MINUTES

SENATE HEALTH & WELFARE COMMITTEE

DATE:	Monday, February 17, 2014
TIME:	3:00 P.M.
PLACE:	Room WW54
MEMBERS PRESENT:	Chairman Heider, Vice Chairman Nuxoll, Senators Lodge, Hagedorn, Guthrie, Martin, Lakey, Bock and Schmidt
ABSENT/ EXCUSED:	None
NOTE:	The sign-in sheet, testimonies and other related materials will be retained with the minutes in the Committee's office until the end of the session and will then be located on file with the minutes in the Legislative Services Library.

CONVENED: **Chairman Heider** called the meeting to order at 3:08 p.m., and requested the Committee Secretary take a silent roll. He wanted to welcome the new Senate Page, Anne Young, to the Committee for the second half of the Session.

S 1329 **Time Sensitive Emergencies: Molly Steckel**, Policy Director, Idaho Medical Association (Association), stated the Association and a lot of other groups are in support of this bill, and have no knowledge of any opposition to the legislation. She then requested to yield the remainder of her time to Dr. Polk.

TESTIMONY: **Dr. Robert Polk**, Chairman of the Health Quality Planning Commission (HQPC) for the state of Idaho, and Vice President and Chief Quality Officer for the Saint Alphonsus Health System. The HQPC was established in 2006 by the Legislature with representatives appointed by the Governor, and are pulled from hospitals, health plans physicians, employers, the public and the Director of Health and Welfare. **Mr. Polk** stated that the initial assignment of the HQPC was to develop and facilitate a plan for the electronic exchange of healthcare information, which eventually became what is now the Idaho Health Data Exchange. The next task was to examine and report on issues of quality and patient safety that impacted citizens of Idaho and that could possibly be improved.

The HQPC has been focusing on these issues of healthcare quality and patient safety, **Mr. Polk** said. The Legislature had asked the HQPC to study stroke systems of care in 2011, and in 2012-2013 the HQPC looked at the various issues involving stroke care and the expeditious care of other conditions. Their recommendation, as a result, showed that Idaho has a lack of an organized system of emergency and subsequent hospital care when needed for three main types of time sensitive emergencies. This study showed that with this lack of an organized system, there were higher death rates and disability from stroke, heart attack and trauma. In 2013 the Legislature responded to the HQPC with the creation of HCR 10, instructing the Department of Health and Welfare to develop a plan for such a system of care for time sensitive emergencies. Time sensitive emergencies constitute those illnesses and injuries where delays in receiving the right care results in significantly worse patient outcomes including death, disability and greater cost.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 1).

DISCUSSION: **Senator Bock** asked about the increase in bad outcomes due to no system in place at this time allowing the ability to track the information. He wanted to know how Idaho compares to other states. **Dr. Polk** responded that the best data comes from the trauma system and every state around Idaho has an organized trauma system. The experience from other states has shown that it has reduced mortality rates by about 15 percent.

TESTIMONY: **Representative John Rusche** said that he had been asked to go through the bill to highlight some of the major points. This bill calls for the creation of a coordinating system for the State with a Time Sensitive Emergency (TSE) Council and local committees made up as specified. He went on to state that the structure of the bill is fairly simple. Section 1 is a Statement of Intent noting that the trauma group has the best understanding on how to setup an effective system. The trauma system is intended to be voluntary and inclusive. Section 2 is definitions, and Section 3 states that it will be a creation of a TSE system within the Department of Health and Welfare. Section 4 talks about the council that would make up the membership being pulled from urban and rural areas and from different branches of healthcare. The members of the council will be appointed by the Governor and serve for four years and may be removed by the Governor at his discretion. Section 5 discusses the duties of the council and Section 6 talks about the ability of the council to designate levels of care and to survey those entities. Section 7 talks about the regional councils in which everyone can participate and take a role since those will be used as the tool to implement the best program for the region. The remainder of the bill, with Section 8, is a renaming in various parts of code the existing trauma registry (maintained for the State by the Hospital Association) to the TSE registry and expanding its scope to accommodate all TSEs.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 2).

DISCUSSION: **Chairman Heider** wanted to know for an urban area with more than one large hospital, how is it determined which one will participate in the TSE system? **Representative Rusche** responded that the idea would be that they all would and could be a part of the TSE system and participating to their fullest extent. Depending on the specialties and capabilities of the hospital, if they couldn't handle the particular trauma, they would recommend the other facility.

Vice Chairman Nuxoll had a question regarding the impact to the State General Fund of $225,750 and wanted to know what that would be used for. **Representative Rusche** answered that the rehabilitation services for one stroke victim can be well over $100,000 and if that can be prevented in the first place, there would be a resulting savings. He then wanted to defer to the Department who had put the budget together for the legislation.

Elke Shaw-Tulloch, Administrator for the Division of Public Health, Department of Health and Welfare (Department), stated that the costs associated with the legislation mirror other states in relation to the population being served. The Department has put together a supporting budget for the legislation and helped with the fiscal note and they made every effort to be as fiscally conscientious as possible. The areas that the funds will be directed towards will be operating costs, with the idea that this is the initial "kick-off" and that eventually, after the first year of funding, the program will be self sustaining. These start-up costs will go towards supporting the state level council, supporting rule promulgation, upgrading the existing trauma registry to include heart attack and stroke data, and the biggest piece for funding is to support the individual hospitals to get them up and running in this effort.

Senator Bock went back to the mortality rate of 15 percent and asked when

determining what should be included in the fiscal note was it a consideration for the actual cost-savings that would be gained by lives saved for the positive impact the bill would have. **Ms. Shaw-Tulloch** stated the issue faced in trying to do what he suggests is that there aren't other states who have this complete comprehensive system with all three components, as this bill will implement for Idaho, in order to do a thorough comparison. What is known are the costs for certain rehabilitative services as mentioned by Representative Rusche that indicate certain cost-savings if these services are not needed due to the effectiveness of the system to be put in place.

Senator Hagedorn wanted to know how this program will be measured for its successes and failures, what the guidelines for those measurements would be and how they would be reported. **Ms. Shaw-Tulloch** said that the purpose of increasing the capacity of the existing trauma registry, by including heart attack and stroke data from the hospitals, is to utilize the information so the state level council and regional advisory committees can do quality improvement work. **Senator Hagedorn** asked if there is a baseline for what the current mortality rate is so that next year, and after that, there will be information to compare with. **Representative Rusche** responded that there is current baseline data for trauma through the existing trauma registry. There's scattered data, mainly from Medicare, for the hospital portion. There's nothing really in place to show statistics from the first call and all the steps in between. This missing information will be gathered with the new system. The actual measurements for improving the program will be the role of the council in place who will manage it with the idea to help better the health and lives of Idahoans.

Senator Lakey noted that the intent of this legislation seemed to be to share information quickly to have that information available for the treatment of patients. **Dr. Polk** stated that he was correct. **Senator Lakey** asked that with existing technology already in place that rural and urban hospitals use between each other, why couldn't they just continue on in this manner without the legislation. **Dr. Polk** answered that every system is designed to get the results that it gets. The way the system is set up now, Idaho will experience 675 deaths a year, but 15 percent of those could be prevented with this system. **Representative Rusche** also wanted to note that most of the problems in the healthcare system are not from the hospital, doctor or the technology, but the connection between the facilities and practitioners. A system approach has been shown to improve situations where delays in treatment can cause more damage and death.

Senator Bock said he thought the purpose of the legislation was to develop a system whereby you could identify weak points in how emergency services are delivered and thereby reduce future mortality, but does not necessarily apply to an individual case. **Representative Rusche** said that if there is already someone hospitalized with a stroke or heart attack, then the system will not be much help at that point, but should improve the survival of future traumas, heart-attacks and strokes. He also stated that in several places throughout the State it's hard to find first-responders due to their isolation.

TESTIMONY: **Les Eaves**, Director of Clearwater County Ambulance, stated that he started with the EMS system in 1968 in Seattle, WA, in the beginnings of the Medic One program. After spending nine years there, and watching their system grow, he could see that they were able to collect the data that showed the information for what person would need to go to which hospital and when and the quickest way to get them there. He said that in Idaho, the EMS system is fractured at best with a lot to learn but they won't be able to learn it if the data isn't there to be studied.

He spoke of the system that has been devised in his county on their own, to know which hospital (Orofino, Spokane, Lewiston, Coeur d'Alene) a person should be sent to, or if they have the authority to make the decision on their own. Many times the local hospital is totally bypassed with the help of a helicopter to transport the patient to a larger hospital farther away. This legislation and system would help tremendously in gathering the data needed to know the best place for a patient to be treated.

DISCUSSION: **Vice Chairman Nuxoll** wanted it explained exactly how this piece of legislation will help with the transport. **Mr. Eaves** responded that it would allow the EMS units to have the prior authorization to bypass the local hospital and notify helicopter transportation to a larger area hospital. **Vice Chairman Nuxoll** asked where the prior authorization comes from. **Mr. Eaves** answered that it would come from the data gathered from the system they are wanting to put in place with this legislation and would include communication between all the area hospitals with a plan in place for different scenarios. **Vice Chairman Nuxoll** confirmed that the prior authorization is coming from the hospitals. **Mr. Eaves** stated it is from the hospitals and other healthcare agencies that would normally be in involved in the transport and care of an individual in an emergency situation.

TESTIMONY: **Dr. Brian O'Byrne**, Trauma Program Director at Eastern Idaho Regional Medical Center, noted that after a car race is finished, the crew in the pit have a chance to go over what went right and wrong to improve their systems to go out and do it better the next time. The same can be applied to healthcare time sensitive events, especially when dealing with stroke, heart attack and other trauma, where time is of the essence. The problem comes sometimes with rural areas staffed by volunteers who do the best they can and are looking for support to do it better, or hospitals with limited staff and resources. The system designed by **S 1329** will allow for a collaboration among hospitals and providers in a region to discuss with each other and produce protocols to be put into place. The idea is to have agencies critiquing their own performance and the ability to critique on a regional basis for later improvements. It is the goal to assist the individual (patient) as well as the facilities and agencies to bring about quality and effective care. He noted that there is a lot for facilities to learn from the review process. Smaller hospitals can't afford certain reviews on their own, but if it is done on the state level that would be very useful and help in improvements.

Senator Hagedorn wanted to confirm that with the current system now, an individual who has a stroke in Orofino, for example, would now be possibly taken to a hospital in Spokane, WA, but with the new system, perhaps it would be better to get the initial treatment locally for stabilization and then be transported to a distant facility. **Dr. O'Byrne** confirmed that was absolutely correct, the system would have the ability to make the call as to what was best for the particular individual and circumstances.

TESTIMONY: **Dr. Bill Morgan**, Medical Director of Trauma Services at Saint Alphonsus Medical Group, said that the idea of helicopters picking up and dropping off patients as in the MASH movies (Korean War), is not how it's done anymore. In the Vietnam War, they found that if a patient was taken to a facility within 30 minutes, that would lower the mortality rate, so the helicopter was even more critical then. Going back to the statistic as quoted by Dr. Polk, if 15 percent of 675 known deaths are prevented, that also represents about 99 people that would be able to get back to work, back to their families, and back to their communities.

This number represents only the trauma patients and doesn't even consider the additional victims of stroke or heart attack, so the numbers would be greater than that. With the system in place, when certain injuries are looked at throughout the system, the participants in the system can assist each other to help the patient correctly.

DISCUSSION: **Senator Guthrie** had a concern that people who are making the judgement call will err on the side of sending a patient to a larger facility, taking time, when the local facility could do just as well and save time. He wanted to know where this is being done in other states, has it changed the market share dynamic significantly with business being routed away from the smaller local hospitals in favor of the larger city hospitals farther away. **Dr. Morgan** responded that he came to Idaho from Texas which has a very active trauma system. The hospital he worked at would receive patients from outlying facilities, but they looked at each of those patients and noticed that every facility finds their own level of comfort for what they can handle and take care of with their staff and resources. Every facility that chooses to become part of the TSE system in Idaho will be able to care for what they know they can care for. This is where the review process will come in handy, to make sure that the treatment given at a smaller hospital, for example, is not sub-standard. After a year, the economic impact would be seen as small, since the more rural facilities would gain confidence in treating patients that perhaps now they are sending to larger urban facilities.

Senator Lakey asked, with Dr. Morgan's different perspectives on the issue, why it has taken so long between all of the groups involved to finally move to this type of system. **Dr. Morgan** answered that he couldn't answer for anything that happened before 2007 when he came to Idaho from Texas. But he can say that for all of the facilities, agencies and providers who have been involved in forming this legislation, there is a desire to do the right thing and make a better system. He noted that, like Texas, Idaho is a geographically separated state. Whereas Texas has 22 regional advisory committees throughout the state, Idaho will have 7. What this will mean is that every region will have a different way of looking at and doing things based on what will work best for them. This will also be a way of holding the facilities more responsible for the things that were done correctly or not.

TESTIMONY: **Jana Perry**, stated that she has been a nurse for 17 years at a variety of facilities and served on the committee involved in drafting the legislation as an expert in trauma care. It was her desire to improve the coordination between EMS and the rehabilitation efforts for patients since trauma affects all people of all ages and circumstances. She supports the legislation since it will ultimately provide appropriate care at the appropriate time that will improve patient outcomes.

Christine Shirazi, said that she has been a nurse for 23 years, and is currently the STEMI coordinator for Saint Alphonsus. She was part of the work group on the legislation in an effort to improve care for heart attack victims throughout the State. The most deadly form of heart attack is the STEMI, and in Indiana, for example, after the implementation of a STEMI system, they went from seeing patients within the 90-minute window (which is the best timeframe to see these patients) from 28 percent of the time to 71 percent. With that they also saw a decrease in the length of stay for those patients and a decrease in hospital costs. As a nurse she supports this legislation and felt that we as a state can do better for our patients.

Nichole Whitener has been a nurse for 25 years and is currently working at Saint Alphonsus Medical Group. She served on the committee as an expert for stroke care. Locally stroke care has changed and by creating a state-wide system of care it would have a positive impact on stroke victims. Within the Treasure Valley, Saint Alphonsus has been partnering with other facilities to help them bring their

protocols and standards of care to the highest level. They've also been educating and communicating with pre-hospital providers and EMS agencies so they are aware the patient can be taken to the local hospital where treatment can be started and then the patient can be moved to a higher level facility if necessary.

Adrean Cavener, representative for the American Heart and American Stroke Associations, who stated that with these two (heart and stroke) minutes truly do matter. She mentioned that one of the survivors, who is on their state board, Mark P. Dunham, was unable to be present, but had written the Committee a letter in support of the legislation.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 3).

MOTION: **Senator Hagedorn** moved to send **S 1329** to the floor with a **do pass** recommendation. **Senator Bock** seconded the motion.

Senator Martin requested to ask a question of Ms. Shaw-Tulloch regarding the fiscal impact of the legislation. He asked what the funds were for, to hire new people, computer time or what. **Ms. Shaw-Tulloch** responded that it is for operating costs, since the Department is covering the personnel piece, so the funds will be supporting the state wide council, rule promulgation, technical support to the hospitals and increasing the trauma registry to include heart attack and stroke. **Senator Martin** wanted to know if this was for additional employees or are the funds for employees; what is already being received from the State? **Ms. Shaw-Tulloch** answered that the personnel portion are funds they already have, the funds for the legislation are purely for operational costs as outlined.

Vice Chairman Nuxoll wanted to comment that she agrees with the idea behind the legislation, and can see that what is really needed is connection and education between the agencies, providers and facilities. She was surprised to see that hospitals are in favor of this legislation since she had heard that initially they weren't and wondered what changed their minds. In rural areas, such as where she comes from, helicopters are used all the time, so there seems to be no problem or issue with the transportation aspect. The hospitals seem to be the ones who should give prior authorizations as far as transporting, and she was concerned that they were not encouraged to come up with a plan to organize this effort without legislation that will require more government intervention. If the system is voluntary, why not put it on a private industry instead of the government, with the Governor having to appoint the board members, requiring more work for the executive branch, the Department of Health and Welfare, etc... She will be voting against the legislation at this time.

ROLL CALL VOTE: **Chairman Heider**, at the request of **Senator Bock**, called for a roll call vote on sending **S 1329** to the floor with a **do pass** recommendation. **Chairman Heider**, **Senators Lodge, Hagedorn, Guthrie, Martin, Lakey, Bock** and **Schmidt** voted aye, with **Vice Chairman Nuxoll** voting nay. The motion carried. Senator Hagedorn will carry **S 1329** to the floor.

PASSED THE GAVEL: Needing to testify before another Committee, Chairman Heider passed the gavel to Vice Chairman Nuxoll for the remainder of the meeting.

S 1293 **Relating to Adoption: Rob Luce**, Administrator for the Division of Family and Community Services for the Department of Health and Welfare (Department), said that he is before the Committee presenting on behalf of Senator Bart Davis who had another commitment and is the sponsor of the bill. He said that **S 1293** is a bill pertaining to technical corrections in the termination of parental rights as referenced in code concerning putative fathers.

During the 2013 Legislative Session, legislation was passed wherein was granted a set date and time certain for putative fathers to take action and protect their rights with their children born out of wedlock when a single birth mother terminates her parental rights. The most common example of a public adoption is where a single mother gives up her parental rights and the child enters the foster care system. With the passage of H 214, they discovered that they had overlooked establishing a similar date and time certain with respect to a smaller group of private adoption scenarios. These situations would include cases such as a step-parent adoption, or where the single mother consents to her termination of parental rights before the child is placed in foster care. At this point, the applicable statutes do not have a specified date and time certain for a putative father to protect his rights in private adoptions. This legislation is merely a correction for what was missed last year.

Supporting documents related to this testimony have been archived and can be accessed in the office of the Committee Secretary (see attachment 4).

Vice Chairman Nuxoll asked when preparing this legislation if they had checked with any private adoption agencies. **Mr. Luce** responded that they had checked with private adoption agencies and attorneys and worked with Senator Davis on the bill language over the summer.

MOTION: **Senator Martin** moved to send **S 1293** to the floor with a **do pass** recommendation. **Senator Bock** seconded the motion. The motion carried by **voice vote**. Senator Martin will carry **S 1293** to the floor.

Senator Lodge did want to ask one clarifying question in the case of a father not paying any attention to the child and then is notified of adoption efforts for the child; does this legislation take all of that into account? **Mr. Luce** stated this is exactly the type of situation the legislation is trying to correct. It was done last year for more public adoptions, and now they are addressing more of the private adoption scenarios.

MINUTES APPROVAL: **Senator Bock** moved to approve the January 20, 2014 Minutes as written. **Senator Schmidt** seconded the motion. The motion carried by **voice vote**.

MINUTES APPROVAL: **Senator Martin** moved to approve the January 27, 2014 Minutes as written. **Senator Lakey** seconded the motion. The motion carried by **voice vote**.

ADJOURNED: There being no further business to come before the Committee, **Vice Chairman Nuxoll** adjourned the meeting at 4:10 p.m.

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Senator Heider
Chair

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Linda Hamlet
Secretary

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Linda Harrison
Assistant Secretary