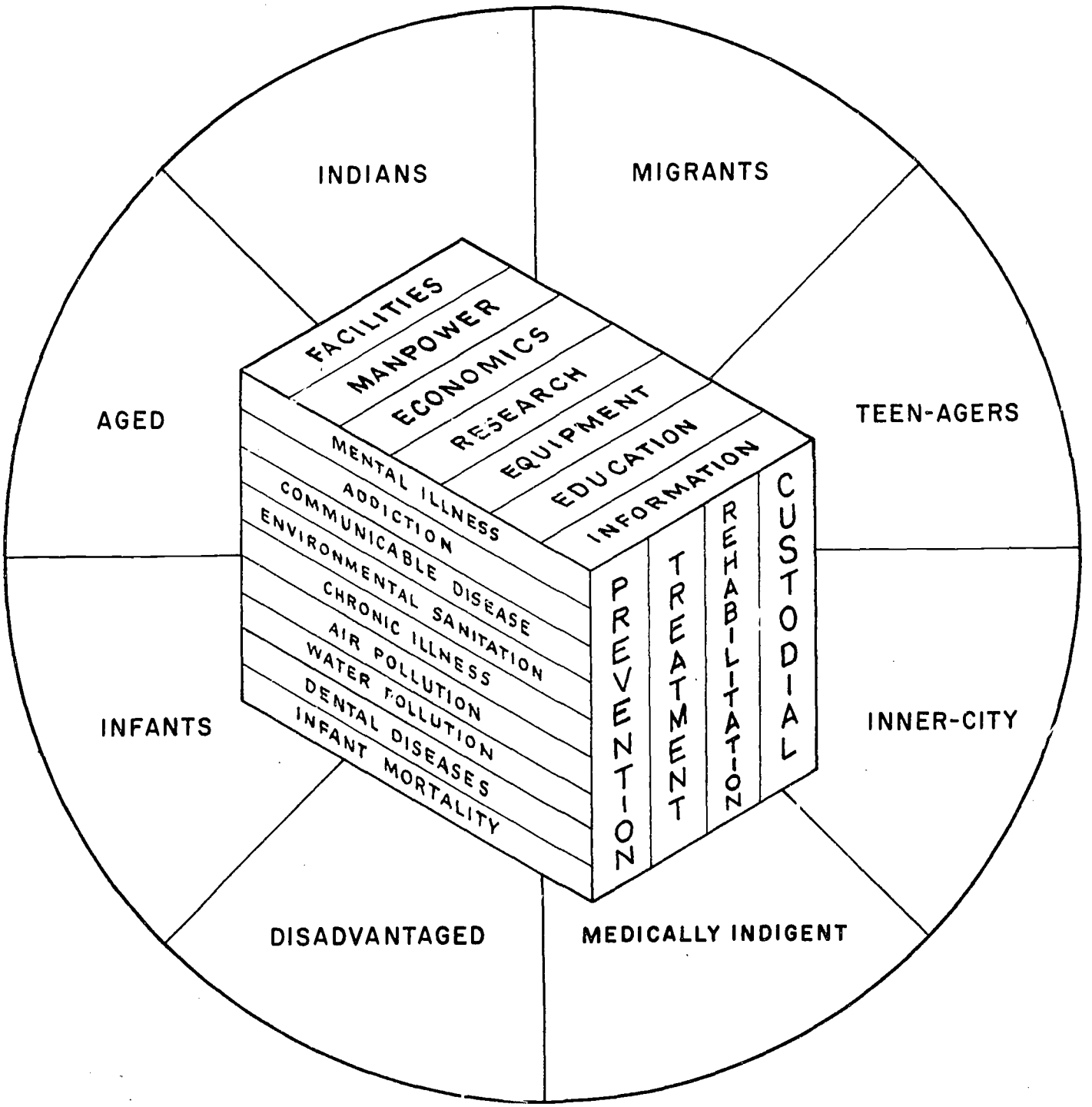
IV. Research (Prevention, Detection, Treatment, Rehabilitation)

V. Facilities and Equipment (New Construction, Modernization, Utilization, Standards)

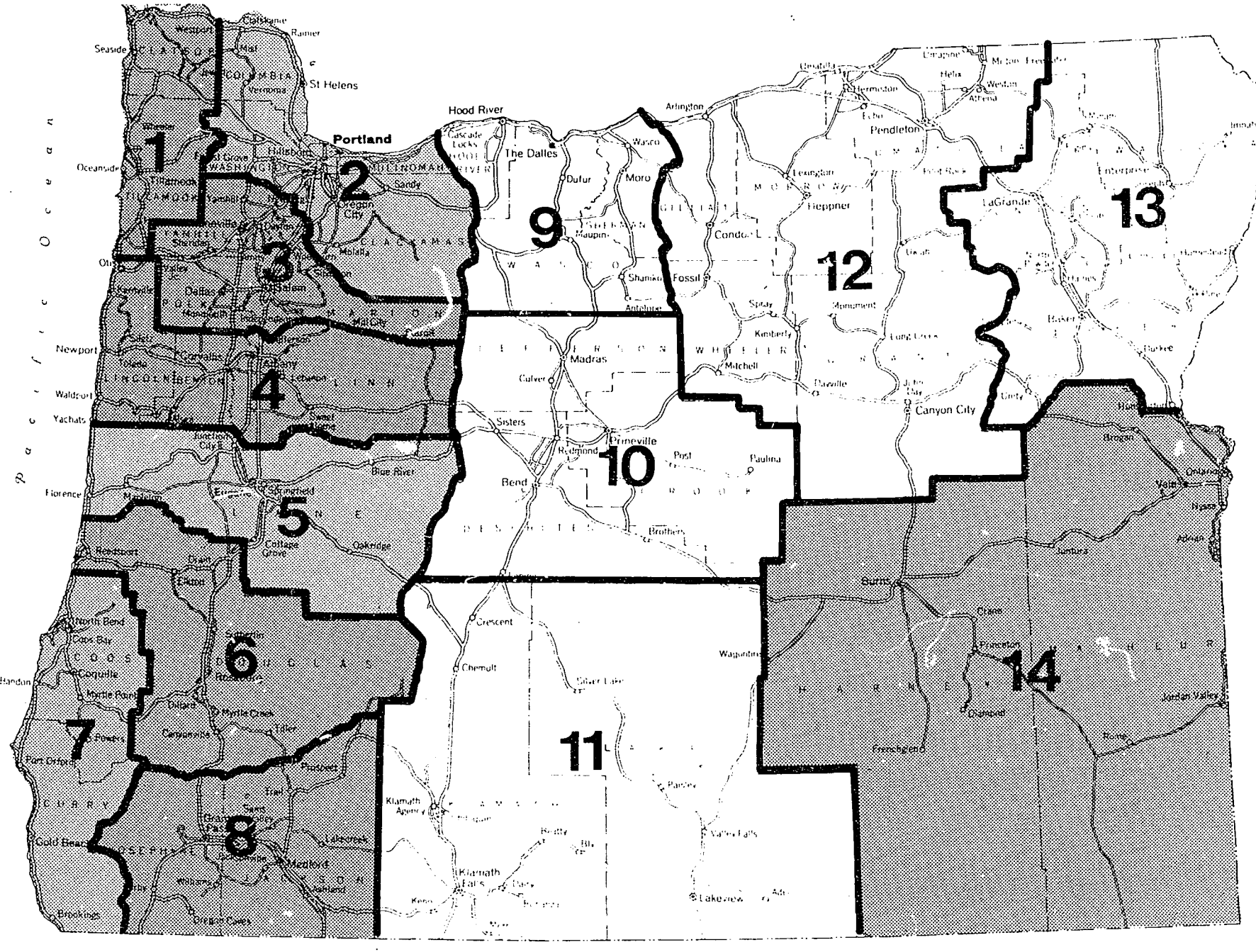
VI. Manpower (Intelligence, Recruitment, Training, Personnel Utilization)

VII. Economics (Cost of Care, Systems of Financing, Efficiency of the System)

VIII. Target Population (Demographic Data, Size, Location)


INDIANS
MIGRANTS
TEEN-AGERS
INNER-CITY
MEDICALLY INDIGENT
DISADVANTAGED
INFANTS
AGED
FACILITIES
MANPOWER
ECONOMICS
RESEARCH
EQUIPMENT
EDUCATION
INFORMATION
MENTAL ILLNESS
ADDICTION
COMMUNICABLE DISEASE
ENVIRONMENTAL SANITATION
CHRONIC ILLNESS
AIR POLLUTION
WATER POLLUTION
DENTAL DISEASES
INFANT MORTALITY
PREVENTION
TREATMENT
REHABILITATION
CUSTODIAL

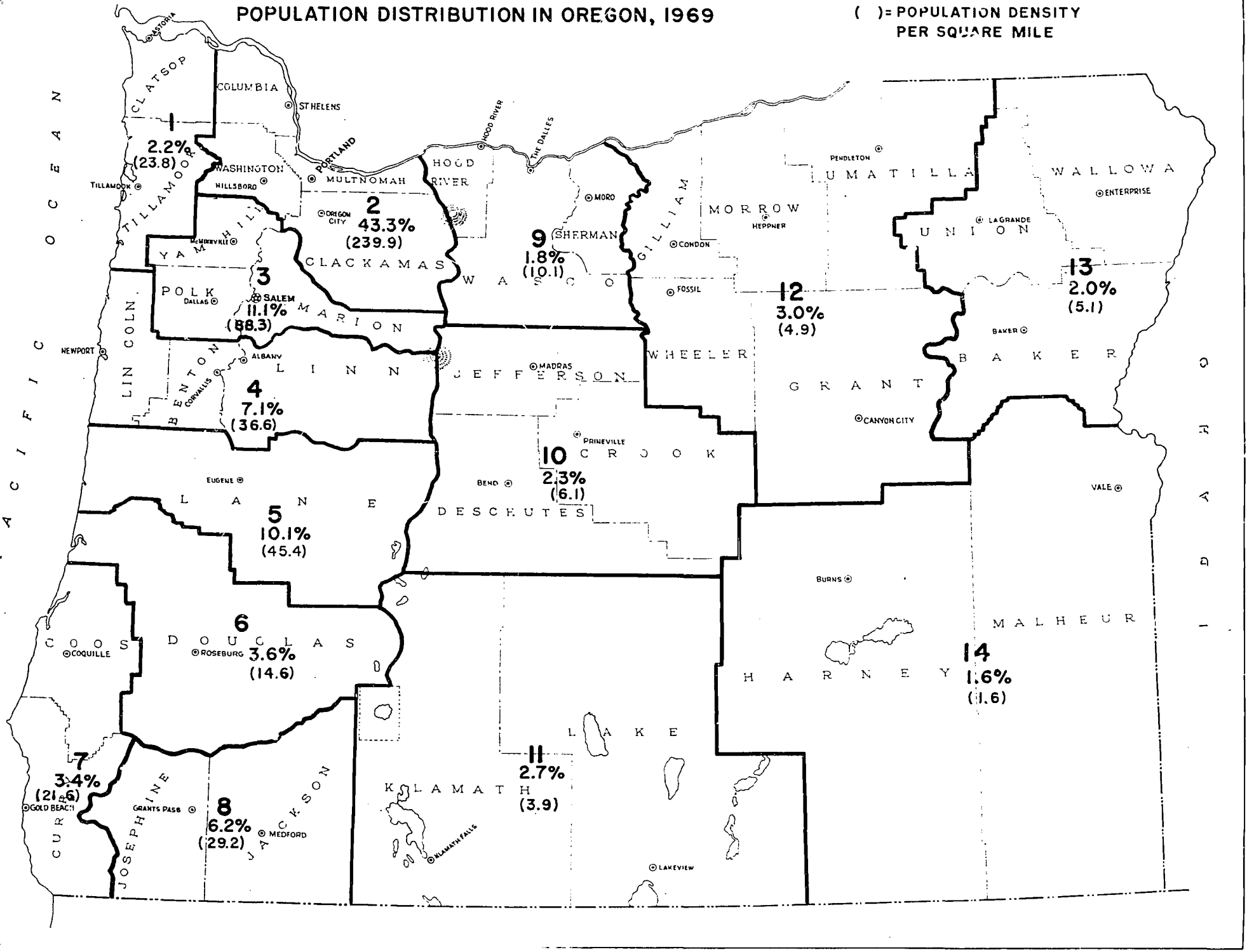
CHARTS AND GRAPHS



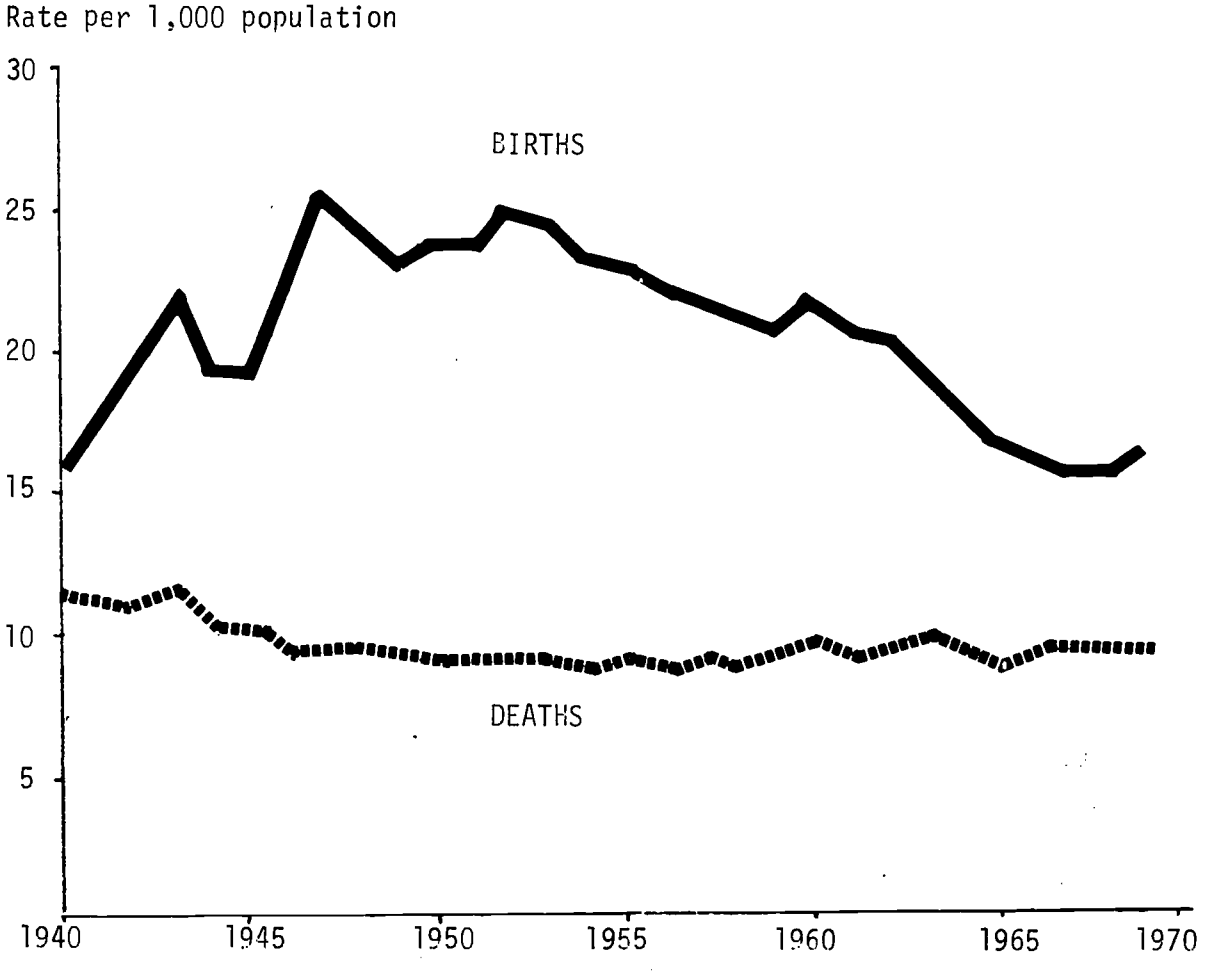
State of Oregon DISTRICTS

FUNDED ACHPC

NON-FUNDED ACHPC

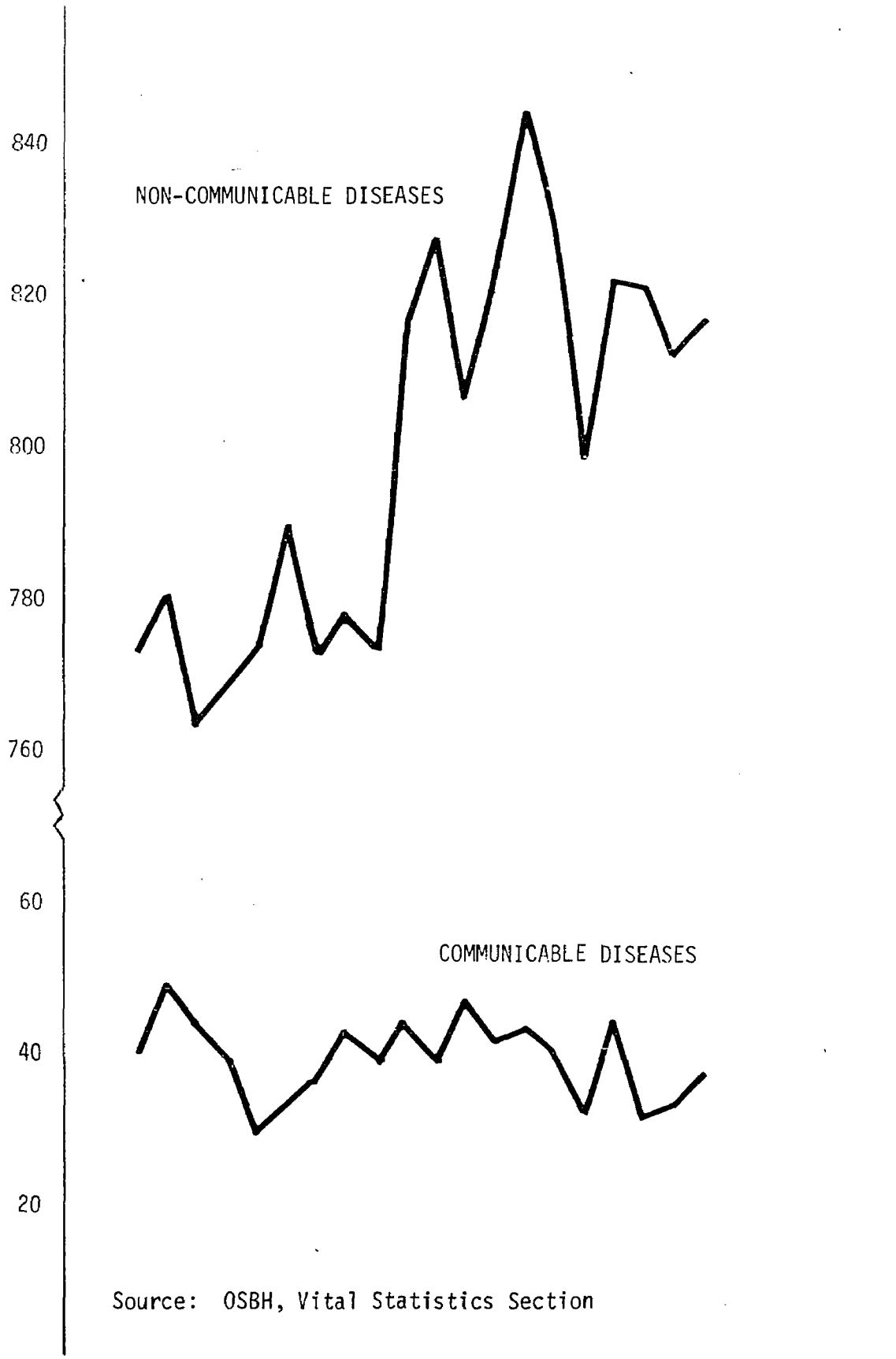

POPULATION DISTRIBUTION IN OREGON, 1969
( )= POPULATION DENSITY PER SQUARE MILE
PACIFIC OCEAN
COLUMBIA
CLATSOP
TILLAMOOK
WASHINGTON
MULTNOMAH
CLACKAMAS
HOOD RIVER
WASCO
SHERMAN
GILLIAM
MORROW
UMATILLA
WALLOWA
UNION
POLK
YAMHILL
MARION
LINCOLN
BENTON
LINN
JEFFERSON
WHEELER
GRANT
BAKER
CROOK
DESCHUTES
LANE
COOS
DOUGLAS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR
1 2.2% (23.8)
2 43.3% (239.9)
3 11.1% (88.3)
4 7.1% (36.6)
5 10.1% (45.4)
6 3.6% (14.6)
7 3.4% (21.6)
8 6.2% (29.2)
9 1.8% (10.1)
10 2.3% (6.1)
11 2.7% (3.9)
12 3.0% (4.9)
13 2.0% (5.1)
14 1.6% (1.6)
ASTORIA
ST HELENS
PORTLAND
HOOD RIVER
THE DALLES
PENDLETON
ENTERPRISE
LA GRANDE
TILLAMOOK
HILLSBORO
OREGON CITY
MCMINNVILLE
DALLAS
SALEM
MORO
CONDON
HEPPNER
FOSSIL
BAKER
NEWPORT
ALBANY
CORVALLIS
MADRAS
PRINEVILLE
CANYON CITY
EUGENE
BEND
VALE
BURNS
COQUILLE
ROSEBURG
GOLD BEACH
GRANTS PASS
MEDFORD
KLAMATH FALLS
LAKEVIEW

BIRTH AND DEATH RATES IN OREGON: 1940-1969



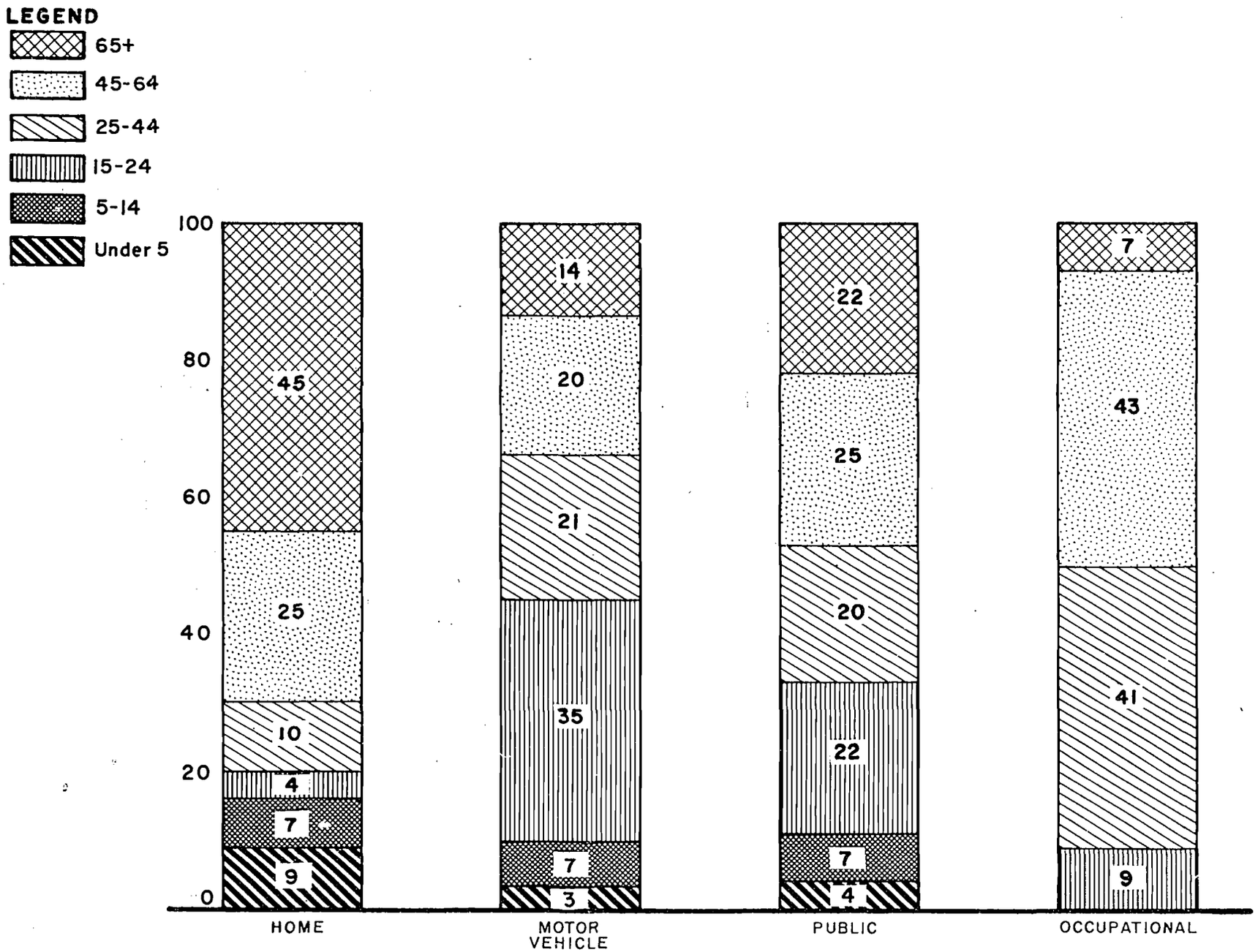
Source: OSBH, 1969 Statistical Report, p. 4.

COMMUNICABLE AND NON-COMMUNICABLE DISEASE
DEATH RATES PER 100,000 POPULATION
OREGON 1950-1969



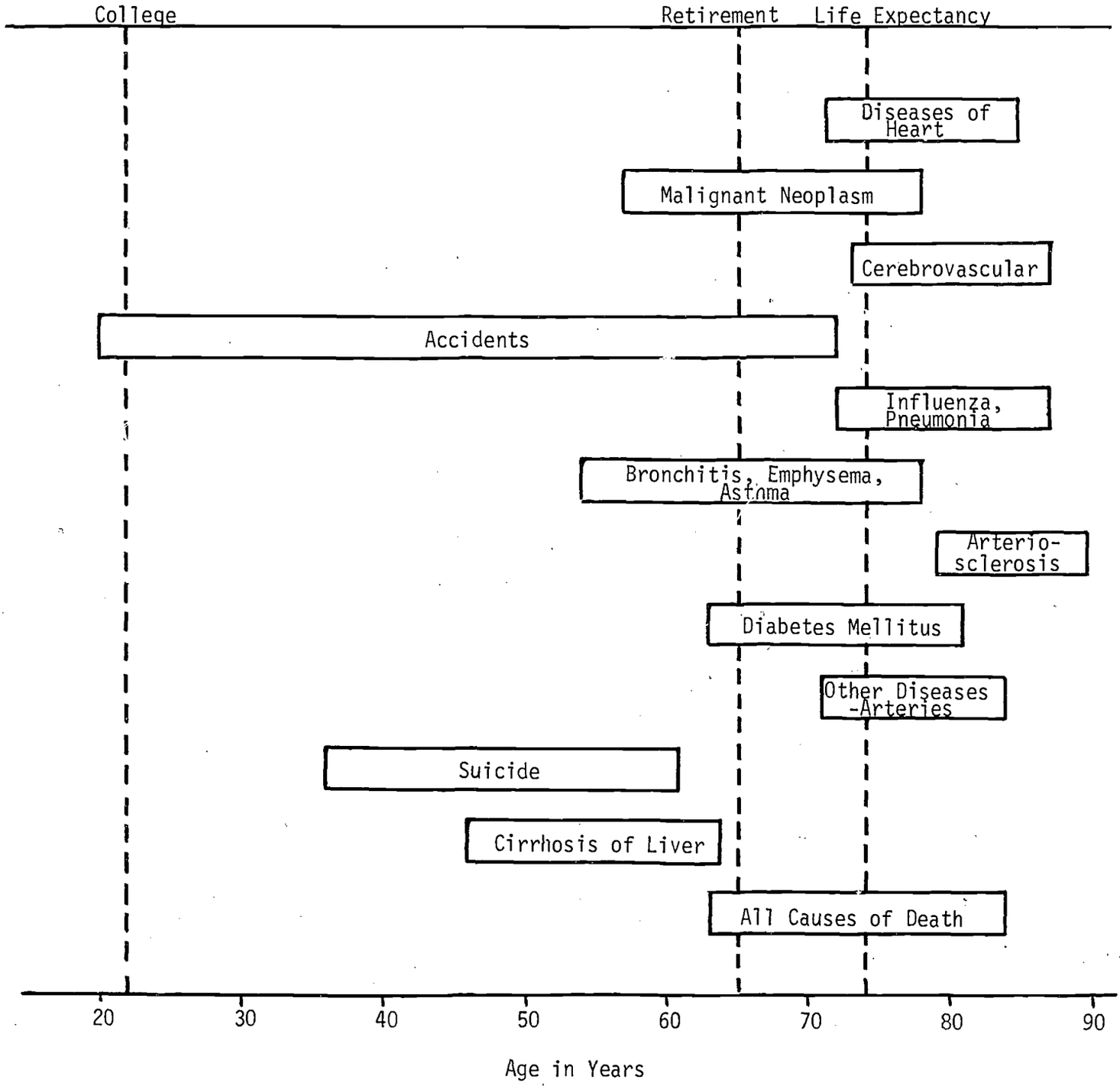
Source: OSBH, Vital Statistics Section

PERCENT DISTRIBUTION OF ACCIDENTAL DEATHS BY AGE FOR MAJOR TYPES OF ACCIDENTS: OREGON, 1969



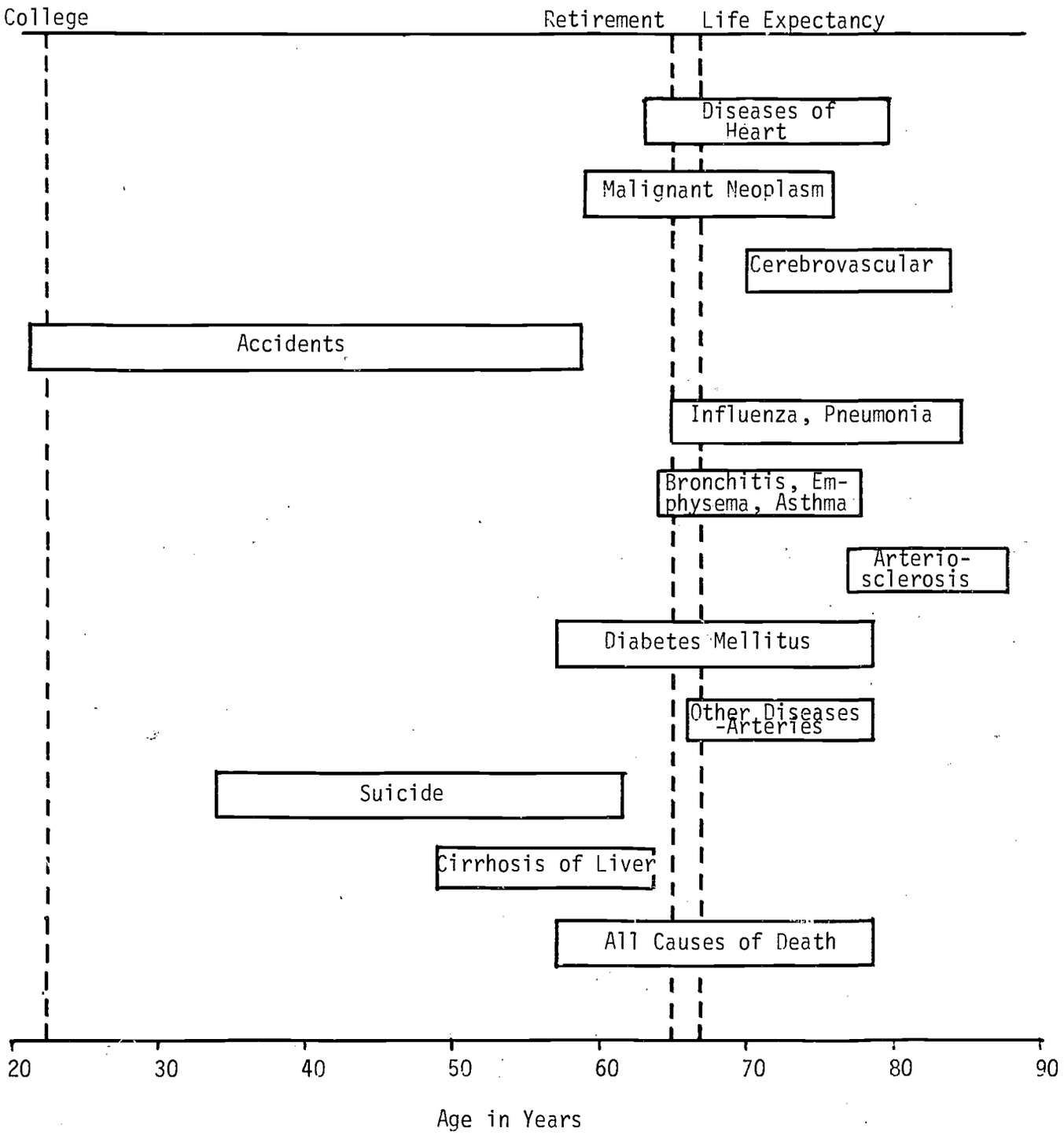
SOURCE: Oregon State Board of Health, Vital Statistics

MID-QUARTILE RANGE OF AGE AT DEATH FOR LEADING CAUSES: OREGON, FEMALE DEATHS, 1969



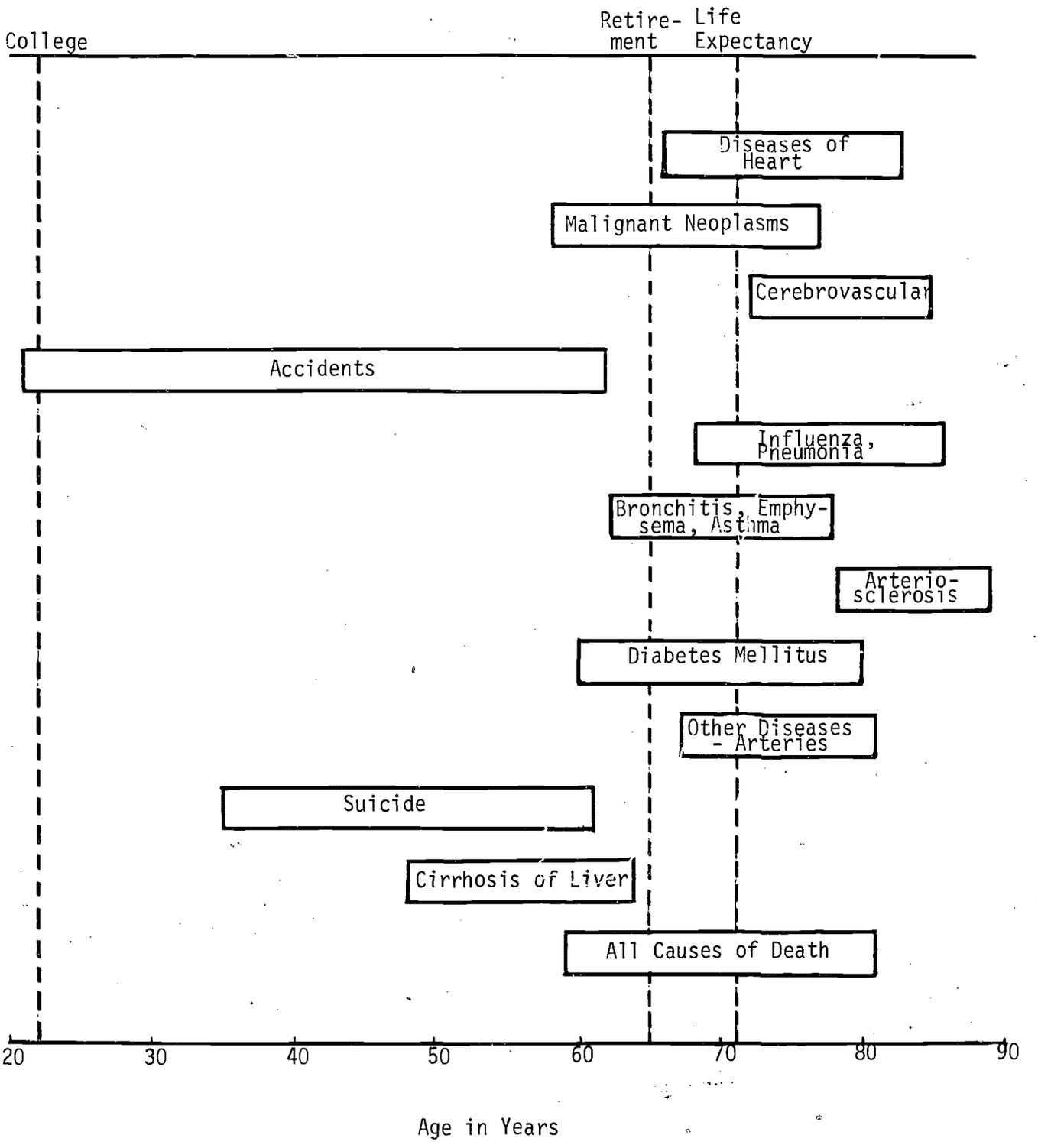
Source: OSBH, Vital Statistics Section

MID-QUARTILE RANGE OF AGE AT DEATH FOR LEADING CAUSES: OREGON, MALE DEATHS, 1969



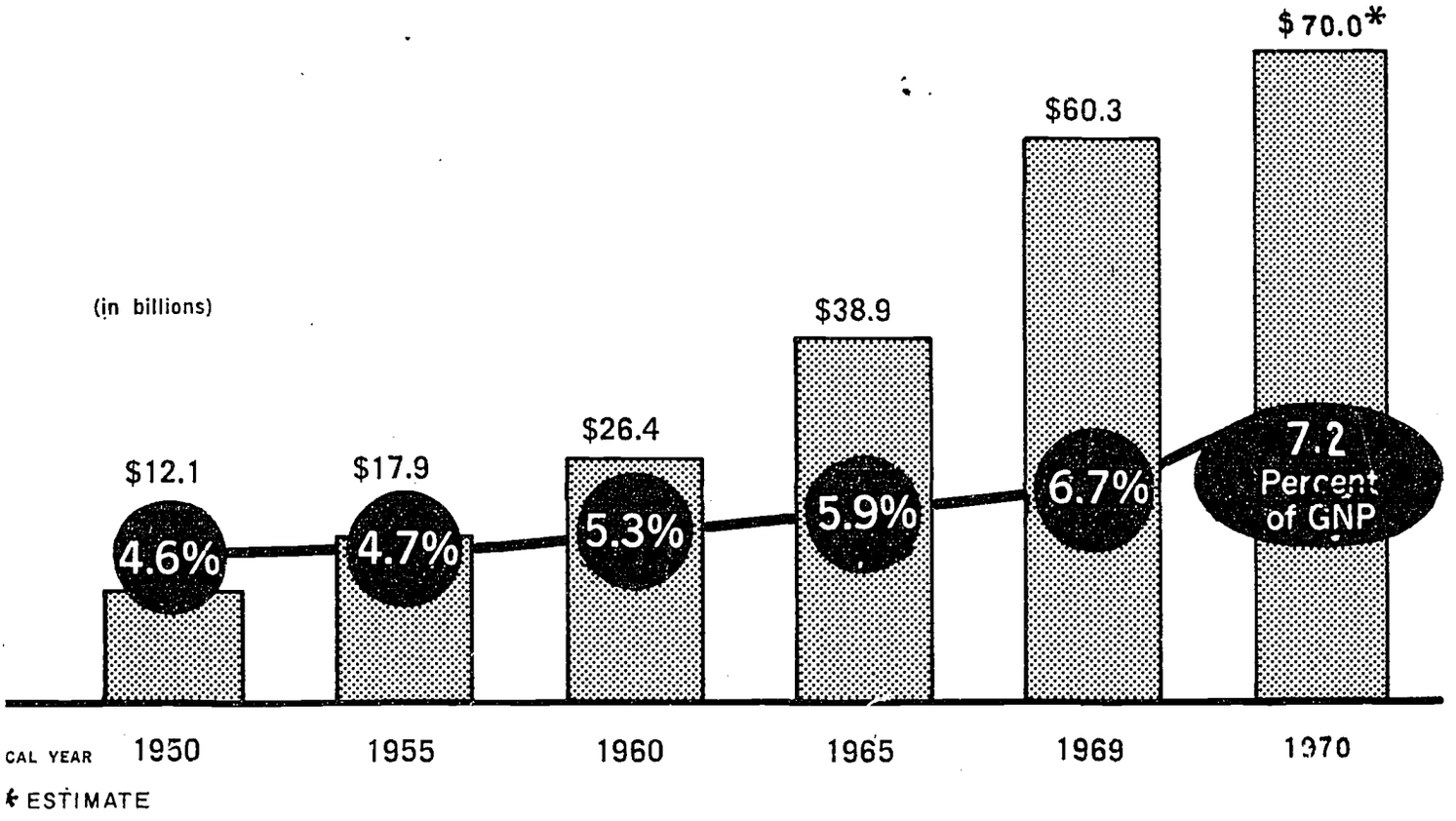
Source: OSBH, Vital Statistics Section

MID-QUARTILE RANGE OF AGE AT DEATH FOR LEADING CAUSES: OREGON, ALL DEATHS, 1969



Source: OSBH, Vital Statistics Section

Today's medical care dollars total $70.0 billion . . .7.2% of GNP



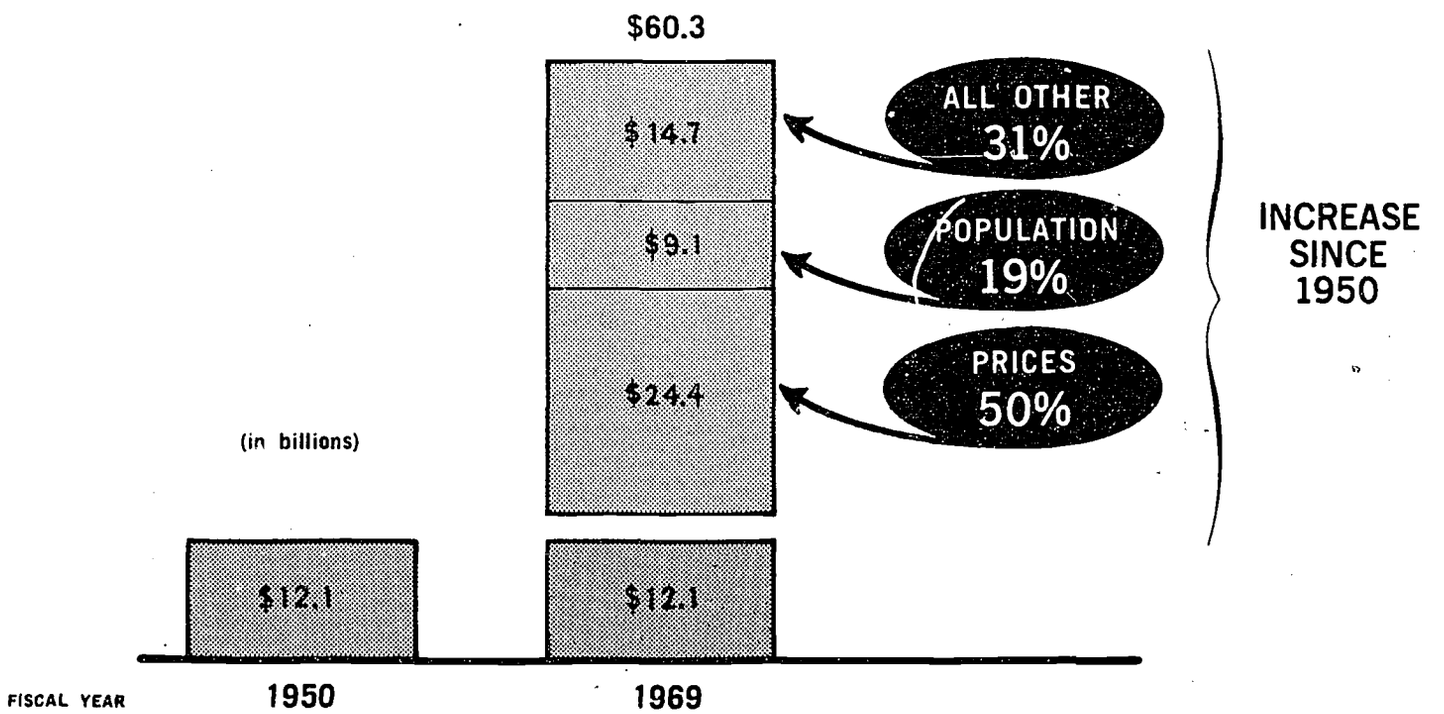
HOW BIG IS THE MEDICAL CARE DOLLAR?

The medical care dollar today is a large one, estimated to reach $70 billion in fiscal 1970. Its growth has been at a rapid pace -- faster than that of the economy in general. In fiscal 1950, medical care expenditures amounted to $12.1 billion and represented 4.6% of the Gross National Product (the total market value of the Nation's annual output of goods and services). By fiscal 1960, its share of GNP had reached 5.3% and today it is up to 6.7%. Part of the increasing share of GNP is the result of the higher prices for medical care compared with other items.

The growth in the size of the medical care dollar, especially in the last few years, has evoked much concern. Are we receiving more and better services for these large outlays? Are rising prices for medical care eating up the growing expenditures? Can efficiency in the health industry be improved?

Medical economists and health experts throughout the country are trying to better understand the underlying reasons for the growth in the medical care dollar and are seeking ways to mitigate these rising costs while still continuing to improve health services.

Higher prices caused half the 19-year growth



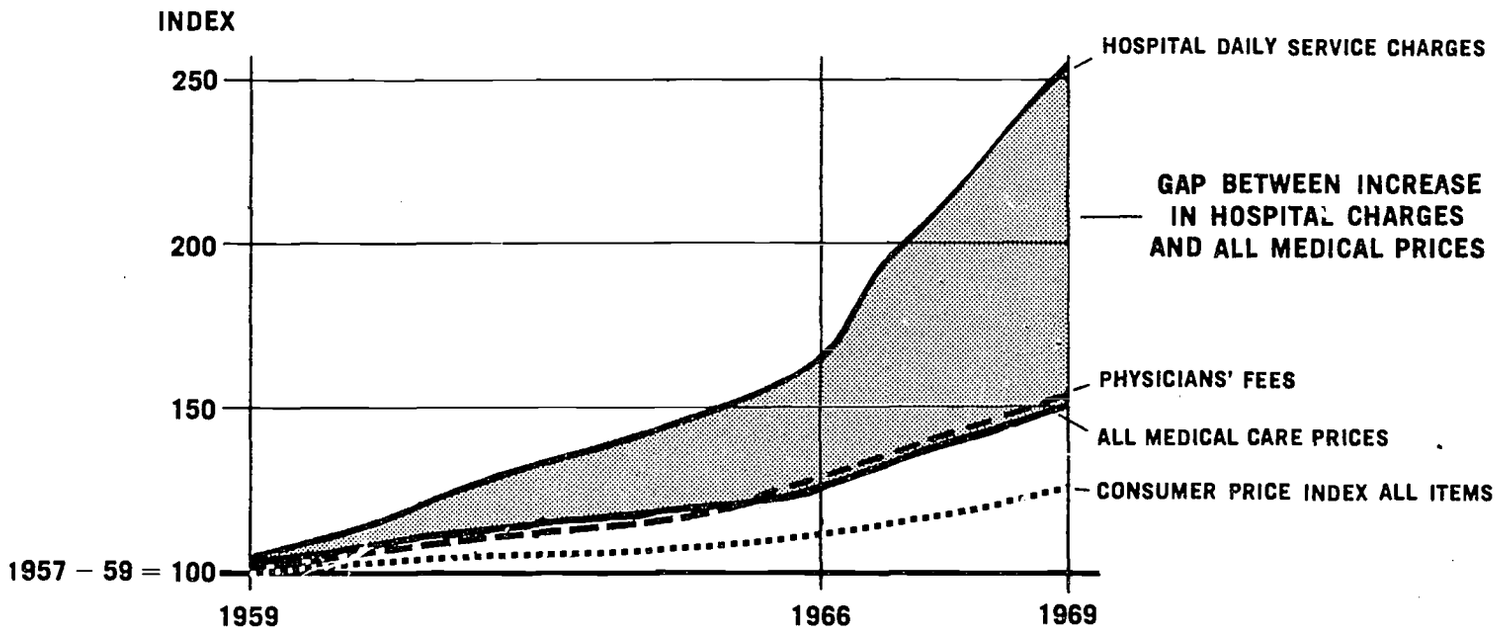
WHAT CAUSED THE GROWTH IN THE MEDICAL CARE DOLLAR?

Increases in expenditures for health may result from several factors: (1) a rise in the price per unit of health service; (2) a growth in the population; and (3) an increase in the use of health services and availability of new medical supplies and techniques.

In the 19-year period since fiscal 1950, health expenditures rose $48.2 billion. Of this rise:

- About 50%, or $24.4 billion, can be attributed to the increase in prices;
- Another 19%, or $9.1 billion, is the result of population growth;
- The remaining 31%, or $14.7 billion, is due to increased use of services, such as seeing the doctor and dentist more often or going to the hospital more, and having access to many miracle drugs not available in 1950 and life-saving, but expensive new techniques, such as open heart surgery or kidney dialysis.

Beginning in 1966, hospital daily service charges have moved fastest



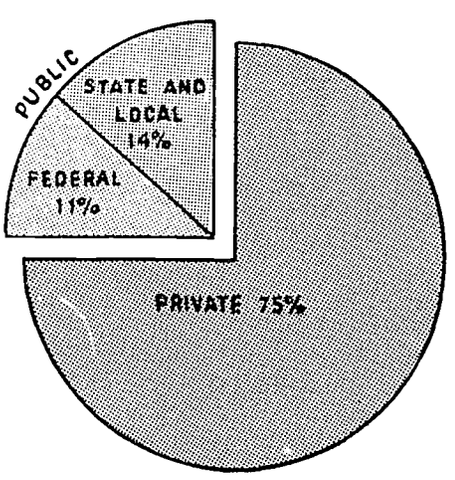
WHICH MEDICAL CARE PRICES HAVE MOVED FASTEST?

The fastest rising medical care prices have been the hospital daily service charges. From 1965 to 1968, hospital daily service charges rose at an annual rate of 13.9% compared with a 5.8% rise for all medical care prices. A significant part of this rise in the hospital daily service charge was due to the increases in the salaries of hospital personnel as a result of the extension of the minimum wage to the hospital industry.

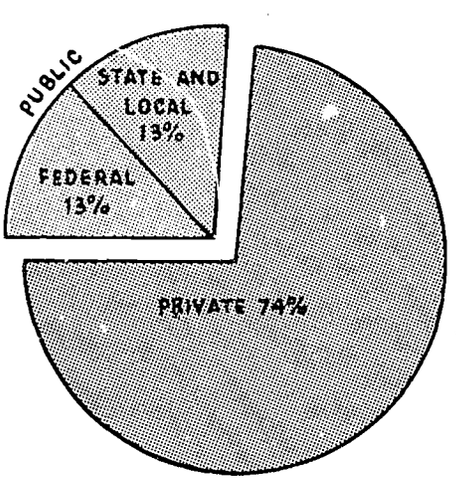
Physicians' fees have also increased rapidly. These fees, which had been rising at a rate of less than 3% annually in the 1960-65 period, averaged 6.1% annually in the 1965 to 1968 years.

Increases in population, especially of the aged who need more services, rising personal income, wider private and public insurance coverage, and other factors have led people to seek doctors' services more often. The average doctor sees more patients than he did years ago. Specialization, however, has decreased the numbers of physicians available to provide care for the entire family. As a result of this increased demand for the services of fewer doctors, their fees have gone up at an increased rate.

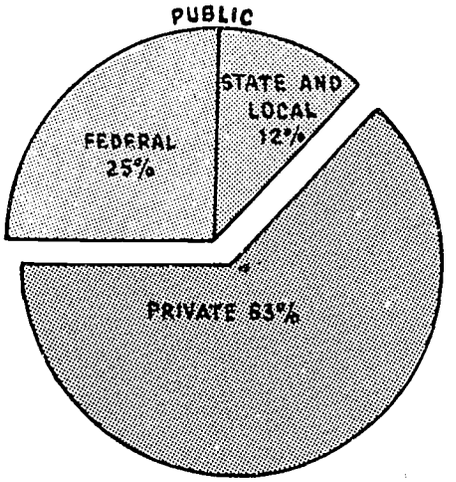
The medical care dollar is financed from private and public funds . . . and the federal share is growing



FY 1950
$12.1 BILLION



FY 1966
$42.3 BILLION



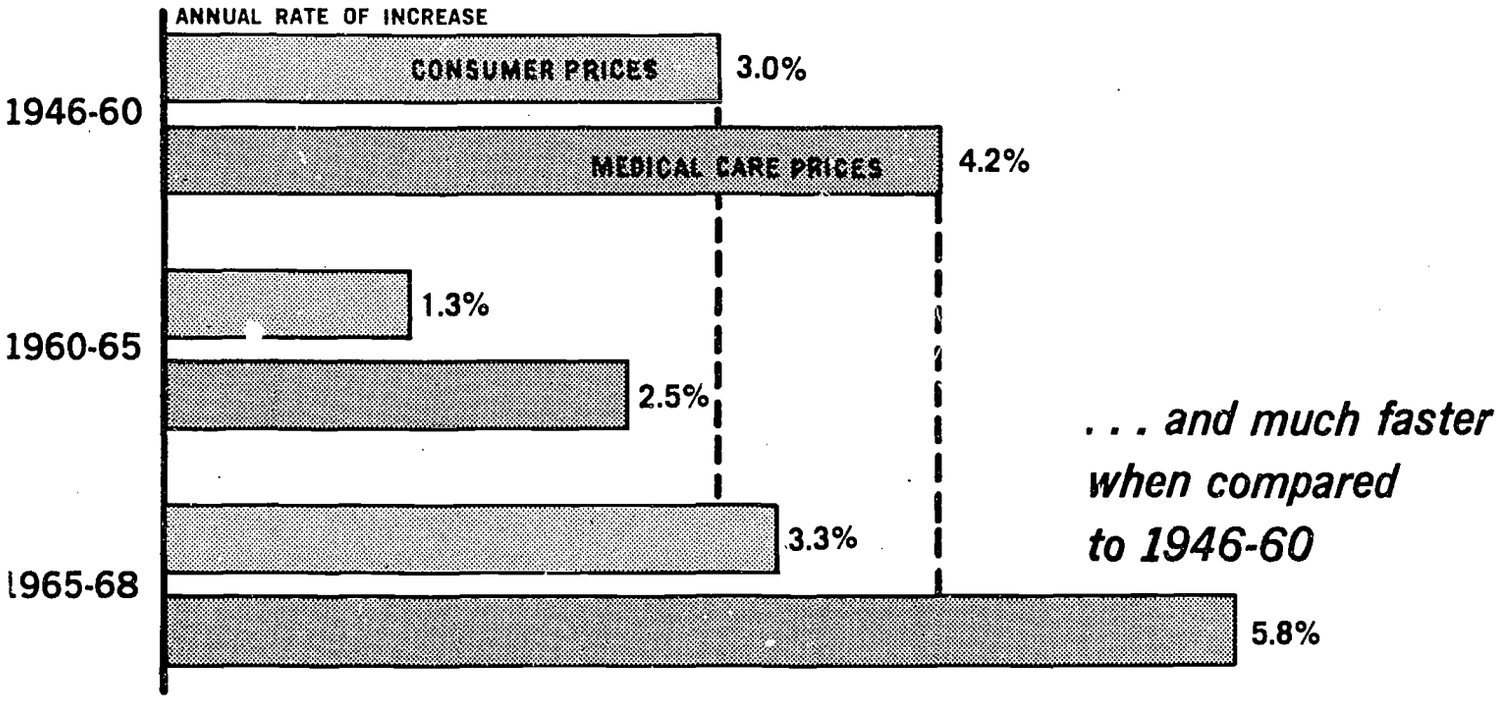
FY 1969
$60.3 BILLION

WHO PAYS?

The medical care dollar is financed both publicly and privately. The private share has always been by far the largest, but in recent years, with the addition of the new public programs of Medicare and Medicaid, a shift to more public financing can be seen.

In fiscal 1950, the Government spent 25¢. By fiscal 1969, the Government's portion had reached 37¢ with much of this increasing share coming from Federal funds. Increased public spending for health has done much to alleviate the financial burden of health care for the Nation's poor and aged.

In the last 3 years, medical care prices have jumped almost twice as fast as prices for all consumer items

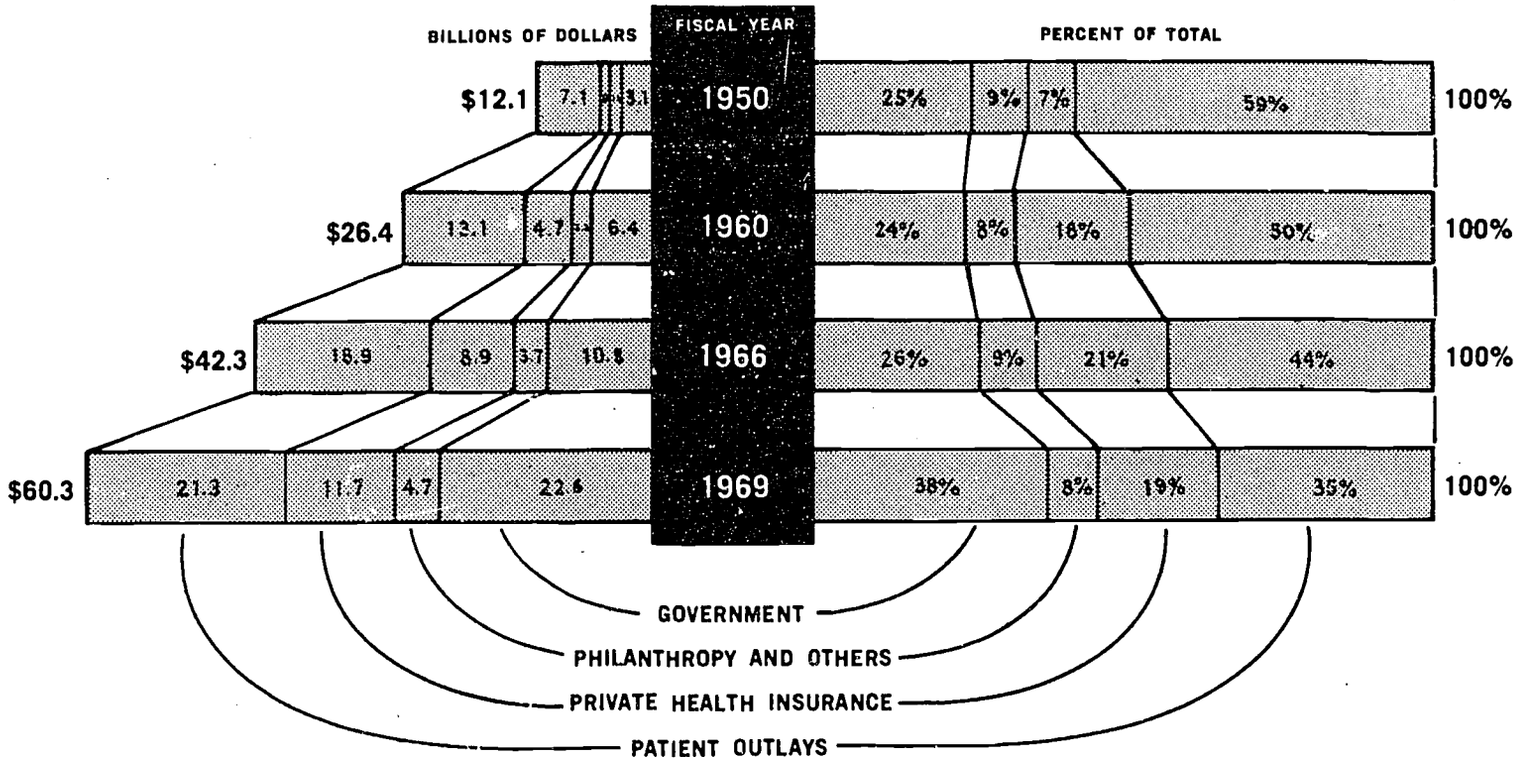


WHAT HAS HAPPENED TO MEDICAL CARE PRICES?

With rising prices responsible for the largest portion of the increase in medical care expenditures, it is apparent that the sizable growth in medical care prices is a matter of concern. A dollar of health care spent today does not go nearly as far in paying for a day of care or a unit of service as it would have several years ago.

Since World War II, the consumer price index (CPI) and its medical care component have been continuously rising, with the latter rapidly outpacing the former. In recent years, however, the gap between the relative increases of these two price indexes has widened considerably. From 1960 to 1965 medical care prices jumped nearly twice as fast as prices for all consumer items and the wide gap has continued. For the three-year period 1965-68, medical care prices increased at the annual rate of 5.8% compared with 3.3% increase for all consumer items.

Government, private health insurance, and philanthropy help reduce patient outlays percentagewise

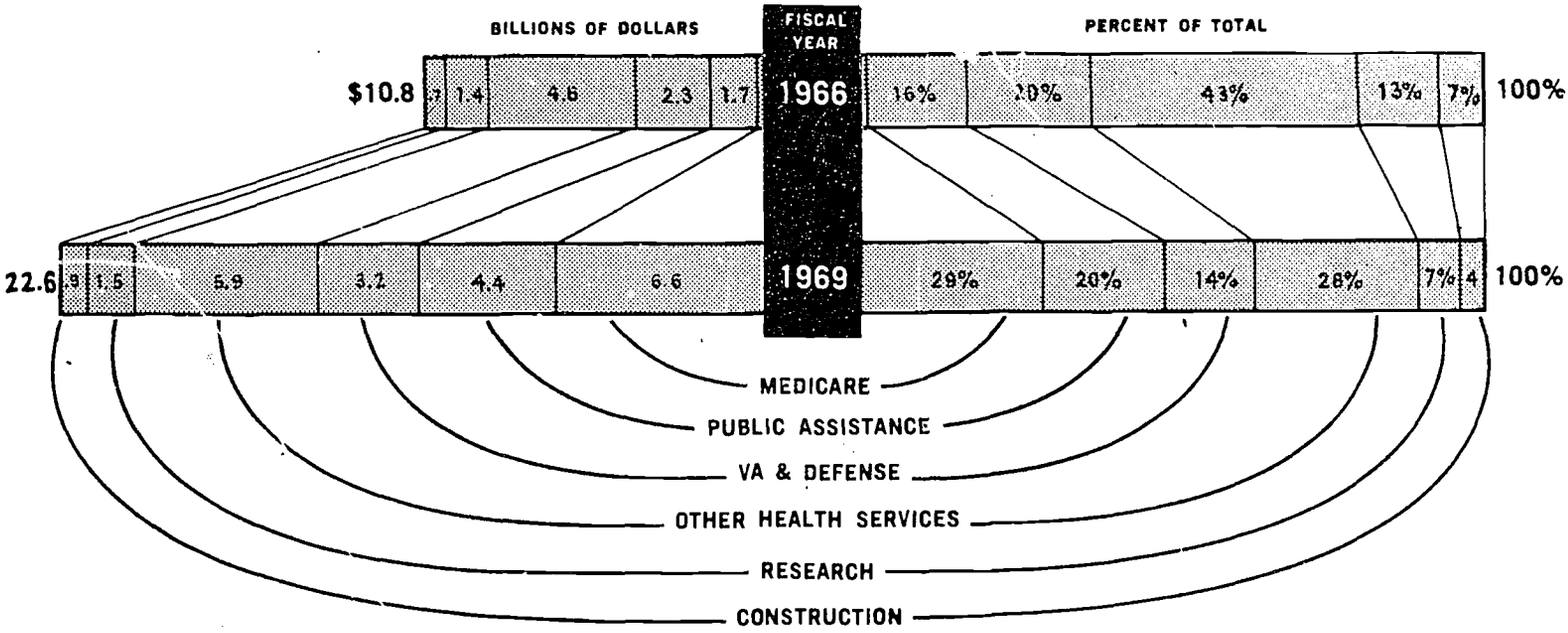


WHERE DOES THE MONEY COME FROM?

The Nation's medical bill is paid by Government at all levels (Federal, State, and local), private health insurance, philanthropy and others (industry and loans), and the private individual from his own pocket. With private health insurance and the Government assuming more of the burden of financing total medical care, a smaller proportion of the medical care dollar now is paid directly by the individual.

In fiscal 1950, 59 cents out of every medical care dollar was a patient outlay. In fiscal 1966, such outlays represented 44 cents of each dollar and by fiscal 1969, they had dropped to 35 cents. These patient outlays are largely for items not presently covered by health insurance, such as drugs, long-term institutional care, and dental care.

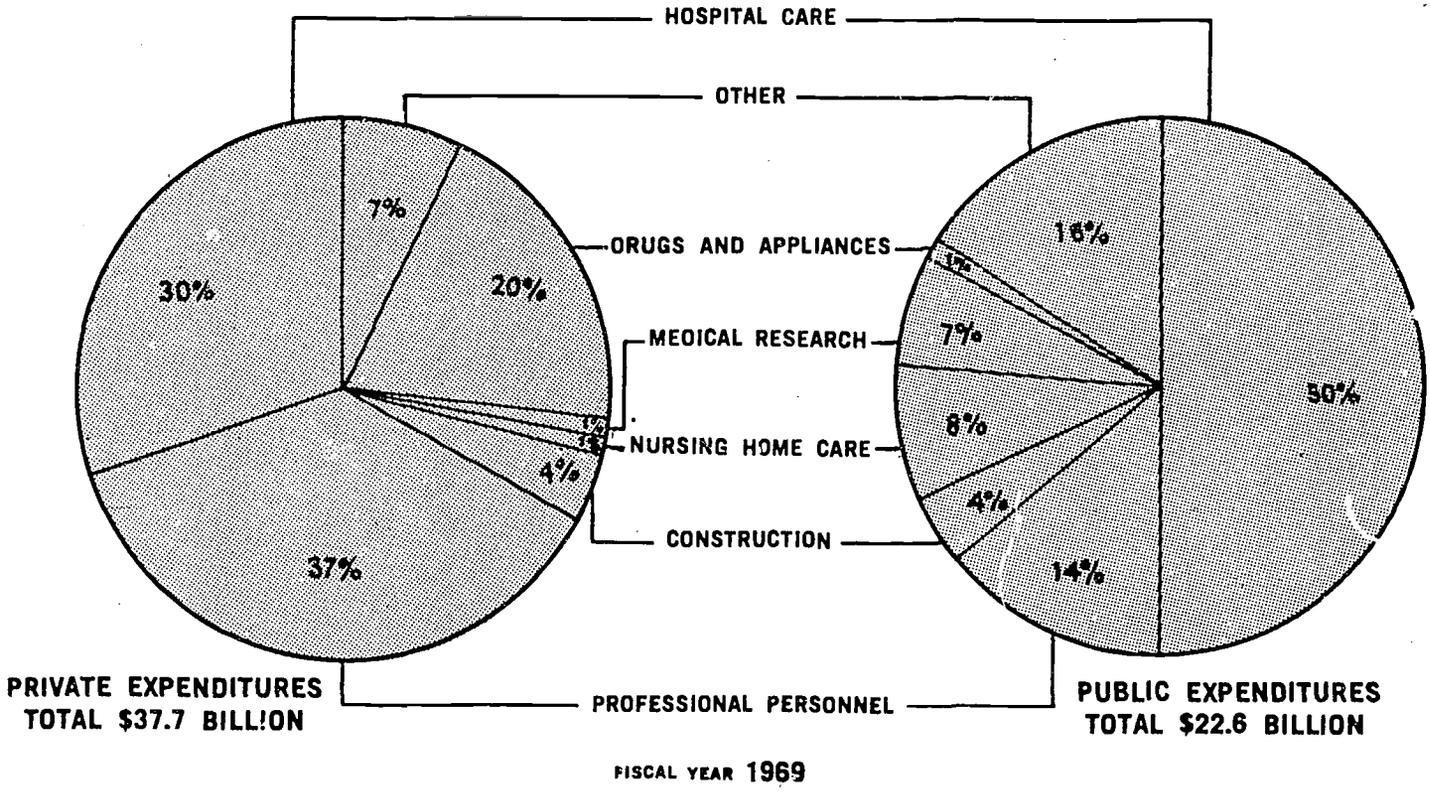
Several public programs spend medical care dollars, but Medicare spends the most



WHICH PUBLIC PROGRAMS SPEND MEDICAL CARE DOLLARS?

The rise in the government share of health expenditures can be readily understood in light of the fact that Government spending for medical care has jumped from $10.8 billion in fiscal 1966 to $22.6 billion in fiscal 1969. Much of this $11.8 billion growth was the result of the Medicare and Medicaid programs. Medicare alone was responsible for $6.5 billion or 55% of the increase. Medicaid, the major component under the vendor medical program of public assistance, was the second largest contributor to the 3-year increase -- $2.7 billion of the growth came from this source.

Private and public health outlays differ

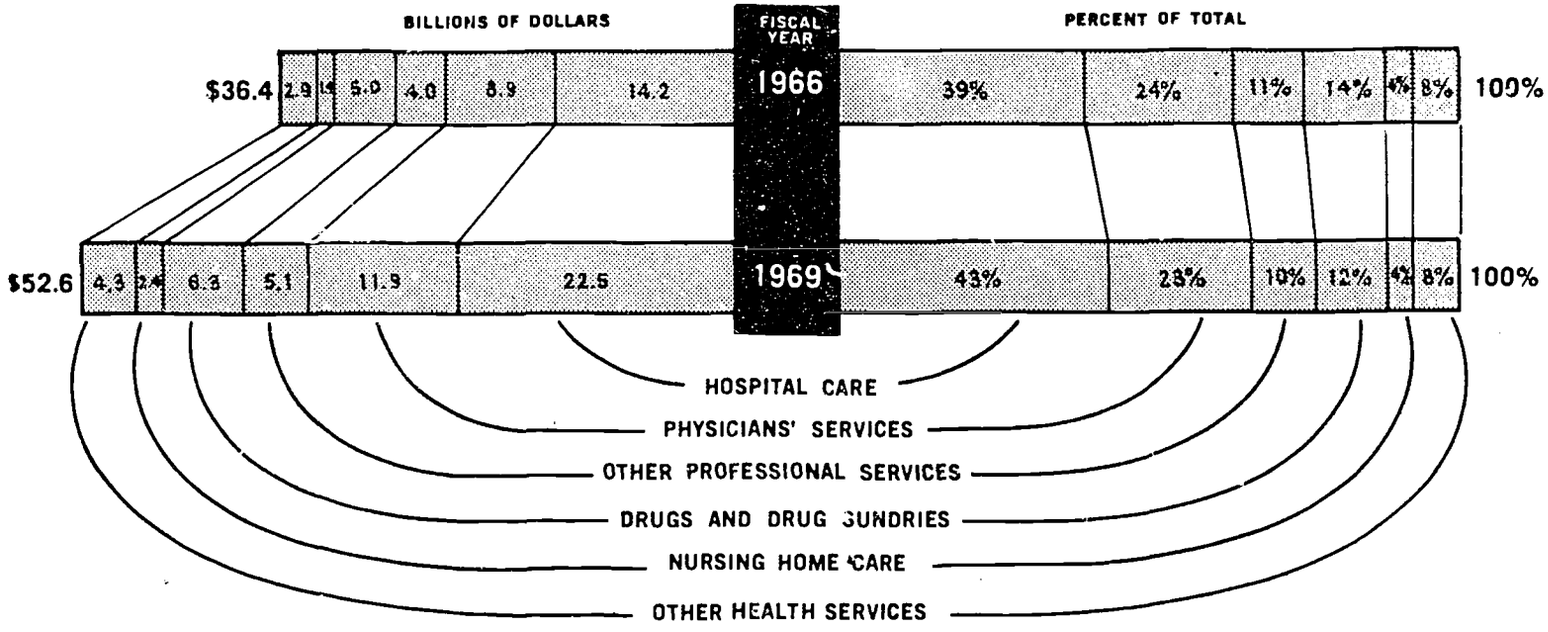


DO PRIVATE AND PUBLIC MEDICAL CARE DOLLARS BUY THE SAME CARE?

Private and public outlays for health differ considerably in the services they buy. Of the $37.7 billion spent in fiscal 1969 from private sources, $3 out of $10 was for hospital care; of the $22.6 billion from public funds, $5 out of $10 was for hospital care. Similarly, nursing home care comprised 1% of private expenditures and 8% of the public. The proportions for medical research were also smaller in the private sector -- 1% compared with 7%.

On the other hand, one-fifth of the private medical care dollar was spent for drugs -- only 1% of the public medical dollar went for this purpose. Likewise, 37% of the private compared with 14% of the public health dollar purchased services of health professionals.

Hospital care and physicians' services consume most of the personal health care dollar



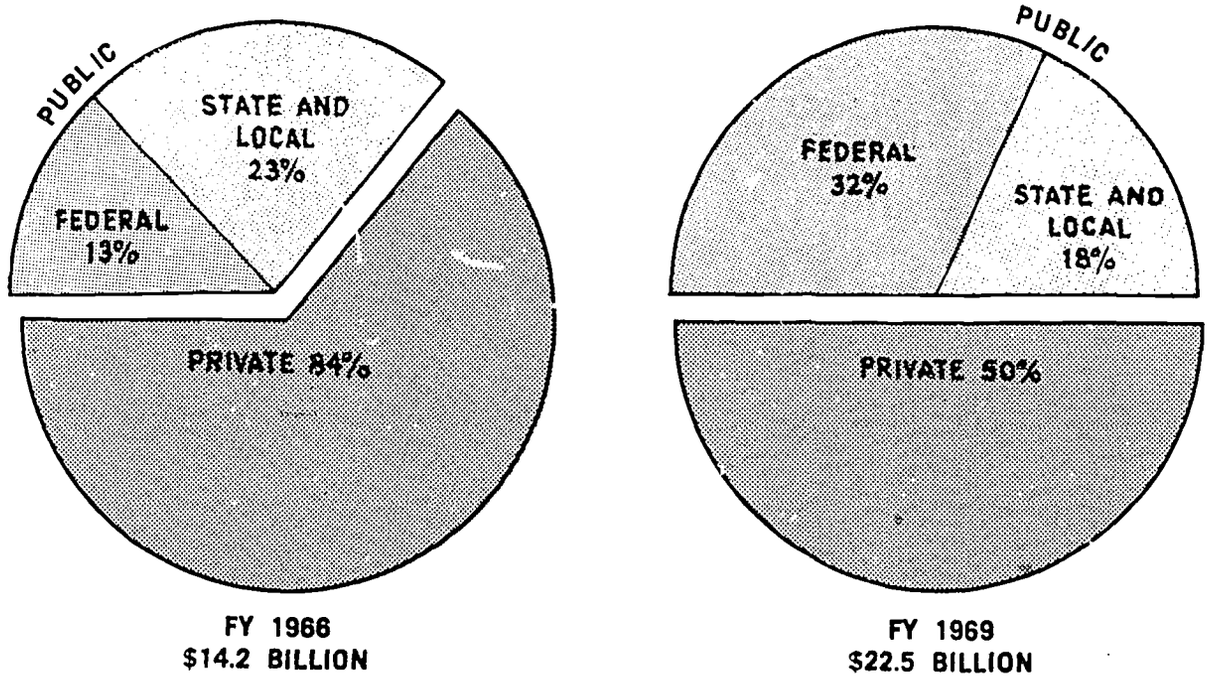
WHAT DOES THE PERSONAL HEALTH CARE DOLLAR BUY?

The medical care dollar is composed of two kinds of expenditures -- personal health care and nonpersonal health care. Personal health care expenditures include all outlays for health and medical care services for the direct benefit of the individual, such as for hospital care, physicians' services, etc. Nonpersonal health care expenditures are those outlays which are spent for the community, such as for medical-facilities construction, research, disease control, and detection programs, etc.

The personal health care dollar is shaped by the type of care purchased. The largest share of this dollar is for hospital care, $22.5 billion, or 43% of the fiscal 1969 total ($52.6 billion). Physicians' services ($11.9 billion), represent the next largest expenditure item comprising 23% of the total. Drugs and drug sundries purchased out of the hospital ($6.3 billion), other professional services ($5.1 billion), and nursing home care ($2.4 billion) follow.

The distribution of health expenditures by type of care was essentially the same for many years. In the last few years, however, with prices for and use of hospital care rising faster than for other medical items, this component has become a larger part of the total.

Private and public funds each now pay about half of the hospital care bill



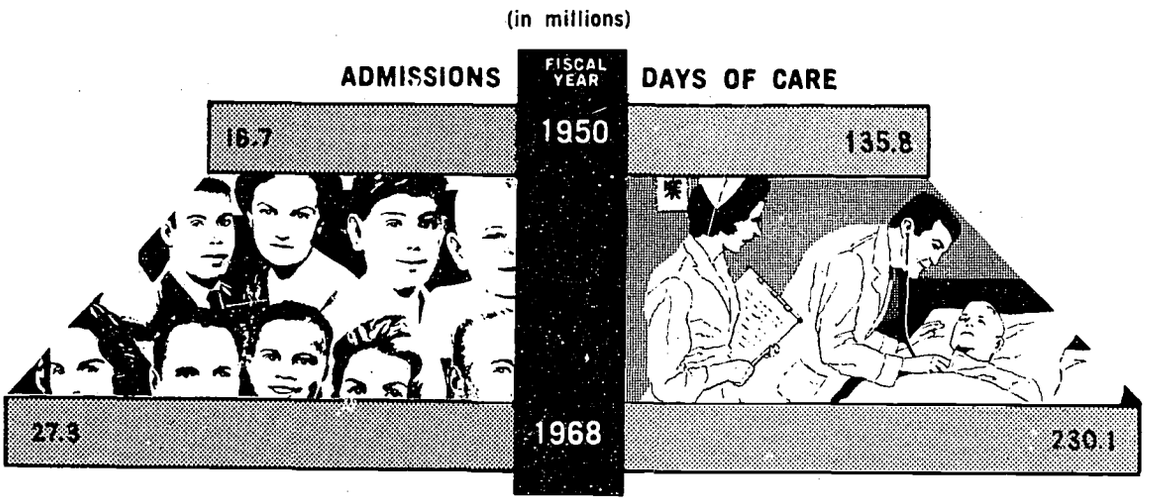
WHO PAYS FOR HOSPITAL CARE?

While hospital care expenditures have been rapidly increasing, the source of financing for this care has been rapidly changing. Medicare and Medicaid have been taking over more and more of the private burden of paying for hospital care.

In fiscal 1966, the year before Medicare, the private sector contributed 64% of the $14.2 billion total; the Federal Government paid 13%, and State and local Governments spent the remaining 23%.

In fiscal 1969, the third year of Medicare and Medicaid, the private sector had declined to 50%. Some of the State and local share also had been shifted to the Federal Government so that by fiscal 1969, 32% came from Federal funds and 18% from State and local spending.

In the past 18 years, hospital admissions increased 63% and hospital days rose 69%



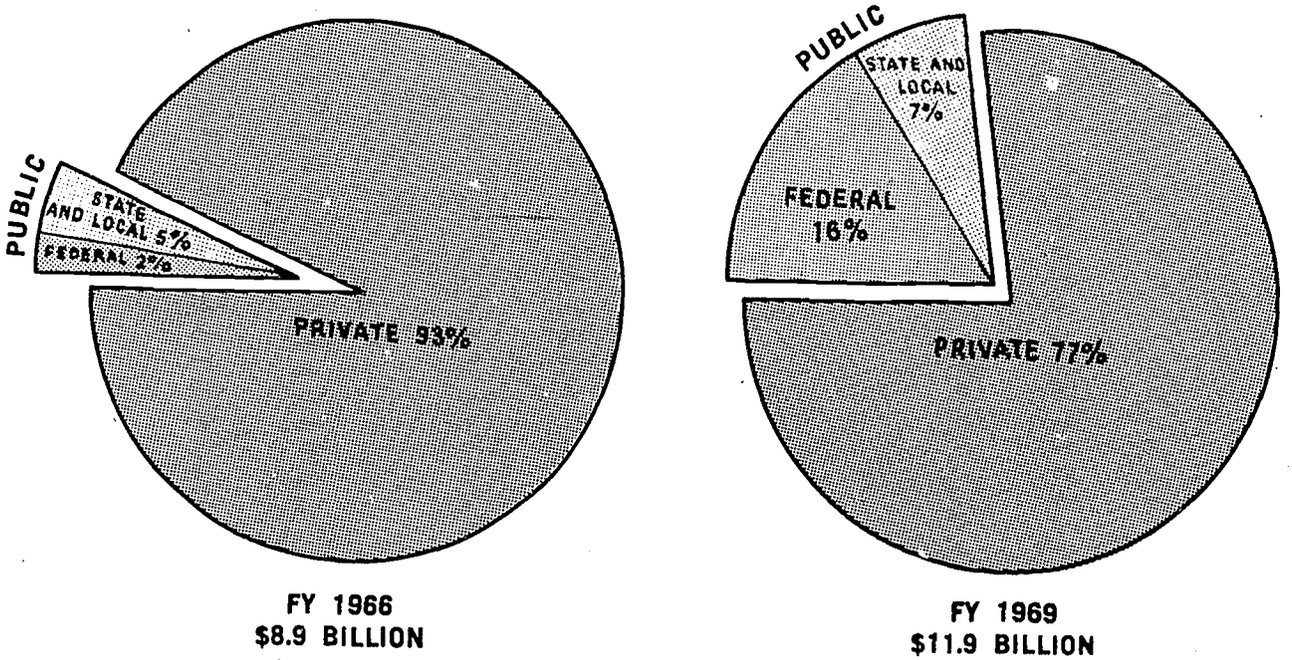
HOW MUCH HAS HOSPITAL USE GROWN?

The growth in the hospital care bill is due partly to increased prices but partly to increased per capita use of the hospital.

In 1950, there were nearly 17 million admissions to community hospitals, or 109 admissions for every 1,000 persons in the population. Today, the number of admissions is 27 million and the rate is about 136.

Because there are more hospital admissions, more days are spent in the hospital. In 1950, 136 million days were spent in a community hospital -- less than one hospital day per person. Today, hospital days total 230 million and on the average there is more than one day spent in the hospital per person each year.

Private funds pay most of the physician's bill, but their share is decreasing

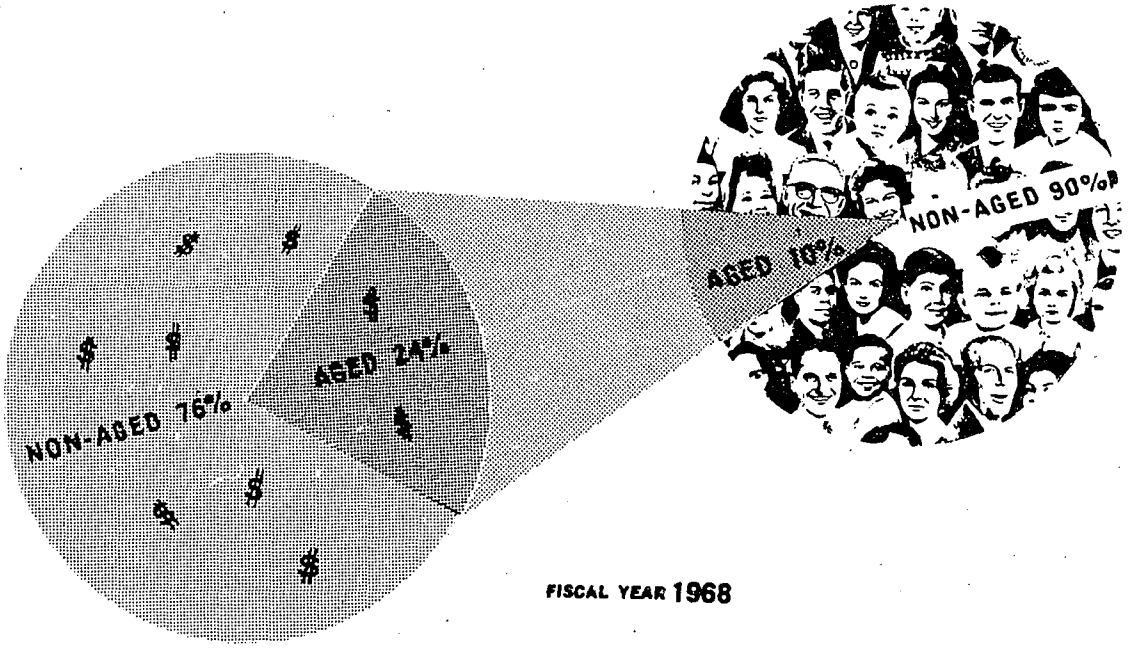


WHO PAYS FOR PHYSICIANS' SERVICES?

Private funds pay most of the bill for physicians' services, but the picture has changed significantly since the advent of Medicare and Medicaid. The private share has decreased from 93% of the total bill in fiscal 1966 to 77% 3 years later.

The Federal share in paying for these services has increased from 2% in fiscal 1966 to 16% in fiscal 1969. Medicare and Medicaid payments of the physicians' bill have been largely responsible for the larger Federal share. Not all of the outlays from these two programs, however, represent a shift in financing. Many aged and medically needy persons who could not afford doctor's care now are receiving his services.

One-quarter of the personal health care dollar is spent for the aged, who comprise one-tenth of the population



FOR WHOM IS THE MEDICAL CARE DOLLAR SPENT?

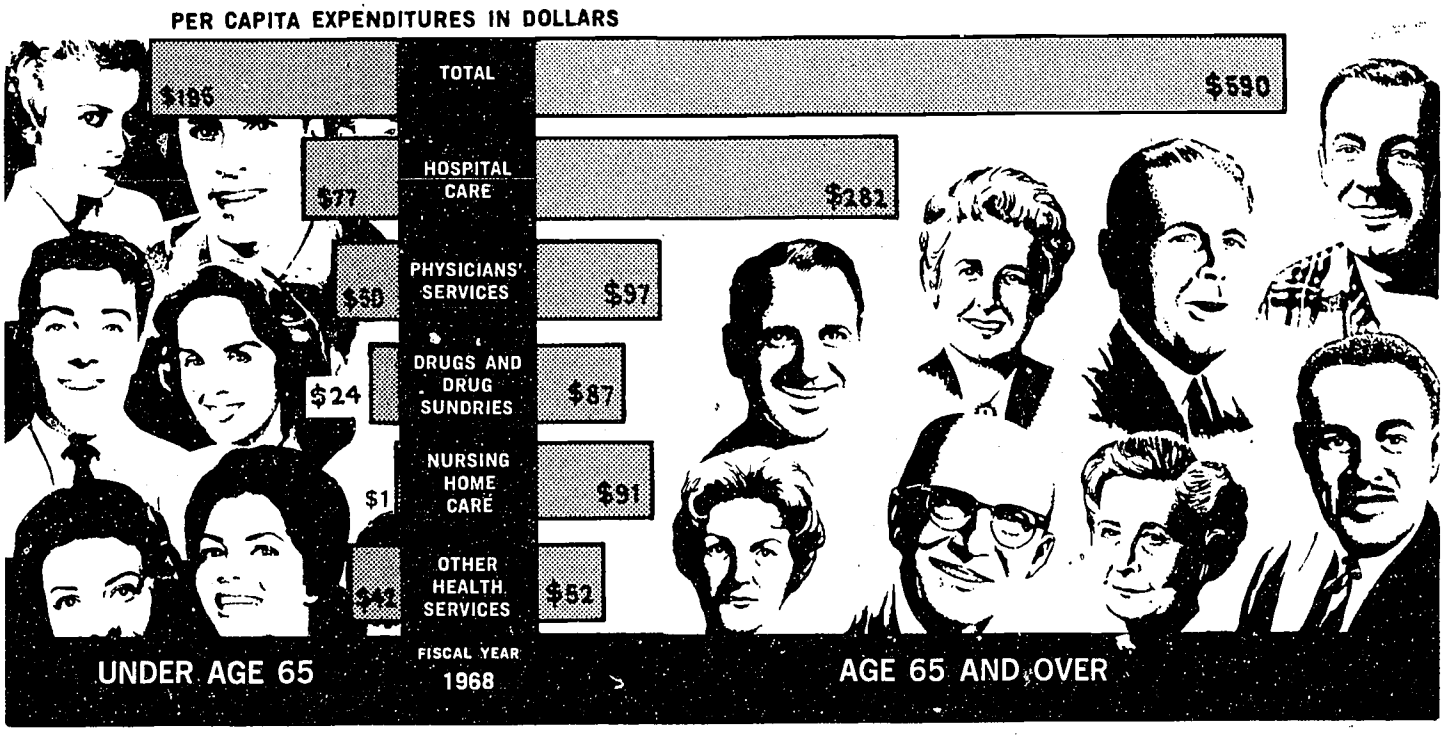
The personal health care dollar is shaped by the age of the persons for whom it is spent.

Of the $46.7 billion personal health care expenditures in fiscal 1968, about one-fourth of this total was spent by or in behalf of the aged, who make up only one-tenth of the total population. In fiscal 1966, the year before Medicare, aged expeditures represented one-fifth of the total.

This large medical bill for the aged reflects the following:

(1) the average aged person has more and costlier illnesses than the average person under age 65.
(2) the older person is twice as likely as the younger one to suffer from one or more chronic conditions and is much more likely to be limited in activity;
(3) an aged person is admitted to hospitals much more frequently and stays longer than a younger person;
(4) an older person, on the average, uses physicians to a far greater extent.

Health expenditures average 3 times more for the aged than for the younger person

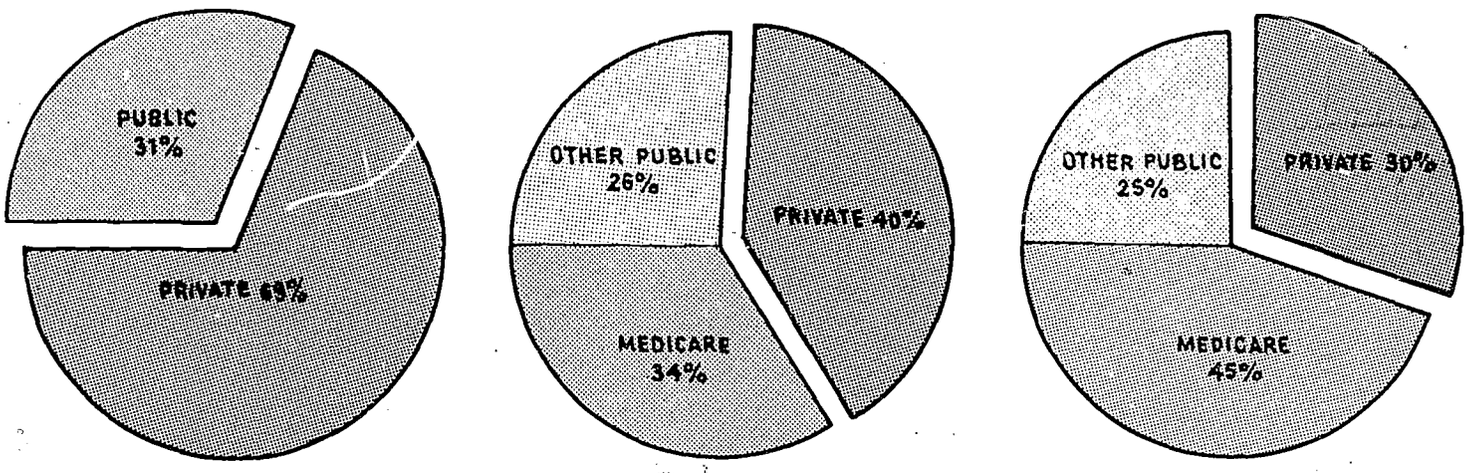


HOW MUCH IS SPENT FOR MEDICAL CARE FOR EACH AGE GROUP?

The medical care dollar is shaped by the people for whom it is spent. The personal health care bill for the average person in the United States was $233 in fiscal year 1968. The bill for the average aged person is about three times that of the younger person -- $590, compared with $195.

The differential between the aged and nonaged varies considerably by type of expenditure. Per capita hospital care expenditures for the aged -- $282 in fiscal year 1968 -- are more than three and a half times that of persons under age 65 ($77), but per capita expenditures for physicians' services for the aged ($97) are only about twice those for the younger age group ($50).

Medicare pays 45% of the personal health care bill of the aged



FY 1966
$7.9 BILLION

FY 1967
$9.4 BILLION

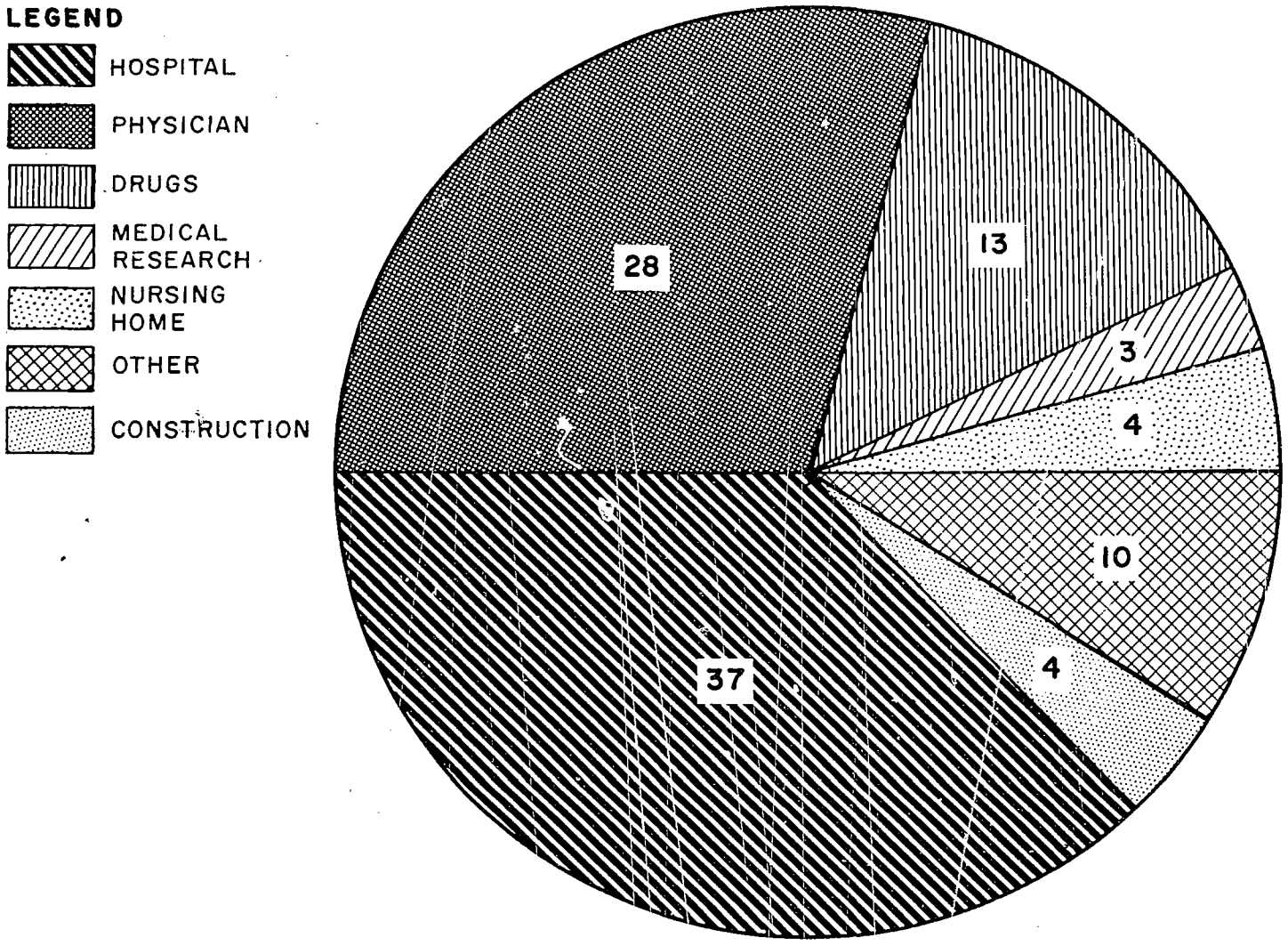
FY 1968
$11.4 BILLION

WHO PAYS THE BILL FOR THE AGED?

The financial burden on the aged of their high costs of hospital and medical care has been substantially reduced as a direct result of the Medicare program. In the year before Medicare, $7 out of $10 of the aged person's medical bill had to be paid privately. Two years later only $3 out of every $10 came from private funds.

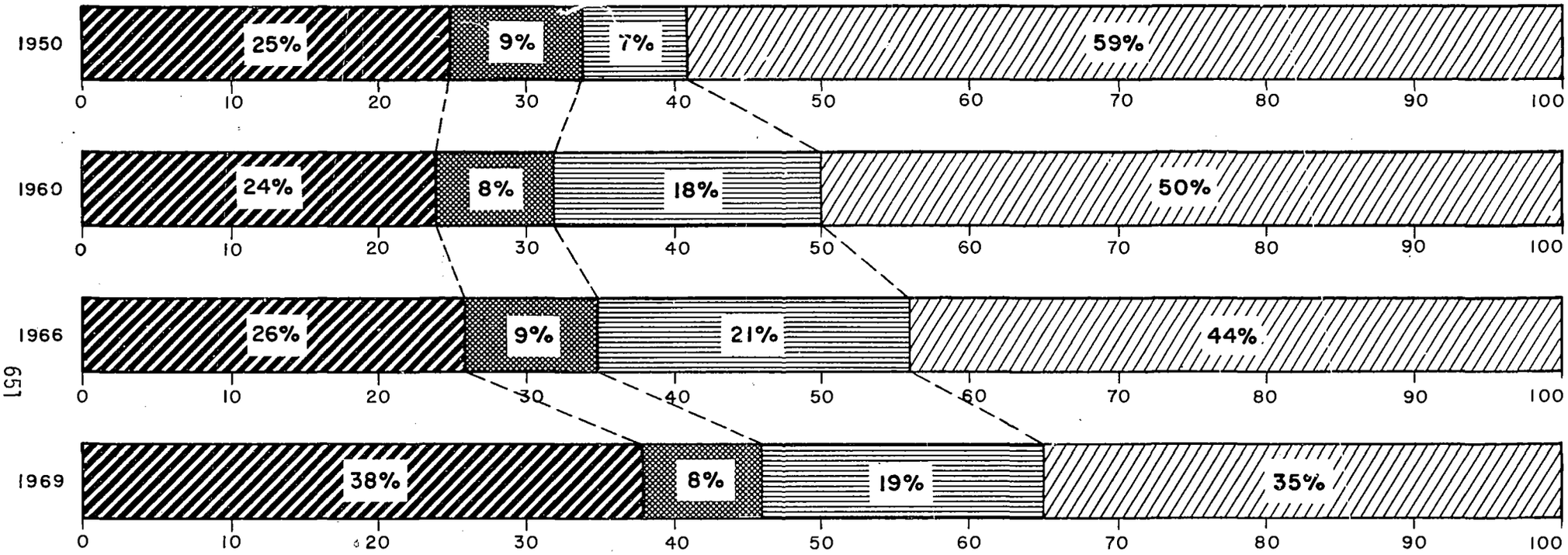
In Medicare's first year, benefit payments under the program represented 34% of the personal health care expenditures for the aged during the year. In Medicare's second year, this proportion had reached 45%. Much of the expenditures not covered by Medicare were for drugs, long-term institutional care, physical check-ups, eyeglasses, appliances such as hearing aids, and dental care. Other public programs such as Medicaid, Veterans Administration, and State and local governments contributed another 25% of the health expenditures of the aged.

DISTRIBUTION OF THE HEALTH DOLLAR-UNITED STATES



TOTAL EXPENDITURES

WHO SPENDS THE HEALTH DOLLAR–UNITED STATES



LEGEND

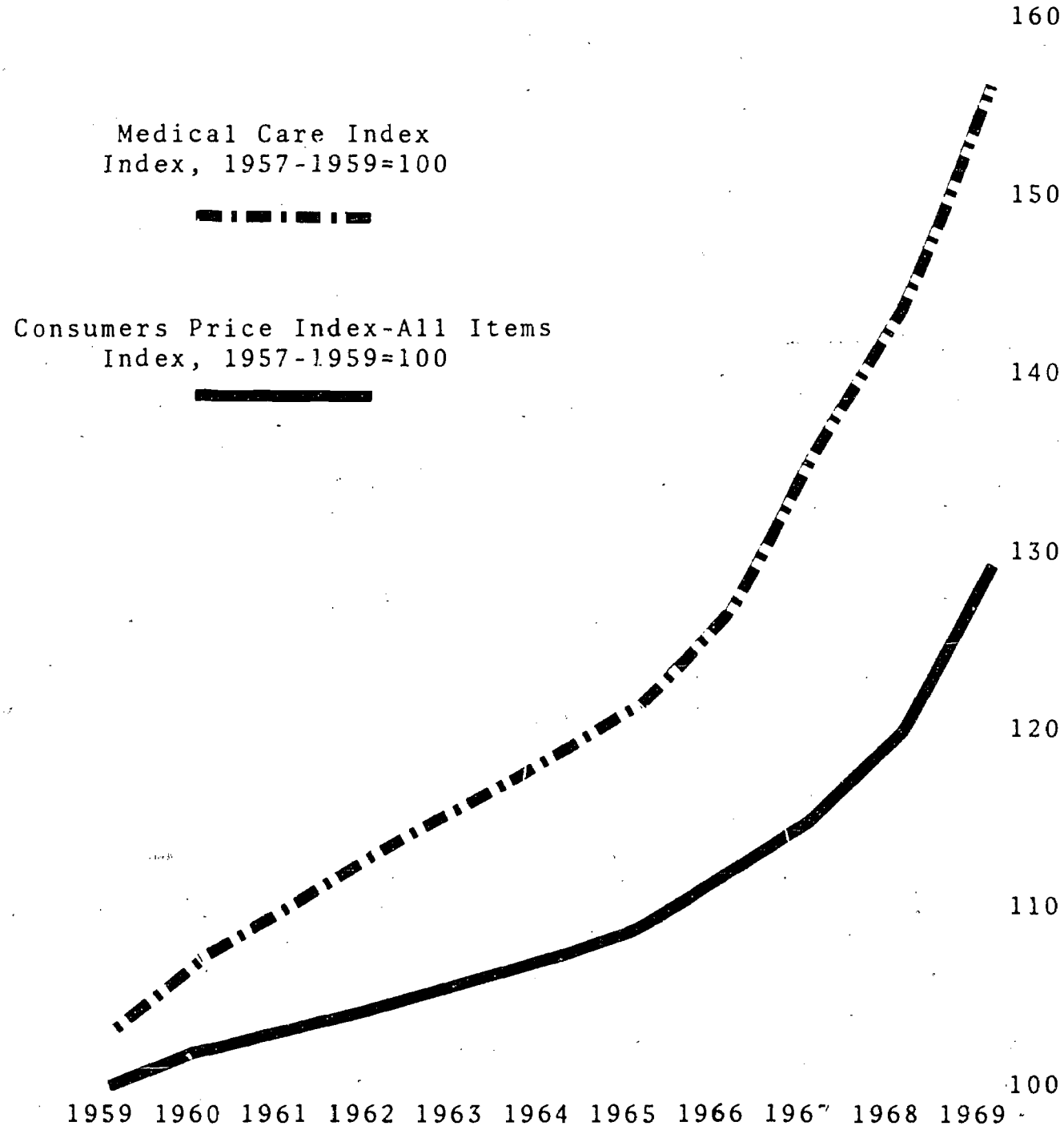
- GOVERNMENT
- PHILANTHROPY
- PRIVATE HEALTH INSURANCE
- PATIENT OUTLAYS

SOURCE: HEW, Social Security Administration
Size and Shape of Health Care Dollar
1969 Washington, D. C.

COST INDEX CHART

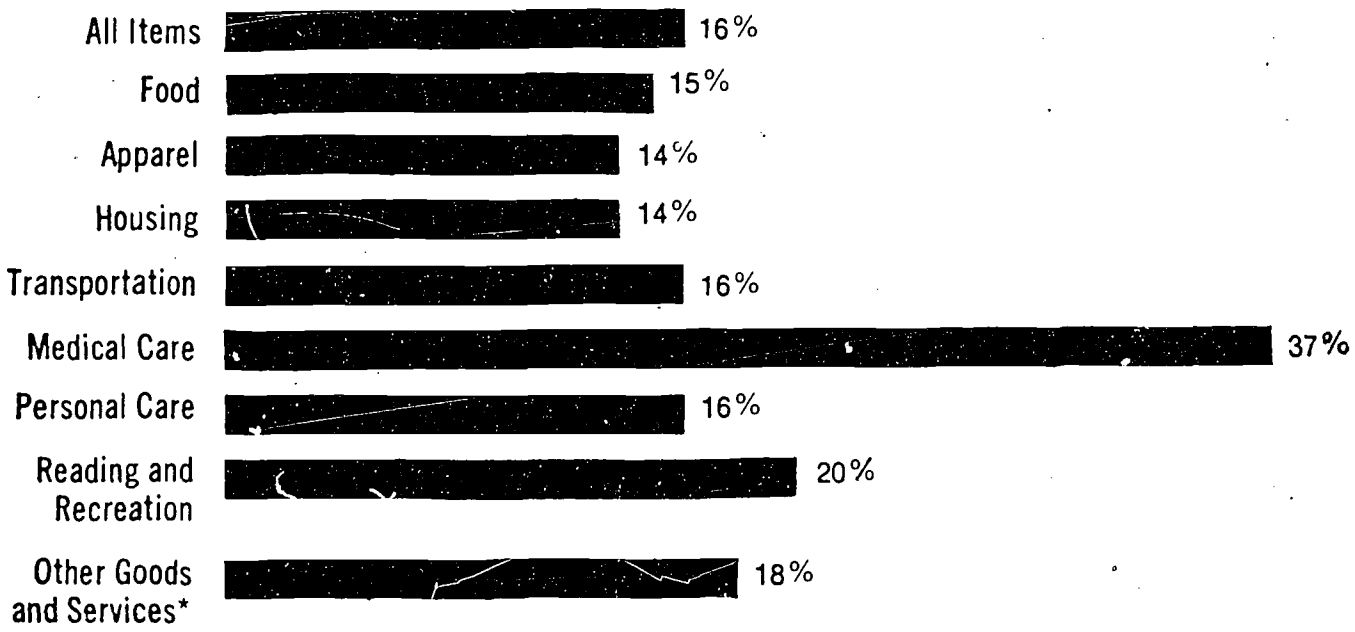
ALL ITEMS COST - MEDICAL CARE COST

(ANNUAL - U.S.)



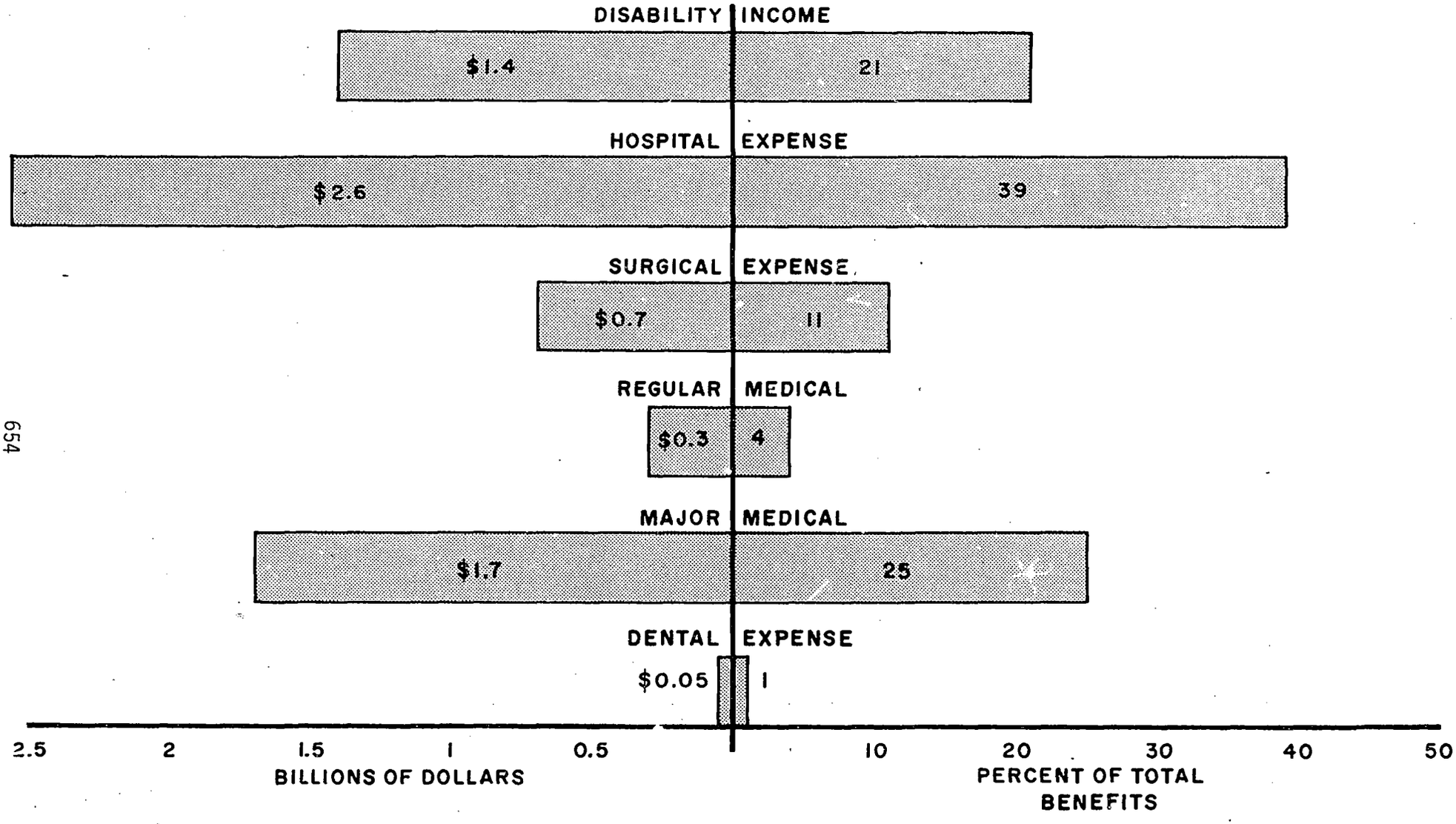
INCREASES IN MEDICAL CARE AND OTHER MAJOR GROUPS IN THE CONSUMER PRICE INDEX

In the United States, 1957-59 — 1967



*Comprises tobacco, alcoholic beverages, legal services, burial services, banking fees, etc.
Source: U.S. Department of Labor, Bureau of Labor Statistics.

HEALTH INSURANCE BENEFIT PAYMENTS OF INSURANCE COMPANIES BY TYPE OF COVERAGE: UNITED STATES, 1968



SOURCE: Source Book of Health Insurance Data, 1969 Health Insurance Institute, New York, Page 40

INTRODUCTION TO INDEX REFERENCE MATRIX

The following Matrix (pages 656-659) provides a quick reference to those reports in this Comprehensive Health Plan in which the "Recommendations and Methods" section refers to select agency/organization responsibility.

The "Agency/Organization Index" (pages 660-662) provides a cross reference of these select agency/organization responsibilities, reflecting the pages on which the specific recommendation or method may be found.

The "Subject Index" (pages 663-665) provides a reference to the "Recommendations and Methods" section of the various reports for select major subject areas of concern.

There has been no attempt to develop a comprehensive index for all of the material contained in this Plan.

	HEALTH DELIVERY SYSTEM							HEALTH SERVICES						TARGET GROUPS					
	Emergency Medical	Facilities	Health Information	Health Manpower	Home Health Services	Local Public Health	Prepaid Health Care	Drugs and Medicines	Accidents-Motor Veh.	Consumer Protection	Family Planning	Nutrition	Pre-Postnatal Care	Rehabilitation	Aged	Medically Indigent	Migrants	Newborns-Infants-Etc.	School-Age Children
GOVERNMENTAL																			
Aging, State Program on															*				
Agriculture Department										*									
Blind Commission														*					
Commerce Department	*	*					*							*					
Congressional Delegation							*								*		*		
Coop. Area Manpower Planning				*															
Dental School				*								*				*	*		*
Economic Opportunity Office					*							*				*			
Education, Board of											*	*			*				
Educ. Coordinating Council				*										*					*
Emergency Services Division	*								*										
Employment Division				*			*										*		
Environmental Quality Dept.																			
General Services Department												*							
Health, Board of	*	*	*		*	*	*		*	*	*	*	*	*	*	*	*	*	*
Health Planning		*	*		*	*		*						*		*			
Higher Education, System of				*							*	*				*	*		*
Human Resources		*	*											*		*			
Justice Department		*																	
Labor, Bureau of																	*		
Legislature	*						*								*	*			
Medical School	*	*	*	*	*						*	*	*	*	*	*	*	*	*
Mental Health Division		*	*			*	*		*		*				*			*	
Motor Veh. Accident Fund					*									*					
Pharmacy, Board of				*				*		*									
Public Welfare Division					*							*		*	*	*			*
State Accident Insur. Fund					*														
State Police Department									*									*	
Traffic Safety Commission	*								*	*									
Transportation Department	*								*										

MENTAL HEALTH				COMMUNICABLE DISEASE						NON-COMMUNICABLE DISEASE														ENVIRONMENTAL					
Mental Health	Alcoholism-Drug Abuse	Mental Retardation	Suicide	Hepatitis	Influenza	Rheumatic Fever	Rubella	Syphilis-Gonorrhea	Tuberculosis	Allergic Disease	Arthritis-Rheumatism	Birth Defects	Cancer	Cardiovascular Dis.	Cerebral Palsy	Bronchitis-Emphysema	Cystic Fibrosis	Dental Health	Diabetes Mellitus	Epilepsy	Multiple Sclerosis	Myasthenia Gravis	Renal Disease	Speech and Hearing	Air Quality	Drinking Water	Sewer-Sewage Control	Solid Waste	Vector Control	Water Quality
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	HEALTH DELIVERY SYSTEM								HEALTH SERVICES						TARGET GROUPS				
	Emergency Medical	Facilities	Health Information	Health Manpower	Home Health Services	Local Public Health	Prepaid Health Care	Drugs and Medicines	Accidents-Motor Veh.	Consumer Protection	Family Planning	Nutrition	Pre-Postnatal Care	Rehabilitation	Aged	Medically Indigent	Migrants	Newborns-Infants-Etc.	School-Age Children
Vocational Rehabilitation Div.					*									*					
Workmen's Compensation Board					*					*									
OTHER																			
Aging, Local Councils on															*				
Community Action Programs												*			*	*			
Consumer Protection, Center for												*							
Cooperative Extension Service												*			*				
Dental Association, Oregon				*											*		*		*
Dental Service, Oregon							*												
Governments, Local	*											*							
GHPC and its Committees		*	*	*	*		*					*		*		*			
Health Departments, Local											*	*	*	*	*	*	*	*	*
Health Insurance Companies	*	*			*		*				*								
Health Manpower Intel. Facility				*										*					
Health Planning, Areawide Com.	*	*	*		*									*		*		*	*
Home Health Agencies		*			*										*				
Hospitals, Ore. Assn. of	*	*		*	*								*	*		*		*	
Medical Association, Oregon		*		*	*	*					*		*	*	*	*		*	*
Mental Health Clinics									*							*			
Nurses Association, Oregon																			*
Nutrition Council, Oregon												*							
Planned Parenthood Assns.											*	*	*						
Professional Licensing Boards		*		*															*
Regional Medical Program					*									*					
Regional Primate Center																			
Rehabilitation Institute														*					
School Districts, Local											*				*			*	*
Veterans' Administration Hosp.														*					
Voluntary Organizations	*			*	*			*			*	*		*			*		

MENTAL HEALTH				COMMUNICABLE DISEASE						NON-COMMUNICABLE DISEASE												ENVIRONMENTAL				
Mental Health	Alcoholism-Drug Abuse	Mental Retardation	Suicide	Hepatitis	Influenza	Rheumatic Fever	Rubella	Syphilis-Gonorrhea	Tuberculosis	Allergic Disease	Arthritis-Rheumatism	Birth Defects	Cancer	Cardiovascular Dis.	Cerebral Palsy	Bronchitis-Emphysema	Cystic Fibrosis	Dental Health	Diabetes Mellitus	Epilepsy	Multiple Sclerosis	Myasthenia Gravis	Renal Disease	Speech and Hearing	Air Quality	Drinking Water	Sewer-Sewage Control	Solid Waste	Vector Control	Water Quality
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AGENCY/ORGANIZATION INDEX

SUBJECT INDEX