

OREGON RURAL HOSPITAL LISTENING TOUR: 2014

July 1, 2015

Organized by:



The Oregon Office of Rural Health

Sponsored by:



The Oregon Rural Healthcare Quality Network

In partnership with:



The Oregon Health Authority



The Oregon Association of Hospitals and Health Systems

The Office of Rural Health would like to acknowledge the following for their support and participation in production of this report:

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EXECUTIVE SUMMARY

In November 2014, the Oregon Office of Rural Health (ORH) organized a listening tour of Oregon's rural hospitals. The tour brought together state partners that work closely with Oregon's rural hospitals in order to collaboratively learn more about what the hospitals think is important and challenging during this period of health reform. Tour attendees included:

- Kelly Ballas, Chief Financial Officer, Oregon Health Authority (OHA)¹
- Katie Harris, Director of Program Management, Oregon Association of Hospitals and Health Systems (OAHHS)
- Troy Soenen, Director of Rural Health Transformation, OAHHS²
- Maeve Trick, Hospital Technical Assistance Specialist³, ORH

Between November 12th and December 15th, twenty-seven rural hospitals⁴ participated in the Listening Tour. They included:

- 21 Critical Access Hospitals (CAHs)
- 3 Type B non-CAH rural hospitals
- 3 Type C non-CAH rural hospitals

The listening tour group spent, on average, one hour with hospital staff in conversation about their priority concerns and successes. Meetings were open to staff at the Chief Executive Officer's discretion (see the Appendix for a list of participants). Common themes were compiled, written up and sent to all hospital participants for validation. Following validation, ORH collected contextual data from recent publications, the Oregon Health Authority and the Department of Human Services in order to provide, where possible, summary information around each theme.

The following five thematic areas were identified:

- Availability of mental health services
- Sustainability of health reform
- Availability of long term care
- Improving access and quality of care
- Workforce challenges

The purpose of this report is to identify current common challenges facing Oregon's rural hospitals and to present an evidence-based summary of these challenges. In doing so, ORH hopes this report will help as state partners and facilities work together to develop solutions.

¹ Now retired

² Now working at Greater Oregon Behavioral Health, Inc. (GOBHI)

³ Now Program Manager for Rural Health Outcomes at ORH

⁴ Oregon has a total of 35 rural hospitals (Type A/B and C). Many analyses of Oregon's rural hospitals exclude Type C for a total of 32 rural hospitals. Please see the appendix for a map of Oregon's rural hospitals.

IDENTIFIED CHALLENGES

Availability of Mental Health Care

Hospital Reported Challenges

Mental health emergencies

All hospitals, including those affiliated with larger systems, reported significant difficulty in finding inpatient beds for mental health patients, with stays in emergency department (ED) hold rooms reportedly lasting up to 18 days.

Mental health outpatient services

Meaningful integration of behavioral health services with physical health services is extremely limited, with only a few primary care clinics integrating behavioral health into their service arrays. All but three of the rural hospitals have affiliated clinics so behavioral health integration in outpatient services is an area of significant interest. Hospitals reported extreme difficulty in providing necessary mental health services in clinic settings due to payment models and challenging partnerships with some local mental health providers. In some situations in which partnerships aren't possible, hospitals have hired their own behavioral health specialists to improve patient care and incorporate patient-centered primary care home (PCPCH) practices. Where integration has been possible, hospitals emphasize they have been seeing positive results for the patients.

Substance and alcohol abuse services

Hospitals commonly reported that substance abuse was a large problem in their communities, with few accessible options for treatment, especially for youth.

Oregon Context

Mental health emergencies

There were 3,902 Medicaid patient visits to rural Oregon emergency departments (EDs) between Quarter 3, 2013 and Quarter 3, 2014⁵ with a mental health primary diagnosis (Office of Health Analytics Mental Health and Substance Abuse Data Set, 2015). Visits by Medicaid patients for mental health related reasons amount to 0.8% of all ED visits in rural Oregon hospitals annually. Oregon's rural population makes up 16% of the state's total population, yet 22% of mental health related ED visits statewide are by rural Medicaid patients (Office of Health Analytics Mental Health and Substance Abuse Data Set, 2015).

Mental health outpatient services

Mental health was the fourth most costly outpatient expense for Medicaid patients in 2014 (Oregon's Health System Transformation Mid-Year Performance Report, 2015). There were 105 hospitalizations of rural Medicaid patients for mental health diagnoses from Quarter 3, 2013 to Quarter 4, 2014. These had an average length of stay of 4.5 days, with stays lasting from 1 to 20 days at the rural hospitals (Office of Health Analytics Mental Health and Substance Abuse Data Set, 2015).

⁵ Quarters are calendar year.

Of Oregon's 16 Coordinated Care Organizations (CCOs), only 6 met the benchmark of 68.8% for timely follow up after mental health hospitalization (Oregon's Health System Transformation Mid-Year Performance Report, 2015). This demonstrates the variation among CCO mental health delivery systems. Hospitals reported that the variation among CCO payment models and the number of mental health providers contracted has a great impact on coordinating care in their clinics.

There is a need for additional mental health providers in Oregon; 19 of the 36 counties in Oregon have less than one full-time Psychiatrist. Ten counties have 0 Psychologists and 2 counties have 0 Social Workers (Table 1). The demand for additional providers is especially high in rural areas and patients are forced to travel lengthy distances for appointments or face long wait times to see a provider in their community. See the Appendix for maps of Oregon's mental health providers by service area.

Table 1. Mental Health Provider Full-Time Equivalents by County

County	Psychiatrists	Psychologists	Social Workers
Baker	0.0	2	18
Benton	12.3	43	81
Clackamas	22.6	134	254
Clatsop	0.0	4	23
Columbia	0.0	2	14
Coos	2.6	3	38
Crook	0.0	1	12
Curry	0.6	5	3
Deschutes	11.9	48	158
Douglas	4.4	9	61
Gilliam	0.0	0	2
Grant	0.5	0	1
Harney	0.0	0	5
Hood River	1.4	8	28
Jackson	9.1	62	176
Jefferson	0.4	1	6
Josephine	3.0	11	41
Klamath	0.8	3	25
Lake	0.0	0	2
Lane	27.1	165	323
Lincoln	1.7	4	28
Linn	2.5	11	57
Malheur	1.4	0	13
Marion	30.4	99	249
Morrow	0.0	0	4
Multnomah	118.1	559	1561
Polk	0.6	10	28
Sherman	0.0	0	0
Tillamook	0.2	0	18
Umatilla	1.1	6	47
Union	0.3	2	21
Wallowa	0.0	0	3
Wasco	0.7	4	27
Washington	31.5	195	375
Wheeler	0.0	0	0
Yamhill	3.1	46	66
TOTAL	288.2	1437	3768

Sources:

Psychiatrist data from Oregon Medical Board, 2014 by FTE
Psychologist data from Board of Psychologist Examiners, 2015
Social Worker data from Board of Clinical Social Workers, 2015

Substance and alcohol abuse services

Over five quarters, starting in Q3 2013, there were 3,702 Medicaid ED visits for substance abuse in rural hospitals. This comprised approximately 23% of substance abuse claims for all Medicaid patients statewide. There were 121 inpatient stays with an average length of stay of 3.6 days (Office of Health Analytics Mental Health and Substance Abuse Data Set, 2015). OHA funds substance abuse prevention programs in all 36 counties (2015-2018 Behavioral Health Strategic Plan, 2014), but rural communities struggle with this issue disproportionately with alcohol abuse treatment rates nearly double the rates in metropolitan areas (2014 Update of the Rural Urban Chartbook).

In Oregon's Health System Transformation Mid-Year Performance Report, Screening, Brief Intervention, and Referral to Treatment (SBIRT) ranged from 0.1% to 12.6% among Oregon's Coordinated Care Organizations (CCOs). Only 7 CCO's met the benchmark of 38.2% for initiation into substance abuse treatment and many CCO's saw a decline in substance abuse engagement between 2013 and 2014.

Stakeholder Action

Oregon Health Authority

In the 2013 to 2015 biennium budget, OHA invested approximately \$60 million in community mental health programming. The report to the Oregon legislature on 2013 investments in community mental health can be accessed [here](#).

OHA introduced a [behavioral health strategic plan for 2015-2018](#) that aims to increase access to psychiatric telehealth services, implement more community programs and provide mental health care in schools. The second of six strategic goals focuses on making a full continuum of behavioral health services available in all regions of the state, including:

- Culturally and linguistically appropriate care
- Expanded access to crisis services
- Expanded statewide access to medication assisted treatment

OHA is currently developing a tool to map availability of mental health services throughout Oregon.

The Healthcare Workforce Committee (a subcommittee of the Oregon Health Policy Board (OHPB)⁶) is charged with providing recommendations to support and sustain the healthcare workforce in Oregon. The committee has contracted with Oregon Healthcare Workforce Institute (OHWI) to do an assessment of and report on Oregon's mental/behavioral health workforce. That work is currently in progress. More information on the Healthcare Workforce Committee is available [here](#).

Oregon Association of Hospitals and Health Systems

OAHHS advocated for several bills during the 2015 legislative session to improve the availability of mental health services, including:

⁶ The Oregon Health Policy Board is an independent Board that provides oversight of OHA. OHPB was established in statute in 2009.

- Clarifying the state's responsibility for cost of care for committed patients who are in acute care hospitals awaiting placement in the Oregon State Hospital or another secure community facility. This was part of HB 3502, which did not make it out of the House in the 2015 Legislative Session.
- Cleaning up archaic statutory language enacted prior to state and national health reform that serves as a barrier to care coordination, also part of HB 3502.
- Enhancing Psychiatric Mental Health Nurse Practitioners' ability to provide care and services, such as involuntary holds, that are currently limited to physicians. SB 840 was signed into law on June 16, 2015.
- Reducing or eliminating ED and hospital boarding for patients awaiting placement in the Oregon State Hospital or another secure community facility. Budget Note #6 requires OHA to present a report to the 2016 legislative session regarding the problem of boarding patients with mental illness in hospital emergency departments while waiting for a bed in an appropriate setting. The report will contain a thorough description of the system and process as it works now and why, including relevant statutes and reimbursements. It will also include data to describe the magnitude of the problem. Finally, the report will contain an analysis of the reasons for the "boarding" such as gaps in necessary services with the system, and proposals for potential solutions.
- Supporting a new psychiatric emergency services facility (Unity Behavioral Health Center) to be built in Portland, serving patients in psychiatric crisis and housing 101 psychiatric beds; support for funding the crisis stabilization services needed to sustain this operation.

Oregon Office of Rural Health

Mental health was the most frequently and urgently cited issue on the Listening Tour. This aligns with further findings from the 'Evaluation of Community Benefit and Engagement Activities of Critical Access Hospitals in Oregon.' ORH contracted Oregon Public Health Institute (OPHI) in March 2015 to analyze Community Health Needs Assessments (CHNAs), Community Health Improvement Plans (CHIPs) and I-990 Schedule H's from Oregon's Critical Access Hospitals (CAHs), Local Health Departments (LHDs) and CCOs to identify community health issues, organizational priorities for CAHs and areas of alignment. Behavioral/mental health was prioritized as one of the top three issues and priorities for CAHs, LHDs and the CCOs. The full report can be found [here](#).

ORH has provided grant funding to Providence Seaside Hospital to increase community-based primary prevention and jail diversion through the "Crisis Intervention Training (CIT) for the North Coast" program. CIT is a primary prevention program that teaches first responders, such as law enforcement and emergency medical services personnel, best practices to assist people undergoing a mental health crisis in order to prevent an unnecessary trip to jail and/or the hospital. The grant will pilot the effectiveness of CIT in a rural region.

ORH has also applied for federal grant funding to improve the accessibility of mental health and substance abuse care in rural Oregon through the evidence-based Extension for Community Health Outcomes (ECHO) project model. In partnership with OHA's Transformation Center, the proposed Project ECHO integrated addiction and psychiatry program will support rural primary care providers to manage complex mental health and addiction patients. More information on Project ECHO's program can be found [here](#).

The Behavioral Health Loan Repayment Program (BHLRP), administered by ORH and funded by OHA, aims to address mental health provider shortages through loan repayment funding for providers working in rural and urban underserved areas. The goal of the program is to relieve the financial

burden of student debt and offset the reduced salaries that newly trained, unlicensed providers receive in order to encourage them to continue to serve underserved populations following licensure. Eligible candidates must serve a minimum of 50% Medicaid patients. Priority is given to applicants working for a community mental health program and those who are bilingual or come from an underrepresented background. Through initial funding in 2015, 10 awards will be given to unlicensed providers working towards licensure; it is anticipated that additional funding in 2016 will enable ORH to make up to 13 new awards.

Sustainability of Health Reform

Hospital Reported Challenges

Differences in CCO models, including community engagement & collaboration

Rural hospitals were enthusiastic about transforming healthcare delivery and are looking for more support to do so. Hospitals reported that CCO models and community collaboration vary among different regions. Best practices, identified by hospitals, include widespread stakeholder involvement in the governing board and Community Advisory Councils (CACs), as well as robust data sharing. In other communities difficulties remain with billing, lack of outreach to rural hospitals, and exclusion of CAHs in CCO contract processes. Some hospitals advocated for a clear method of OHA oversight to verify that services being paid for were being adequately provided. Hospitals, while enthusiastic about health reform, are concerned about what they see as a continuous increase in related rules and regulations that can create additional burdens and barriers.

Alternative Payment Methodologies (APM) and payment for well-care

Payment methodologies to promote wellness and coordinated care need more development, including alignment of financial incentives to support improved coordination of care. Some hospitals expressed concern about losing cost-based reimbursement (CBR) for Medicaid patients. While there has been a decline overall, some hospitals are seeing an increase in bad debt, in part due to high deductible health plans and lack of reimbursement for navigator and presumptive eligibility services. All hospitals visited have serious concerns about their continued financial sustainability. One hospital suggested that Medicaid adopt Medicare codes for payment of care coordination, transition care, care plans and annual wellness visits.

Oregon Context

The financial health of rural Oregon hospitals is declining. While coverage expansion has helped bad debt decrease by an average of 33% for rural hospitals between 2010 and 2014, this has not led to a positive bottom line (2014 Community Hospital Report). Since 2010, the average operating margin of small rural hospitals has steadily declined from -0.22% in 2010 to -0.46% in 2014. In 2014, 17 of the 32⁷ rural Oregon hospitals had a negative operating margin. Twenty-six of the 32 had an operating margin of less than 5%. CAHs and Type A hospitals are the most vulnerable. CAHs had an average operating margin of -0.68% in 2014, with 14 of the 25 in the red. Type A hospitals had an average operating margin of -1.41% in 2014 with 7 of the 12 in the red.⁸

Stakeholder Action

Oregon Health Authority

The Oregon Legislature passed HB 3650 in 2011, directing OHA to begin transitioning rural hospitals to APM consistent with the coordinated care model. Instead of cost-based Medicaid reimbursement (CBR), payment rates are now negotiated between hospitals and CCOs. OHA was also charged with identifying and transitioning only those rural hospitals that could remain financially viable after changing their method of payment.

Oregon Association of Hospitals and Health Systems

OAHHS convened the [Rural Health Reform Initiative \(RHRI\)](#) in 2011 to begin responding collaboratively to health care reform. One of RHRI's first objectives was to propose a framework for transitioning hospitals from CBR to an APM as well as providing an optional APM. In 2013, an advisory work group composed of representatives from the CCOs, CAHs, OAHHS, OHA and ORH worked to

⁷ 32 rural hospitals: Excludes Type C hospitals from the total.

⁸ This data comes from Databank: the state-mandated monthly financial and utilization data collection system.

develop recommendations for the OHA Director. The recommendations outlined a process for which hospitals should maintain CBR or move to APM. The financial evaluation work successfully concluded in 2014. Fifteen of 32 Type A/B rural hospitals were identified to transition to a Medicaid APM. All 32 rural hospitals will be reevaluated in 2015 for the 2016 CCO contracting year. The results of the 2015 analysis will be in place for the next two years.

The APM that was developed for these hospitals, and later adopted by state administrative rule, creates a floor for negotiations for CCOs and their hospital partners. The goal of the APM was to align incentives as well as reflect the unique aspects of rural hospital financing. There is a volume adjustment payment associated with the APM to accommodate rates based on volume swings that will enable rural hospitals to cover their fixed costs. Additionally, the APM is a floor and additional elements of the APM can be a part of hospital and CCO negotiations, as has been the case in several areas around the state. More information can be found [here](#).

All 32 rural Type A and B hospitals participated in the OAHHS Value Based Care (VBC) Readiness Assessment in February of 2015. This assessment identified financial risk taking as an area of significant weakness among Oregon rural hospitals. The Oregon Rural Health Summit took place June 3 and 4, 2015 to discuss identified readiness issues and related state policy. OAHHS is currently working with interested rural hospitals to develop individual action plans.

Oregon Office of Rural Health

ORH provides financial support to OAHHS for part of its rural hospital programming through the federal Medicare Rural Hospital Flexibility grant program. This includes portions of RHRI, the VBC assessments and the Rural Health Summit. ORH was part of the RHRI Advisory Committee and its annual [Areas of Unmet Health Care Need \(AUHCN\) Report](#) was part of the decision tree tool used to recommend which rural hospitals should be transitioned from CBR to APM.

The Center for Evidence-based Policy at Oregon Health & Science University (OHSU) is currently conducting a multiphase project on analysis of best practices for APMs, including those used by CCOs. The most recent phase produced a report outlining best practices: *Alternative Payment Methodologies in Oregon: The State of Reform, 2014*. The report, accessed [here](#), concluded that APMs show potential for improvement in cost and quality, but evidence is mixed and more models need to be tested with Medicaid populations. Six best practices in the development of APMs were identified in the report including: (1) establishing trusting relationships, (2) creating win-win models, (3) keeping it simple, (4) securing high quality and actionable data, (5) exercising strong leadership and (6) employing perseverance. The next phase of the project will include providing technical assistance on these best practices to CCOs.

Availability of Long-term Care

Hospital Reported Challenges

Lack of long-term care facilities

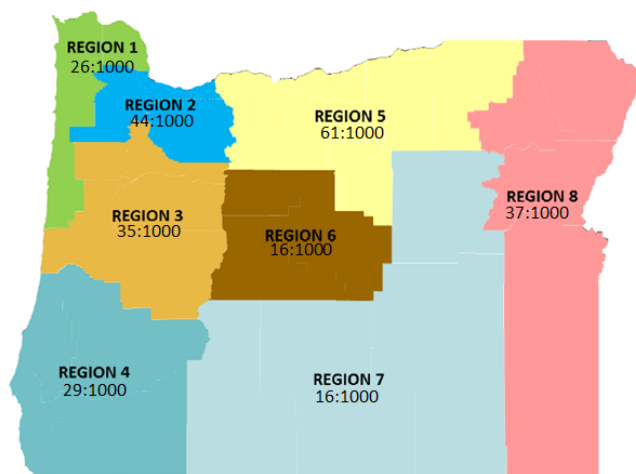
Many rural hospitals reported that the closure of long-term care facilities makes it difficult for patients to find care close to home, with reports of patients being placed as many as two hours away from their hometowns. Three facilities have closed in the past 18 months in eastern Oregon. Communities with both high and low ratios of nursing home beds to population over 75 years of age reported difficulty in placing patients in the appropriate level of care.

Oregon Context

Rural Oregon has a higher percentage of persons greater than 65 years of age (19.8%) as compared to the state (13.9%) (Nielsen, 2015). While data is unavailable for all small and rural hospitals, it is known that 33% of Oregon CAHs provide skilled nursing care, 29% provide intermediate care, 75% provide home health services, 70% provide hospice care and just 4% (one hospital) provide long term care (Community Benefit Activities of Critical Access, Other Rural, and Urban Hospitals: National and Oregon Data, 2015).

Researchers from Oregon State University, in partnership with the Department of Human Services (DHS), recently assessed the availability and utilization of nursing facilities in the state from 2009 to 2014. This report used a regionalized approach to assess availability and utilization of nursing homes services. Regions were divided geographically as pictured in Figure 1. The state average ratio of “set up” beds (beds immediately ready to receive residents) to the population age 75 or greater is 36:1000. Using the report’s regional divisions, this ratio of beds to population ranges from 16:1000 to 61:1000 (see Figure 1). These numbers do not reflect the recent closures in eastern Oregon.

Figure 1. DHS Regional Ratios of Set Up Beds Per 1000 Residents Over Age 75



Recent analysis confirms concerns from hospitals that availability of long-term care services is decreasing. The number of long-term care facilities has decreased by 8% over the past 15 years and the number of beds available has decreased by 25% (State of Nursing Facilities in Oregon, 2015).

Stakeholder Action

Department of Human Services

Oregon's long-term care services range from in-home care to comprehensive skilled nursing care. Services are designed to support the individual's

independence, dignity and choice. The top priorities for DHS' State Unit on Aging include promoting livable communities for older rural Oregonians and targeting services to those most in need. The Unit works with the 17 Area Agencies on Aging around Oregon to provide:

- Family caregiving assistance
- Information and assistance services and Aging & Disability Resource Centers
- Elder rights and legal assistance

- Health promotion
- Nutrition Services

DHS has noted an overall decline in the number of long-term care facilities in Oregon as in-home and community-based care services have increased. DHS plans to annually report on the state of long-term and community-based care facilities.

Oregon Office of Rural Health

ORH is working with the Department of Human Services (DHS) to further analyze Senate Bill 21, which laid the foundation for DHS' current plan for the future of long-term care services and support to older adults and persons with disabilities. Senate Bill 21 focuses on prioritizing transportation, housing and caregiving in order to support seniors and persons with disabilities to: (1) stay in their own homes and communities, (2) achieve and maintain their independence and (3) serve all people and cultures equitably, in a manner they choose. More information can be found [here](#). ORH will publish a report in September 2015 that details:

- The demographics of Oregon's rural aging population
- A comprehensive inventory of the services currently available to seniors in rural Oregon
- An assessment of senior needs for aging in place as well as a projection of future needs
- The potential impacts of these findings on SB21 work in rural Oregon.

Improving Access and Quality of Care

Hospital Reported Challenges

Access to care

Newly insured patients in some communities are having difficulty finding providers taking new patients or accepting Medicaid. Access to specialist care is also a challenge in rural Oregon. Hospitals are pursuing a variety of options to increase access to care, including both staff sharing and telehealth. Hospitals reported that telehealth has been helpful, particularly telepsychiatry, and that restrictions on how equipment can be used, reimbursement rates and internet bandwidth are all barriers to using telehealth to its full potential.

Emergency department use

Some hospitals have seen an increase in ED use for primary care among the newly insured. Some hospitals voiced a need for education and policies to help people seek appropriate care.

Electronic health records suitable for small hospitals

Limited information technology support hinders small hospitals' ability to effectively and consistently utilize their electronic health records (EHRs).

Data reporting

Many hospitals expressed frustration with the burden of data collection and the multitude of reporting channels. They reported that burdensome reporting requirements and processes are impeding quality improvement because of the amount of staff time needed. They also voiced a concern that more metrics are required than can realistically be improved.

Oregon Context

Access to care

While the percentage of rural Oregonians with insurance coverage increased, the number of physicians practicing in rural areas decreased; Oregon's rural primary care physician workforce diminished by 12% between 2010 and 2012. Forty percent of Oregon's rural primary care workforce is over age 55, requiring rural facilities to dedicate yet more resources to recruitment efforts in the next 10 years (Retention of Oregon's Rural and Frontier Physicians 2008 -2012, 2014).

Access to specialist care is severely limited in rural Oregon. In addition to the previously mentioned lack of Psychiatrists, 56% of counties have no Cardiologists, 53% have no Cardiovascular Specialists, Dermatologists or Neurologists and 64% have no Oncologists (Table 2).

Table 2. Number of Oregon Counties with Specialist Providers

Out of 36 Oregon Counties:	Cardiology	Cardiovascular	Dermatology	Neurology	Oncology
Number of counties with 0 providers	20	19	19	19	23
Number of counties with 1 to 3 providers	8	10	8	8	8
Number of counties with 4 to 10 providers	5	5	4	5	4
Number of counties with 11 to 20 providers	2	1	3	2	0
Number of counties with 21+ providers	1	1	2	2	1

Source: Licensure data from Oregon Medical Board, 2014

Mortality data indicate some significant disparities in death rates between rural and urban Oregon populations (Table 3).

Table 3. Oregon's Rural Versus Urban Death Rates

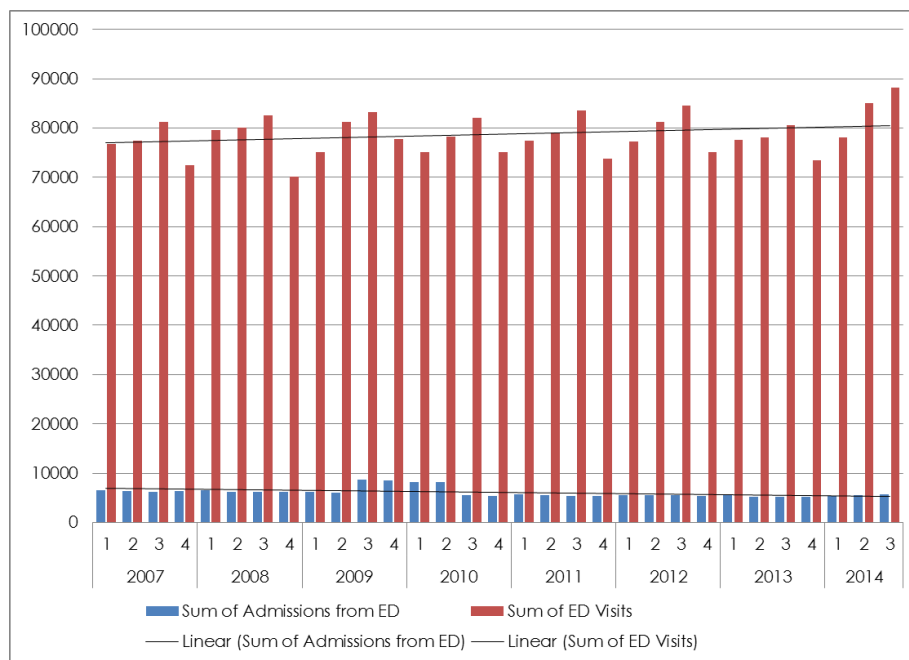
	Rural	Urban	Oregon
Total Deaths per 100,000 people	1011.1	705.3	818
Cancer	243.11	164.76	193.34
Heart Disease	200.49	132.19	157.17
Chronic Lower Respiratory Disease	67.45	39.47	49.63
Cerebrovascular Disease	56.30	39.75	45.82
Accidents	49.52	36.04	41.41

Source: 2009-2013 from Center for Health Statistics, Oregon Health Authority

Emergency department use

The number of Oregon rural hospital ED visits rose 9% between Q3 2013 and Q3 2014 (Figure 2) and have increased gradually over the past year, despite an overall decline statewide (Oregon Acute Care Hospitals: Financial and Utilization Trends, 2014). Anywhere from 3.9% to 14.3% of these ED visits are avoidable (Oregon's Health System Transformation Mid-Year Performance Report, 2015).

Figure 2. Visits and Admissions in Rural Oregon Emergency Departments: 2007 - 2014



Source: Oregon Health Authority: Health System Data and Research (2015). Data Bank: Databank Pivot 2007-2014 (Q3)

Electronic health records suitable for small hospitals

Oregon's rural hospitals currently use 11 different electronic health records (EHRs) companies (Table 4). All Oregon rural hospitals have, at a minimum, partially adopted an EHR. There is substantial need for greater technical assistance in this area.

Table 4. EHRs used by Oregon's Rural Hospitals

EHR Company	Number of Hospitals
CPSI	2
Healthwise	2
Cerner	5
Healthland	5
Mckesson	6
Meditech	6
EPIC	9

Source: Oregon Health Authority; Medicaid EHR Incentive Program data as of April 2015

Data reporting

Rural hospitals report data to five or more sources including: Apprise Health Insights, the Centers for Medicaid and Medicare Services (CMS), the Medicare Beneficiary Quality Improvement Program (MBQIP), the Oregon Health Authority, and quality improvement collaboratives. This can take substantial time, and is a particular burden for smaller hospitals with few IT and quality staff. Oregon CAHs typically have one or two staff members in their quality departments, and some hospitals lack staff to focus on quality improvement exclusively. Notably, system hospitals generally report a larger number of CMS measures, presumably because greater resources are available to fulfill such requirements.

Stakeholder Action

Oregon Health Authority

The OHA Office of Health Information Technology (OHIT) develops and supports effective health IT policies, programs, and partnerships that enable improved health for all Oregonians. This is achieved through support of the adoption of electronic health records, the secure exchange of health information, and the achievement of meaningful use in the state. OHIT works across state, private and public programs, providing planning, coordination, policy analysis and the development of collaborative partnerships to further health IT in Oregon. OHIT staffs the HIT Oversight Council (HITOC), which reports to the Oregon Health Policy Board. HITOC is tasked with setting goals and developing a strategic HIT plan for the state, as well as monitoring progress in achieving those goals and providing oversight for the implementation of the plan.

Oregon received a State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI) in April 2013. The SIM grant supports Oregon's ongoing health system transformation and funds innovative approaches to improving health and lowering costs across the healthcare system. A portion of Oregon's SIM grant is dedicated to supporting and accelerating statewide HIT initiatives. In November 2014, OHIT partnered with ORH to administer a telehealth pilot project grant program. Sixty-seven applications were received and 5 grants were awarded for innovation projects that will run through August 2016. Grant awardees and descriptions of their projects can be found [here](#).

Oregon Association for Hospitals and Health Systems

Currently the Oregon Health Leadership Council is working on a data aggregation work group to reduce the burden of duplicative reporting. The data aggregation and analytics project, now being referred to as the Collaborative for Health Information Technology in Oregon (CHITO) initiative, includes: the Oregon Health Care Quality Organization (Q Corp), Apprise Health Insights (Oregon Association of Hospitals and Health Systems) and OCHIN. The group worked with Intercase consulting

to assist the leadership in defining the vision, business case and strategy for next steps. That work having concluded, the team is now working to identify opportunities for incremental health information technology pilot projects related to data and analytics, to achieve greater value through collaboration and leveraging existing resources, such as a provider directory.

Hospitals are now reporting additional data to Apprise Health Insights, the data subsidiary for OAHHS. During Quarter 4 2014, all Oregon hospitals began submitting all inpatient, outpatient, outpatient surgical and emergency department discharge data. In addition to the data collection, Apprise's Information Network for Oregon Hospitals (INFOH) Dimensions platform provides a suite of custom analytics and reporting to the hospitals. This platform provides hospitals with comparative analysis to understand market share, service line utilization and procedure charges among all hospitals.

Oregon Office of Rural Health

Nearly all of the previously mentioned telehealth pilot grant applications were received from rural and frontier Oregon. This included 4 CCOs, 9 rural hospitals and 11 local community-based organizations. When ORH analyzed the applications by region, type of applicant and thematic area, an alignment of need between the CCOs and the CAH applicants was apparent. Both types of applicants independently proposed solutions to improve population health using telehealth to change behaviors and do health coaching outreach. These applications focused on implementing behavior change through mobile applications and/or providing videoconferencing health coaching for complex patients who need more dedicated and frequent support. The average proposed budget for these projects for 18-month implementation was \$80,000. ORH has requested federal funding through the Medicare Rural Hospital Flexibility Grant to offer grants to CAHs partnering with their CCO and community organizations to implement telehealth projects for health behavior change.

The 2003 Oregon Legislature passed SB24, requiring group and individual commercial health benefit plans in Oregon to cover telemedicine. The 2015 Oregon Legislative Session saw the passage of SB144, which requires coverage of telehealth services offered directly from a provider to a patient, regardless of where the patient is located when receiving the service. This includes home, school and work, using synchronous two-way interactive videoconference.

OCHIN

In 2007, OCHIN received \$20 million from the Federal Communication Commission (FCC) Rural Pilot Program to install a minimum 10mpbs fiber in rural communities to support telemedicine, electronic health record and distance education implementation. This was the 5th largest award granted out of 62 awardees. Oregon grants provided matching funds of \$1.85 million. Recognizing that many rural facilities continue to face challenges, OCHIN brought on two new network engineers and have requested that any rural hospitals facing network issues (or those that need a copy of their original network design) contact Kim Klupenger, Vice President of Business Development and Account Management: klupengerk@ochin.org.

Workforce Challenges

Hospital Reported Challenges

Lack of rural-ready physicians

Several hospitals expressed dissatisfaction with Oregon Health & Science University's (OHSU) commitment to a rural workforce and think that new doctors are not ready to practice in a rural environment. The OHSU decision to make a rural rotation optional for medical students was viewed as detrimental to rural health recruitment and practice.

Training recent nursing graduates

Several hospitals, particularly those in western Oregon, cited issues with retention and recruitment of recent nursing school graduates. New nurses often cannot find jobs at urban facilities. Rural facilities find that they invest significant resources in training new graduates, only to have them leave after one or two years to work at urban facilities.

Loan repayment program effectiveness

While some hospitals think that the two-year loan repayment program is effective for recruitment, many suggested that a five-year repayment program would improve retention.

Oregon Context

The expansion of health insurance coverage in 2014 greatly increased demands on the existing primary care workforce and fueled the need for more primary care clinicians in Oregon. Demand for physicians, nurse practitioners and physician assistants will increase in Oregon by 16% between 2013 and 2020. This prediction represents 1,726 physician FTEs, 332 nurse practitioner FTEs and 168 physician assistant FTEs (Oregon Healthcare Workforce Institute: Projected Demand for Physicians, Nurse Practitioners and Physician Assistants in Oregon: 2013 -2020). Models of team-based care, particularly the Patient Centered Primary Care Home program in Oregon, rely on increased utilization of nurse practitioners and physician assistants to meet patient demands, but these providers are also in short supply.

Lack of rural-ready physicians

Oregon's physician retention rate was 77% between 2010 and 2012 in rural Oregon. The number of rural active licensed physicians increased from 1,826 in 2008 to 2,030 in 2012, but retention rates ranged from 40% to 100% in individual counties. Eighteen percent of Oregon's rural physicians trained in California, 16% in Oregon and 9% in Washington (Retention of Oregon's Rural and Frontier Physicians 2008-2010, 2014).

OHSU conducted a listening tour of rural communities in 2013 asking what traits they would like to see in future practitioners. Following that, OHSU launched a multi-year curriculum transformation initiative. More information on the OHSU initiative can be found [here](#).

The College of Osteopathic Medicine of the Pacific-Northwest (COMP-NW) began training physicians at its campus in the rural community of Lebanon, Oregon in 2011. The first class of COMP-NW students graduated in 2015; effectively doubling the number of MD/DO degrees awarded each year in Oregon.

Training recent nursing graduates

Nationally, registered nurses with less than two years of experience, account for 47% of turnover. Oregon-specific data is not available however small hospitals nationwide (defined as less than 200 beds) have the highest registered nurse (RN) turnover rates at 16.2%. This is an increase of 2

percentage points in the past year (Nursing Solutions: 2014 National Healthcare RN Retention Report). Medical-surgical nurses have the highest turnover rate at 24%, a specialty that is valuable to rural hospitals.

Loan repayment program effectiveness

State and federal loan repayment programs currently support only providers practicing in outpatient primary care settings. One program offers a five-year commitment option: the state Medicaid Primary Care Loan Repayment Program. This option is available to part-time providers only; to date, no one has applied to the program under this option. The 2015 Oregon Legislature put a 2018 sunset on all programs pending an interim study to determine the return on investment and relative effectiveness of all state funded provider incentive programs.

Stakeholder Action

Oregon Health Authority

The Primary Care Office provides state level support for the federal National Health Service Corps and Nurse Corps Loan Repayment Program run by the Health Resource and Service Administration (HRSA). Eligible applicants include health care providers in medical, dental and behavioral health disciplines. Awardees are eligible for up to \$50,000 in loan repayment in exchange for a two-year service obligation at a NHSC eligible site. Sites must apply for approval through the Primary Care Office.

OHA contracts with ORH to administer two other loan repayment programs, the Behavioral Loan Repayment Program (BLRP) and Medicaid Primary Care Loan Repayment Program (MLRP).

Oregon Office of Rural Health

ORH's workforce team addresses provider shortages by working with policy makers, communities, facilities, providers and students. ORH is a member of the 'Recruitment and Retention Partnership,' which includes the Oregon Primary Care Office, the Oregon Healthcare Workforce Institute (OHWI), Area Health Education Center (AHEC), OHA Office of Equity and Inclusion (OEI), the Health Resources and Services Administration (HRSA) regional office and the Oregon Primary Care Association (OPCA). This partnership comes together to leverage resources and conduct collaborative outreach.

ORH provides recruitment support and resources for any rural clinic, hospital or community that requests assistance. Through a recent partnership with OPCA, ORH now provides the same services for all Federally Qualified Health Centers (FQHCs) in Oregon. ORH is the Oregon member of the 3RNet: National Rural Recruitment and Retention Network. The network is made up of one member per state who connects candidates to facilities in underserved communities through referrals and online job postings. 280 sites in Oregon currently utilize ORH workforce services.

ORH administers three loan repayment programs and a loan forgiveness program that are all directly aimed at addressing health care provider shortages (including dental and mental health care). ORH administers the Primary Care Loan Forgiveness Program (PCLF) with three participating institutions: Pacific University, COMP-NW and OHSU. Students enrolled in the PCLF rural training tracks can receive loan forgiveness for one year of tuition and fees in exchange for a one-year service

obligation in a rural area of Oregon. ORH assists OHSU students participating in the Scholars for a Healthy Oregon Initiative (SHOI) find work in rural and underserved areas to fulfill their scholarship obligation. ORH administers three additional loan repayment programs: (1) the Behavioral Health Loan Repayment Program (BLRP), (2) the Oregon Partnership State Loan Repayment Program (SLRP) and (3) the Medicaid Primary Care Loan Repayment Program (MLRP). Qualified medical, dental or behavioral health providers can apply for loan repayment funding to pay back qualified loans in exchange for a 1 to 3 year service commitment in a rural or urban underserved practice site. Currently 52 sites have loan repayment participants.

Other

The Area Health Education Center (AHEC) and ORH are addressing the need for rural-ready physicians in Oregon through support of and work with the new OHSU Campus for Rural Health. Medical, dental, pharmacy, nursing, physician assistant and public health students will receive interprofessional education and training designed to equip them for practice in rural Oregon communities. The Campus for Rural Health's first students will begin in the fall of 2015. Headquartered in Klamath Falls, students will also complete rotations in Coos Bay. Clinical sites in other rural Oregon communities will be added in the future as the campus expands across the state.

The Oregon Healthcare Workforce Institute (OHWI) provides workforce data and projections to assist with the development and goals of current and future incentive programs to recruit and retain primary care clinicians in rural and urban underserved areas of Oregon.

SOURCES

2014 Community Hospital Report (2014). Apprise Health Insights. Published report.

2015-2018 OHA Behavioral Health Plan (2014) Oregon Health Authority.
<http://www.oregon.gov/oha/amh/Pages/strategic.aspx>.

Oregon Health Authority: Health System Data and Research (2015). Data Bank: Databank Pivot 2007-2014 (Q3). <http://www.oregon.gov/oha/OHPR/RSCH/Pages/databank.aspx>

Center for Health Statistics (2014). Oregon Health Authority. 2009-2013 Average. Compiled Health Data.

Leof, A., Curtis, P., Gordon, C., Thielke, A., Evans, R. & Pinson, N. (2014). Alternative Payment Methodologies in Oregon: The State of Reform. Portland, OR: Center for Evidence-based Policy, Oregon Health & Science University.

Meit, Michael, et al. "The 2014 Update of the Rural-Urban Chartbook." Rural Health Reform Policy Research Center (2014).

Nielsen (2015). Population Data By Zip Code. Published Data Set.

NSI Nursing Solutions, Inc. 2014 National Healthcare & RN Retention Report (2014). Published Report.

OAHHS Legislative Advocacy 2015: <http://www.oahhs.org/advocacy/2015-legislative-session/oregon-legislative-agenda#sthash.UCKkhHiT.dpuf>.

OCHIN Network. Valued Broadband Network Services WebPage. Accessed June 2015.
<https://ochin.org/member-portal/oregon-health-network/https://ochin.org/member-portal/oregon-health-network/>

OHITOC Business Plan Framework. Oregon Health Authority (2014).
http://www.oregon.gov/oha/OHPR/HITOC/Documents/HIT_Final_BusinessPlanFramework_ForRelease_2014-05-30.pdf

Oregon Acute Care Hospitals: Financial and Utilization Trends: 3rd Quarter 2014 (2014) Oregon Health Authority: Office of Health Analytics. Data

Oregon Association of Hospitals and Health Systems Value Based Care Survey (OAHHS VBC Survey) (2015). Oregon Association of Hospitals and Health Systems. Preliminary results.

Oregon CAH Community Engagement and Population Health Report (2015). Oregon Public Health Institute (contracted).

Oregon Community Based Care Resident and Community Characteristics Report (2014). Carter et al. Published Report.

Oregon Health Authority. Office of Health Analytics. Mental Health and Substance Abuse Data Quarter 3 2013- Quarter 3 2014 (2015).

Oregon's Family Practice Physicians (2015). Oregon Healthcare Workforce Institute. Published Report.

Oregon's Health System Transformation Mid-Year Performance Report (January 14, 2015). Oregon Health Authority Office of Health Analytics. Published report for measurement period July 2013 – June 2014.

Report on 2013 Community Mental Health Investments (2015). Oregon Health Authority Addictions and Mental Health. <http://www.oregon.gov/oha/amh/Pages/MHinvestments.aspx>.

Retention of Oregon's Rural and Frontier Physicians 2008-2012. (2014). Oregon Healthcare Workforce Institute.

Senate Bill 21 Report (2015). Department of Human Services. Published report.

The State of Nursing Facilities in Oregon (2014). Mendez-Luck et al. OSU College of Public Health and Human Sciences. 2015. Published Report.

APPENDIX

Listening Tour Participants

11/11/2014

Good Shepherd Health Care System

Beds available: 25

Type: A, CAH

Saint Alphonsus Medical Center Baker City

Beds available: 25

Type: A, CAH

11/12/2014

Wallowa Memorial Hospital

Beds available: 25

Type: A, CAH

CHI St Anthony Hospital

Beds available: 25

Type: A, CAH

Pioneer Memorial Hospital

Beds available: 6

Type: A, CAH

11/19/2014

Grande Ronde Hospital

Beds available: 25

Type: A, CAH

Blue Mountain Hospital

Beds available: 16

Type: A, CAH

11/20/2014

St. Charles (Redmond, Madras and Prineville)

Redmond

Beds available: 28

Type: B

Madras

Beds available: 25

Type: B, CAH

Prineville

Beds available: 25

Type: B, CAH

Harney District Hospital

Beds available: 25

Type: A, CAH

Lake Health District

Beds available: 21

Type: A, CAH

11/21/2014

Asante Ashland & Three Rivers

Ashland

Beds available: 37

Type: B

Three Rivers

Beds available: 107

Type: C

Mercy Medical Center

Beds available: 141

Type: C

11/24/2014

Samaritan North Lincoln

Beds available: 25

Type: B, CAH

Peace Harbor PeaceHealth

Beds available: 21

Type: B, CAH

Samaritan Pacific Communities Hospital/Samaritan Pacific Health Services

Beds available: 25

Type: B, CAH

12/1/2014

Providence Hood River

Beds available: 25

Type: B, CAH

Mid Columbia Medical Center

Beds available: 49

Type: B

12/8/2014

Curry General Hospital

Beds available: 24

Type: A, CAH

Southern Coos Hospital
Beds available: 19
Type: B, CAH

Coquille Valley Hospital
Beds available: 25
Type: B, CAH

Lower Umpqua District Hospital
Beds available: 16
Type: B, CAH

12/12/2014

PeaceHealth Cottage Grove Community Hospital
Beds available: 14
Type: B, CAH

12/15/2014

Willamette Valley Medical Center
Beds available: 95
Type: C

Tillamook Regional Medical Center
Beds available: 25
Type: A, CAH

Codes for Medicaid Mental Health and Substance Abuse

OHA Office of Health Analytics pulled data in April 2015 for Medicaid claims relating to mental health and substance abuse treatment. Codes used to identify visits for mental health and substance abuse data are described below. The data was analyzed in Microsoft Excel by ORH.

Mental Health and Substance Abuse Inpatient

Data are pulled by utilizing the Diagnosis Related Group (DRG) codes:

- 876 O.R. procedure w/Principle Diagnosis of Mental Illness
- 880 Acute Adjust Reaction & Psychosocial Dysfunction
- 881 Depressive neuroses
- 882 Neuroses except depressive
- 883 D/O of personality & impulse control
- 884 Organic disturbances & MR
- 885 Psychoses
- 886 Behavioral & developmental d/o
- 887 Other mental d/o dx
- 894 Alcohol/drug abuse or dependence left AMA

along with Claim type A (inpatient crossover) & I (Inpatient). The timeline is utilizing the "From Date of Service" – this is the actual date the service(s) were delivered and does not connect with the actual payment date.

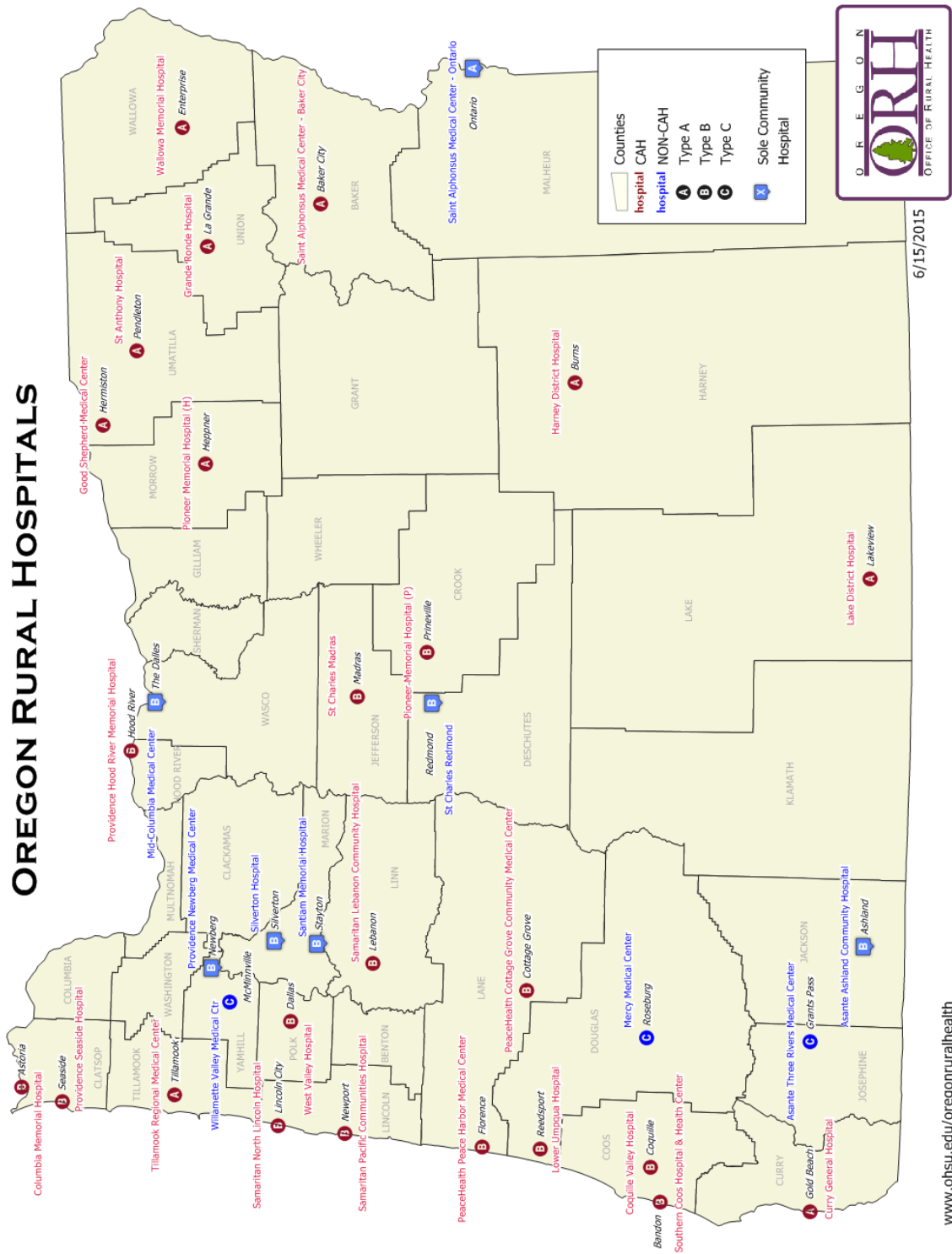
Emergency Department Outpatient

Data are pulled by utilizing the outpatient revenue codes:

- 0981 Prof. fee/Emergency Room
- 0450 Emergency Room
- 0451 EMTALA Emergency Med Screening Svc
- 0452 ER Beyond EMTALA Screen
- 0459 Other Emergency Room

In addition to the Revenue codes; all mental health diagnosis are part of the criteria (290, 293-302, 306-316). The following PERC codes are excluded from the ED data: QB, CW, SL, QI, CX, CS, CT, CU, & CV.

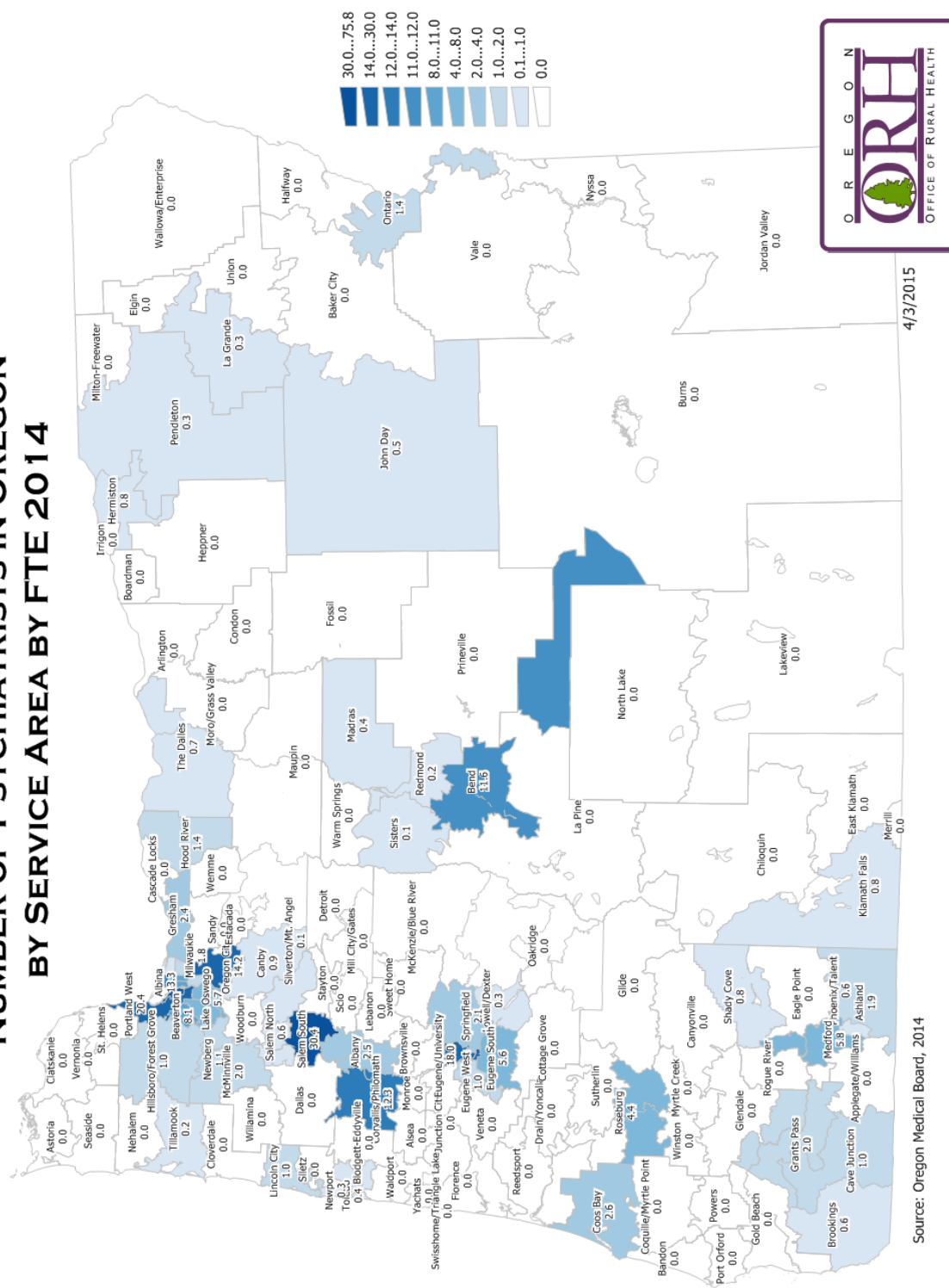
Oregon's Rural Hospitals



6/15/2015

www.ohsu.edu/oregonruralhealth

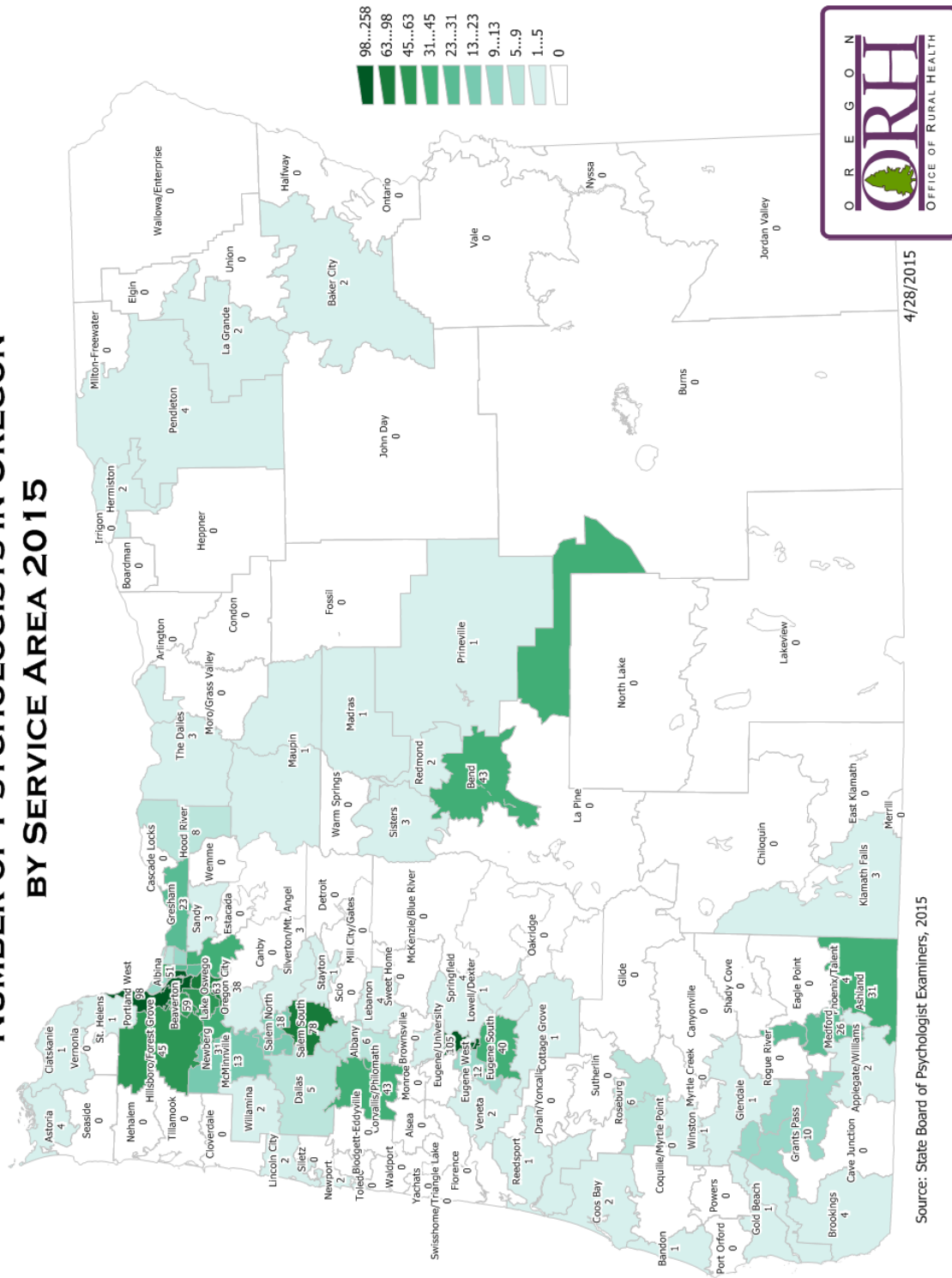
**NUMBER OF PSYCHIATRISTS IN OREGON
BY SERVICE AREA BY FTE 2014**



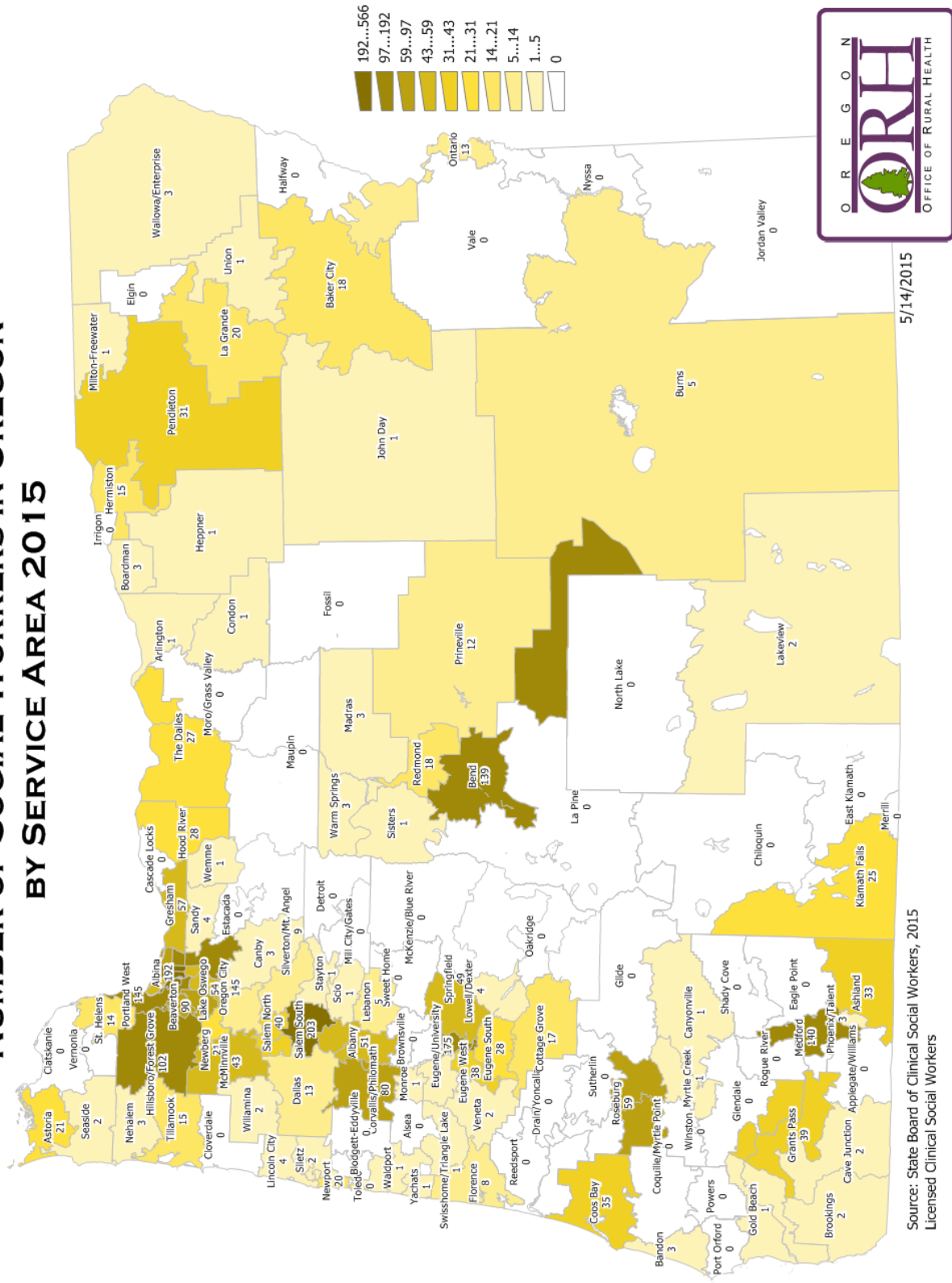
Source: Oregon Medical Board, 2014

4/3/2015

NUMBER OF PSYCHOLOGISTS IN OREGON BY SERVICE AREA 2015



NUMBER OF SOCIAL WORKERS IN OREGON BY SERVICE AREA 2015



Source: State Board of Clinical Social Workers, 2015
Licensed Clinical Social Workers

5/14/2015



Oregon's Provider Incentive Programs

(Administered by ORH)

Program	Eligible Provider Types	Duration of Service Commitment	Awards Given (To date)	Legislative Updates
Oregon Partnership State Loan Repayment Program (SLRP)	Physicians (MD/DO), NPs, PAs, RNs, Pharmacists, Certified Nurse Midwives, Dentists (DMD/DDS), Dental Hygienists, Licensed Mental/Behavioral Health Providers	2 year service obligation (full time) 4 year service obligation (part time)	2011: 6 2012: 5 2013: 18 2014: 16 2015: 8	This is a federal program with no state support. ORH was awarded a 3-year grant; 2 nd year begins September 1, 2015.
Medicaid Primary Care Loan Repayment Program (MPCLRP)	Physicians (MD/DO), NPs, PAs, Dentists (DMD/DDS), Expanded Practice Dental Hygienists, Licensed Mental/Behavioral Health Providers (excluding Licensed Professional Counselors)	3 year service obligation (full time) 5 year service obligation (part time)	2014: 17 2015: 22	2015 Oregon Legislature funded through June 30, 2017.
Behavioral Health Loan Repayment Program (BHLRP)	Unlicensed providers practicing: Clinical Social Work, Psychiatry, Counseling or Clinical Psychology, Professional Counseling, Marriage and Family Counseling, Psychiatric Nursing (licensed PMHNPs can apply)	1 year service obligation (full time) 2 year service obligation (part time)	2015: 5	Program extended through June 30, 2018.
Primary Health Care Loan Forgiveness Program	Admitted to an approved Oregon rural training track for MD/DO, NP or PA -Second or third year students can apply -Must be enrolled full-time -Prepared to begin practice in an approved rural facility within 90 days of program completion	One year of clinical service in an approved rural Oregon practice site in exchange for each year of tuition and fees granted through this program	2012: 5 2013: 4 2014: 10 2015: 10	2015 Oregon Legislature funded through June 30, 2017.

Scholars for Healthy Oregon Initiative (SHOI)	OHSU students enrolled in the following degree programs: Doctor of Medicine, Doctor of Dental Medicine, Master of Physician Assistant Studies and Master of Nursing in Nurse Anesthesia, Family Nurse Practitioner, Nurse Midwifery or Psychiatric Mental Health	One year of clinical service in an approved rural or urban underserved Oregon practice site in exchange for each year of tuition and fees granted through this program	2014: 21	2015 Oregon Legislature funded through June 30, 2017.
Rural Medical Provider Tax Credit	Physicians (MD/DO), PAs, NPs, Certified Nurse Anesthetists, Podiatrists, Dentists and Optometrists.	Providers must practice in a rural area at least an average of 20 hours per week and agree to take Medicaid and Medicare patients in exchange for a \$5000 per year personal income tax credit	1,859 providers claimed the credit in 2012 (most recent data available)	2015 Oregon Legislature revised eligibility criteria and amount of credit, extended program for two additional years; new sunset of December 31, 2017.