

Oregon Rural Health Plan



Oregon Rural Hospital Flexibility Program

**Submitted to:
Regional Office
Health Care Financing Administration**

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Section I. Background

In August 1997, as part of the Balanced Budget Act (BBA), Congress authorized the Medicare Rural Hospital Flexibility Program that creates a new type of rural hospital, the Critical Access Hospital (CAH). The new program is administered by the Health Care Financing Administration (HCFA), which adopted final interim regulations to implement the program on August 29, 1997.

Characteristics of the CAH include:

- Hospital must be rural according to federal standards, i.e., *not* located in a Metropolitan Statistical Area (MSA) and/or *not* classified as an urban hospital for Medicare payment purposes;
- Hospital must be at least 35 miles from another hospital (15 miles in mountainous terrain or where only secondary roads are available) *or* be certified by the state as a “necessary provider” of health care services¹
- Hospital must have a current Medicare participation agreement;
- Hospital must be not-for-profit or public;
- Hospital may contain up to 15 acute care beds;
- With some exceptions², length of stay cannot exceed 96 hours;
- Hospital may maintain up to 25 “swing” beds, but no more than 15 can be used for acute care at any one time;
- Hospital must participate in a rural health network that includes at least one full service hospital;
- Agreements must be maintained for patient referral and transfer, development and use of communications systems, provision of transportation services and credentialing and quality assurance procedures;
- Hospital must offer 24 hour emergency and nursing services, but need not otherwise staff the facility except when an inpatient is present;
- Inpatient services may be provided by a physician assistant, nurse practitioner or clinical nurse specialist subject to the oversight of a physician who does not have to be present in the facility;
- Certified CAHs will be reimbursed by HCFA on a reasonable cost basis for inpatient and outpatient services provided to Medicare beneficiaries.

The Medicare Rural Hospital Flexibility Program was created to allow rural areas to maintain access to emergency, inpatient and primary care services provided or coordinated by a hospital. By allowing reduced service and staffing levels and providing for Medicare payment on a reasonable cost basis, the CAH

¹ “Necessary provider” criteria are discussed in Section VIII of this report.

² Exceptions are allowed for “special circumstances” defined by HCFA as well as waivers granted by a Professional Review Organization (PRO) or equivalent entity.

designation may be an alternative to closure for some of Oregon's most vulnerable rural hospitals.

States interested in establishing a Medicare Rural Hospital Flexibility Program must submit an application signed by an official of the state to the Regional Administrator of the Health Care Financing Administration (HCFA) Regional Office responsible for oversight of Medicare in the state. The application must ensure that the state has or is in the process of developing a state rural health plan that:

- provides for creation of one or more rural health networks,
- promotes regionalization of rural health services,
- improves access to hospitals or other health services for rural residents, and
- has designated rural nonprofit or public hospitals or facilities located in the state as Critical Access Hospitals (CAHs).

The plan must be developed in consultation with the state hospital association, rural hospitals in the state and the state office of rural health. In addition to these minimal requirements, Oregon intends to submit its plan to the Rural Health Coordinating Council (RHCC) for further review and comment. The RHCC is the governor-appointed advisory council to the Oregon Office of Rural Health and includes representatives from provider groups, as well as rural consumers of health care (see Appendix One for roster).

Accordingly, the purpose of this rural health plan is to describe Oregon's rural areas and the challenges facing provision of health care to rural residents, especially those that threaten access to hospital care. Criteria for designation of critical access hospitals will be provided and potential candidates for CAH conversion will be presented. Members of the planning work group (see Appendix Two) envision that this plan accomplishes the following:

- identifies the unique demographic, geographic and health status issues that may impede access to affordable, quality health care for rural Oregonians;
- profiles Oregon's rural hospitals and their important financial and operating characteristics;
- identifies regional rural networks and suggests strategies for additional regionalization as needed;
- proposes cost-effective regulatory flexibility for Oregon's rural hospitals;
- offers fair and reasonable criteria that will allow certain hospitals to participate in the Rural Hospital Flexibility Program; and
- enhances access to hospital and other health care services for all rural Oregon residents.

Section II. Rural Oregon

Oregon is a diverse state, both geographically and demographically. Topography ranges from ocean beaches in the west that are flanked by the coastal range, to rich agricultural valleys beyond, to the Cascade Mountain Range that bisects the state north to south and the high desert plains that lay to the east.

Oregon's Office of Rural Health has adopted a definition of "rural" in administrative rule in response to legislative initiatives affecting rural health providers, as follows:

"Rural is a geographic area ten or more miles from a population center of 30,000 or more. Rural areas are of three general types reflecting relative distances between principal health care delivery sites.

FRONTIER areas are counties that have a population density of six people per square mile or less.

REMOTE RURAL areas are more than 30 minutes average travel time* from a population center of 10,000 or more and are not within a frontier area.

LESS REMOTE RURAL areas are 30 minutes or less average travel time* from a population center of 10,000 or more and are not within a frontier area.

*"Thirty minutes travel time means

"(a) In mountainous terrain, on coastal highways or in areas with only secondary roads available, 15 miles; or

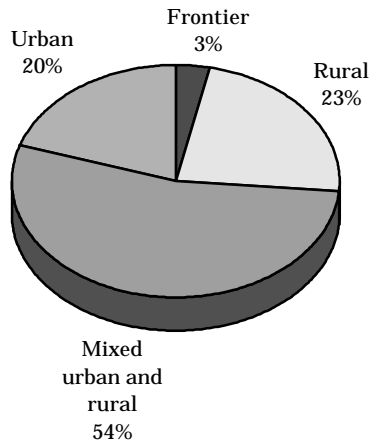
(b) Under normal conditions with only primary roads available, 20 miles; or

(b) In flat terrain or in areas connected by interstate highways, 25 miles.

For purposes of this rural health plan, Oregon's counties will be classified into four types:

1. Those whose entire geographic area is *frontier rural*;
2. Those whose entire geographic area is either *remote rural* or *less remote rural*;
3. Those whose geographic area is a *mixture of urban and rural*; and
4. Those whose geographic area is entirely *urban*.

Using these four categories, Oregon's population breaks down as follows:



Oregon's 36 counties are classified below, and a map depicting their categorization is included on the next page.

Frontier counties

- Baker
- Crook
- Gilliam
- Grant
- Harney
- Lake
- Malheur
- Morrow
- Sherman
- Wallowa
- Wheeler

Rural counties:

- Clatsop
- Columbia
- Coos
- Curry
- Douglas
- Hood River
- Jefferson
- Josephine

Mixed urban and rural counties

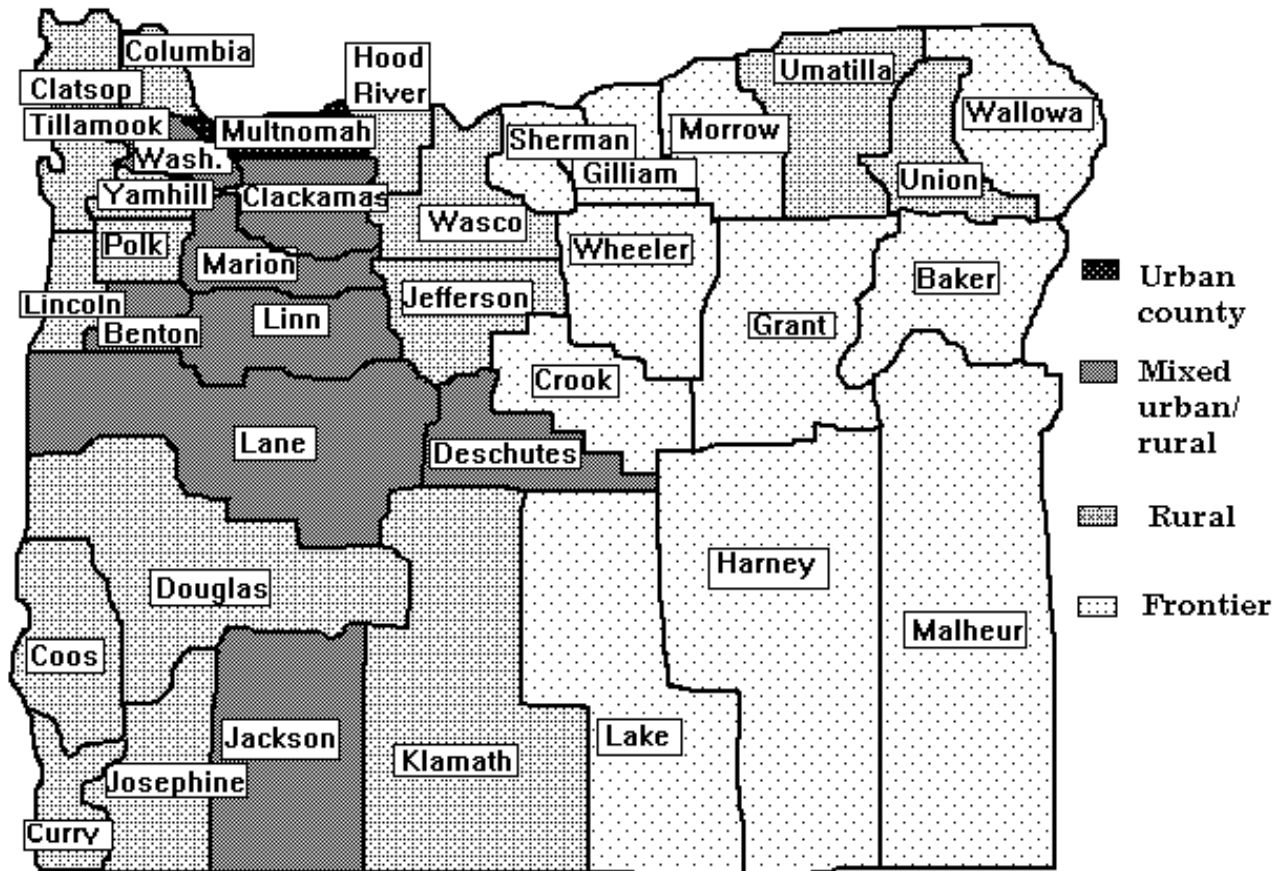
- Benton
- Clackamas
- Deschutes
- Jackson
- Lane
- Linn
- Marion
- Washington

Urban county: Multnomah

Rural counties (cont.)

- Klamath
- Lincoln
- Polk
- Tillamook
- Umatilla
- Union
- Wasco
- Yamhill

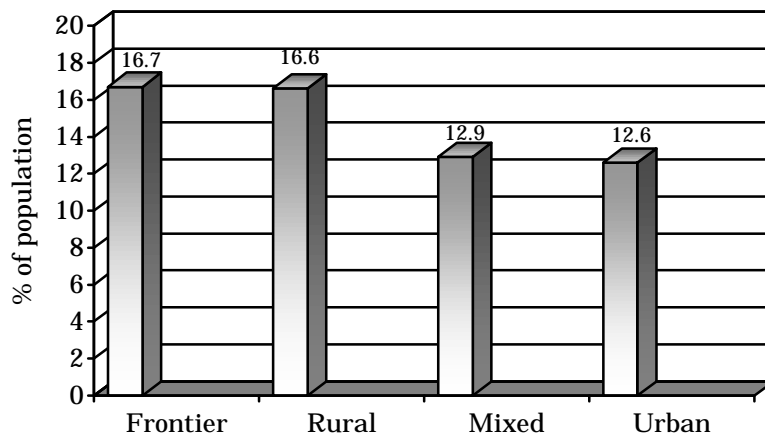
Figure 1. Oregon's counties, by category



Section III. Characteristics of Rural Oregon

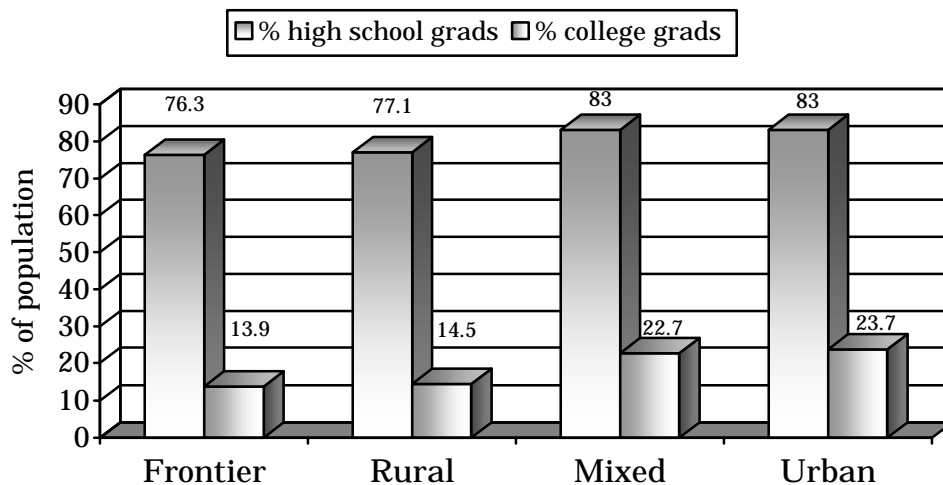
Like most states, Oregon's rural populations exhibit demographic characteristics that create additional challenges for health care accessibility and delivery. 1997-estimated census data shows that, while the average proportions of elderly (65 or older) population in Oregon is high (15.7%), it is highest in frontier and rural counties.

Percent over 65 in Oregon



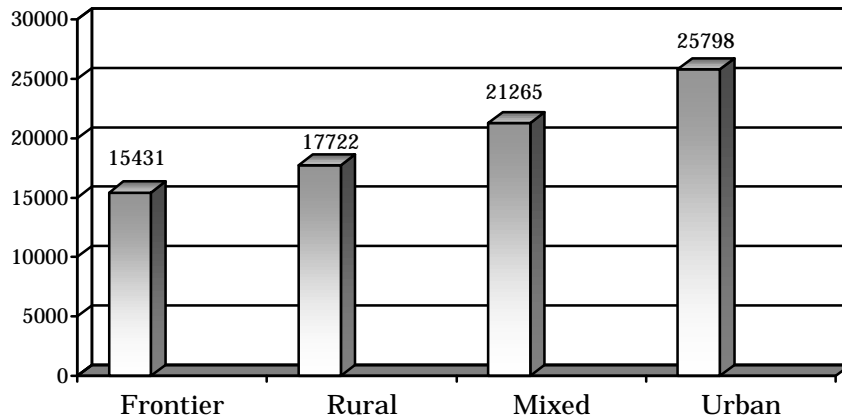
Rural Oregonians as a group have not attained the educational levels found in more urban areas of the state. The following 1998 data are from the Oregon Employment Department's Labor Market Information System (OLMIS) :

Educational levels in Oregon



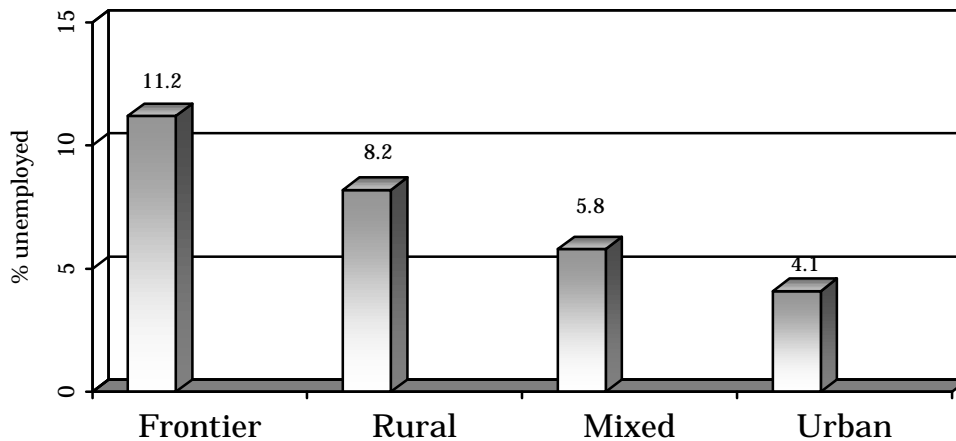
The same source (OLMIS) reveals that frontier and rural Oregonians have a lower per capita income:

Oregon per capita income, 1995



OLMIS data further show that frontier and rural unemployment rates are higher:

Oregon Unemployment Rates, March 1998



The demographic measures that uniquely characterize rural Oregon inevitably affect the organization, availability and effectiveness of health care delivery to rural residents. The next section examines the current state of health care in rural Oregon in order to provide a contextual framework for the Medicare Rural Hospital Flexibility Program.

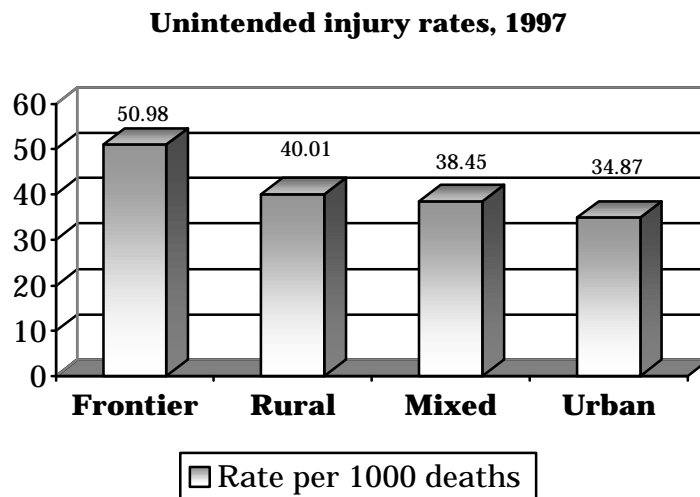
Section IV. Health Status and Access to Health Care in Rural Oregon

Health status and access measures:

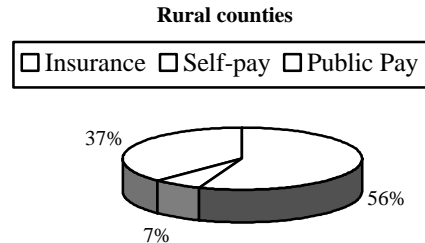
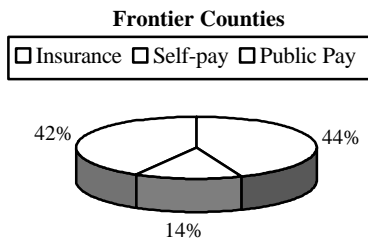
Challenging demographics, coupled with other factors, may contribute to certain unfavorable health status indicators in Oregon's rural areas. Using a number of commonly-applied surrogates for inferring adequate access to health care, 1996 and 1997 data from Oregon's Center for Health Statistics were analyzed. No significant relationships were found between Oregon's annual infant mortality rates or low birthweight rates and gross geographic variables. Nor does the Health Division's "Health Status of Oregonians" publication reveal that rural Oregonians perceive themselves as less healthy or more impaired than their urban counterparts. Some notable differences, however, are apparent.

One widely used measure of access to health care is adequacy of prenatal care. Defined as "less than five prenatal visits or care begun in third trimester," Oregon's inadequate prenatal care rate overall in 1996 was 5.4%. Of the 12 counties that exceeded that rate, nine were either frontier or rural. Malheur and Morrow Counties, both classified as frontier, demonstrated the highest rates of inadequate prenatal care, at 13.3% and 18.4% respectively.

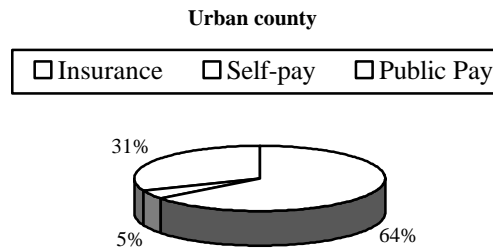
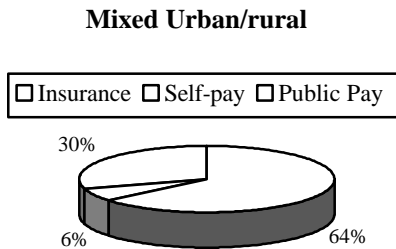
Frontier and rural Oregonians also demonstrate a much higher rate of death from unintentional injuries, which may be a reflection of many factors, such as lifestyle and adequacy of emergency medical response systems. The following chart, using data from Oregon's Center for Health Statistics, illustrates 1997 deaths by region from unintended injuries, which result primarily from motor vehicle accidents:



Further inferences regarding the differences between frontier, rural and urban Oregonians can be made by examining the source of payment for prenatal and delivery services, a data element which is collected by the Center for Health Statistics via birth certificates. 1997 data show significant variance among the four categories.



In applying these data to the general public, one must bear in mind that



Oregon’s Medicaid/Oregon Health Plan eligibility criteria place a high priority on insuring pregnant women. The relatively large percentage of apparently unsponsored births (14%) in frontier counties may indicate the need for increased outreach to potentially eligible women in these remote areas.

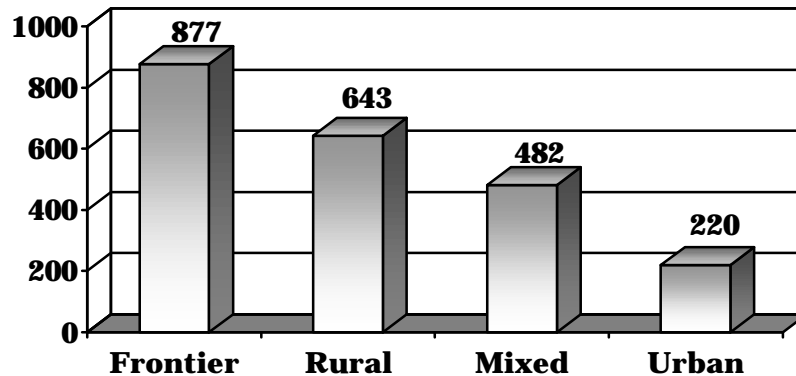
Oregon’s Office of Health Plan Policy and Research (OHPPR), in its publication, “The Uninsured in Oregon, 1997” also concludes, however, that rural populations generally are less likely to be insured. According to their research, 70% of the uninsured live outside the Portland metropolitan area³. Most recently, the OHPPR estimates that 9% of metropolitan Oregonians are uninsured, compared to 15% of nonmetro Oregonians.⁴

Clearly, relatively higher proportions of uninsured and public pay patients place additional stress on rural health providers, both practitioners and hospitals.

³ Office of Health Plan Policy and Research, The Uninsured in Oregon, 1997, Executive Summary

⁴ Office of Health Plan Policy and Research, Oregon Population Survey, January 1999

Oregon population per provider



Oregon's safety net:

Oregon currently has 52 federally designated Health Professions Shortage Areas (HPSAs) and 24 federally designated Medically Underserved Areas (MUAs). Oregon's certified rural health clinics (RHCs) and federally-qualified health centers (FQHCs) have historically served as their communities' safety nets, i.e., "providers of last resort." The advent of the Oregon Health Plan in February 1994 reduced the numbers of uninsured Oregonians significantly and also made Medicaid-sponsored patients more attractive to so-called "mainstream" health care providers. At the same time, however, the cost-based reimbursement received by RHCs and FQHCs for Medicaid patients was changed from fee-for-service to a monthly capitation for those who enrolled in managed care plans. In nearly all cases this resulted in lost revenues to safety net clinics.

Oregon's 23 certified Rural Health Clinics represent the most financially fragile providers of primary health care in the state. By definition these clinics are in medically underserved areas or in health professional shortage areas. A recent survey conducted by the Office of Rural Health revealed that, for these clinics, patient revenues do not cover costs. Financial data for 1996-97 from fifteen of 23 Rural Health Clinics (six of the 23 are proprietary) show that patient revenues cover only 70% of operating costs. The 15 clinics had expenses of approximately \$3.7 million while patient revenues from all sources totaled about \$2.6 million. In the sample, the average non-profit rural clinic had an annual budget of \$250,000, patient revenues of \$175,000 and a deficit of nearly \$75,000. Annual expenditures ranged from under \$50,000 for remote and frontier Jordan Valley to \$526,000 in Pacific City.

A large majority of clinics must look to non-operating revenues to survive. Of the 23 certified Rural Health Clinics, six depend on special health districts to help make up their respective deficits, and six are partially subsidized by a nearby hospital. Six are for-profit and remain competitive, yet sometimes show a loss, and five are private non-profit and look to the community for support. All clinics seek funds from donations and grants for both operation and capital projects.

The most financially fragile sometimes must close their doors. This has happened to four RHCs and three FQHCs in the past four years.

Loss of Medicaid revenues is not the only factor affecting RHC and FQHC viability. Changes in Medicaid, however, have encouraged global changes in Oregon’s health care delivery system. Both public and private insurers have restricted payments or required additional administrative procedures, which have increased operating costs. Employers have sought ever lower-cost health plans or eliminated coverage. Many jobs in the timber industry and manufacturing have been lost; the Oregon Economic Development Department has recently defined nearly all communities with rural health clinics as economically “distressed” areas.

The extent to which Oregon’s rural practitioners are concerned about economic issues is best summed up by a survey of rural physicians, nurse practitioners and physicians assistants conducted by the Office of Rural Health in 1994. Respondents numbered 477, and consisted of 83% physicians, 12% nurse practitioners and 5% physician assistants. When asked to rate, on a scale of 1-10, the importance of various factors that may negatively affect their decisions to remain in a rural practice site, respondents replied as follows:

Factor	Score (1-10)
Policy of insurers to reimburse rural providers less \$\$\$	7.05
Changing Medicare and Medicaid requirements	6.85
Longer working hours	6.70
Lower pay than urban counterparts	6.65
Rising practice costs/overhead	6.51
Noneffectiveness of federal legislation to assist rural providers	6.26
Noneffectiveness of state legislation to assist rural providers	5.88
Lack of reimbursement for time spent on call	5.54
Poor local economy	5.46
Threat of frivolous lawsuits	5.38
Poor local schools	5.27
Difficulty recruiting additional providers	5.23
Lack of educational opportunities in rural areas	5.17
Lack of specialty backup	5.15
Cost of malpractice insurance premiums	5.10
Lack of community support	5.07
Changing rural demographics	4.72
Threat of local hospital closure	4.51
Distance from technology	4.02

Oregon's Emergency Medical Services System:

Oregon has been recognized as a national leader in regionalization of emergency medical services, and was the first state to organize a statewide trauma system that includes rural areas. Oregon is also characterized by a statewide 9-1-1 system, with plans for statewide enhanced 9-1-1 service by the year 2000. A report published in 1992⁵, however, identified several deficiencies in Oregon's EMS system, most of which remain uncorrected. The following elements describe the current Oregon EMS system.

EMS Personnel: Most recent data (Oregon Health Division, 1996) indicate that there are 7,282 licensed EMTs in Oregon, although only 78% report being employed by an Oregon EMS agency. Of the licensed EMT providers in Oregon, 29.9% are EMT-Paramedics, 17.9% are EMT-Intermediates, and 52.2% are EMT-Basics. These proportions differ considerably in rural areas of the state, especially in frontier counties, as illustrated by the following table:

County name	EMT-Basic		EMT-Intermediate		EMT-Paramedic	
	Number	Percent	Number	Percent	Number	Percent
FRONTIER COUNTIES						
Baker	24	61.5%	14	35.9%	1	2.6%
Crook	13	59.0%	4	18.2%	5	22.7%
Gilliam	10	62.5%	6	37.5%	---	---
Grant	36	66.7%	14	25.9%	4	7.4%
Harney	6	22.2%	16	59.3%	5	18.5%
Lake	31	75.6%	9	21.9%	1	2.4%
Malheur	36	64.3%	19	33.9%	1	1.8%
Morrow	26	66.7%	11	28.2%	2	5.1%
Sherman	11	100%	----	----	----	----
Wallowa	10	47.6%	5	23.8%	6	28.6%

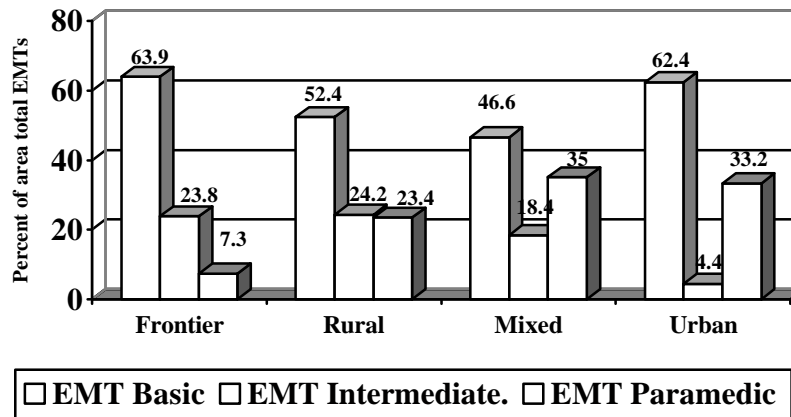
⁵State of Oregon, An Assessment of Emergency Medical Services, National Highway Traffic Safety Administration Technical Assistance Team, May 1992

County name	EMT-Basic		EMT-Intermediate		EMT-Paramedic	
	Number	Percent	Number	Percent	Number	Percent
Wheeler	15	100%	----	----	----	
RURAL COUNTIES						
Clatsop	52	63.4%	19	23.2%	11	13.4%
Columbia	66	52.0%	27	21.3%	34	26.8%
Coos	61	55.0%	29	26.1%	21	18.9%
Curry	15	40.5%	11	29.7%	11	29.7%
Douglas	119	44.2%	73	27.1%	77	28.6%
Hood River	29	53.7%	12	22.2%	13	24.0%
Klamath	91	59.8%	34	22.4%	27	17.8%
Jefferson	42	67.7%	12	19.4%	8	12.9%
Josephine	35	46.0%	18	23.7%	23	30.2%
Lincoln	48	47.5%	32	31.7%	21	20.8%
Polk	41	52.6%	22	28.2%	15	19.2%
Tillamook	14	35.9%	8	20.5%	17	43.6%
Union	29	50.8%	17	29.8%	11	19.3%
Umatilla	59	58.4%	15	14.9%	27	26.6%
Wasco	20	40.0%	21	42.0%	9	18.0%
Yamhill	74	56.5%	25	19.1%	32	24.4%
MIXED URBAN AND RURAL COUNTIES						
Benton	42	42.9%	27	27.6%	29	29.6%
Clackamas	222	44.9%	107	21.7%	165	33.4%
Deschutes	107	52.5%	21	10.3%	76	37.3%
Jackson	146	49.3%	45	15.2%	105	35.4%
Lane	160	32.0%	166	33.2%	174	34.8%
Linn	66	41.0%	23	14.3%	72	44.7%
Marion	250	51.8%	67	13.9%	166	34.3%
Washington	263	56.9%	41	8.9%	158	34.2%

County name	EMT-Basic		EMT-Intermediate		EMT-Paramedic	
	Number	Percent	Number	Percent	Number	Percent
ALL FRONTIER COUNTIES	218	63.9%	98	28.7%	25	7.3%
ALL RURAL COUNTIES	804	52.4%	371	24.2%	359	23.4%
ALL MIXED COUNTIES	1256	46.6%	497	18.4%	945	35.0%
URBAN COUNTY (Multnomah)	696	62.4%	49	4.4%	370	33.2%
ALL COUNTIES	2965	52.2%	1019	17.9%	1697	29.3%

These 1996 Health Division data are even more striking when viewed in a graphic form:

Types of EMTs by Area

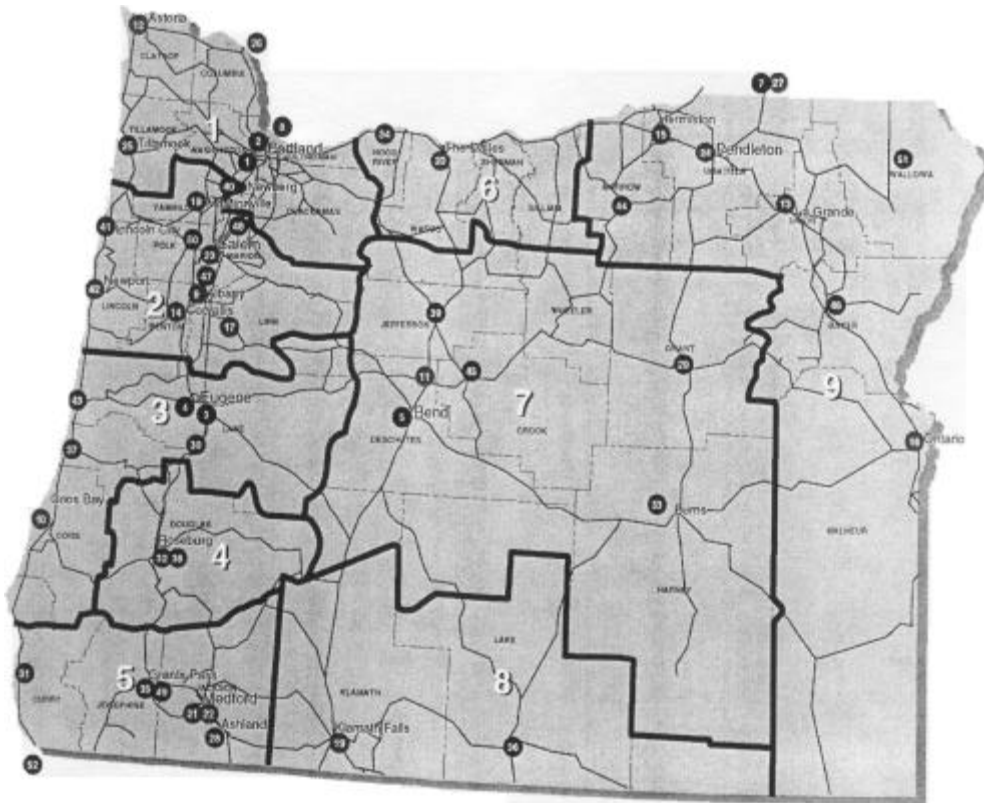


Considering that many rural EMTs are volunteers, it is no surprise that few in the most rural communities have the time, resources or opportunity to pursue advanced training. Two recent Oregon initiatives have been designed to address the training needs of rural EMTs and increase numbers of paramedics in rural and frontier counties:

- enhanced mobile training capability through the addition of a second mobile training unit with a secure and stable funding source; and
- statewide EMT training via live video conferencing through a partnership with the Northeast Oregon Area Health Education Center.

Oregon's Trauma System:

In 1985, Oregon's Legislature passed the Oregon Emergency Medical Services and Trauma System Act, which acknowledged that numerous deaths and long term disabilities could be prevented if victims have access to immediate treatment by medical professionals trained in emergency and trauma care and equipped with necessary medical technology. The trauma care system, which has evolved, is unique in that the most rural hospitals have been included. The system is organized on the basis of nine regional trauma system areas



administered by Area Trauma Advisory Board (ATABs):

Participating hospitals are listed below and on the following page:

Map#	Level	ATAB	Name
1	I	1	Oregon Health Sciences University, Portland
2	I	1	Legacy Emanuel Hospital and Health Center, Portland
3	II	3	McKenzie Willamette Hospital, Springfield
4	II	3	Sacred Heart General Hospital, Eugene
5	II	7	St. Charles Medical Center, Bend

Map#	Level	ATAB	Name
6	II	9	St. Alphonsus Regional Medical Center, Boise, ID
7	II	9	St. Mary Medical Center, Walla Walla, WA
8	II	1	SW Washington Medical Center, Vancouver, WA
9	III	2	Albany General Hospital, Albany
10	III	3	Bay Area Hospital, Coos Bay
11	III	7	Central Oregon District Hospital, Redmond
12	III	1	Columbia Memorial Hospital, Astoria
13	III	9	Grande Ronde Hospital, La Grande
14	III	2	Good Samaritan Hospital, Corvallis
15	III	9	Good Shepherd Hospital, Hermiston
16	III	9	Holy Rosary Hospital, Ontario
17	III	2	Lebanon Community Hospital, Lebanon
18	III	2	McMinnville Community Hospital, McMinnville
19	III	8	Merle West Medical Center, Klamath Falls
20	III	6	Mid-Columbia Medical Center, The Dalles
21	III	5	Providence Hospital, Medford
22	III	5	Rogue Valley Medical Center, Medford
23	III	2	Salem Hospital, Salem
24	III	9	St. Anthony Hospital, Pendleton
25	III	1	Tillamook County General Hospital, Tillamook
26	III	1	St. John's Medical Center, Longview, WA
27	III	9	Walla Walla General Hospital, Walla Walla, WA
28	IV	5	Ashland Community Hospital, Ashland
29	IV	7	Blue Mountain Hospital, John Day
30	IV	3	Cottage Grove Hospital, Cottage Grove (temporarily closed)
31	IV	5	Curry General Hospital, Gold Beach
32	IV	4	Douglas Community Hospital, Roseburg
33	IV	7	Harney District Hospital, Burns
34	IV	6	Hood River Memorial Hospital, Hood River
35	IV	5	Josephine Memorial Hospital, Grants Pass (now Three Rivers)
36	IV	8	Lake District Hospital, Lakeview
37	IV	3	Lower Umpqua Hospital, Reedsport
38	IV	4	Mercy Medical Center, Roseburg
39	IV	7	Mountain View Hospital, Madras
40	IV	1	Newberg Community Hospital, Newberg
41	IV	2	North Lincoln Hospital, Lincoln City
42	IV	2	Pacific Communities Hospital, Newport
43	IV	3	Peace Harbor Hospital, Florence
44	IV	9	Pioneer Memorial Hospital, Heppner
45	IV	7	Pioneer Memorial Hospital, Prineville
46	IV	9	St. Elizabeth Hospital, Baker City
47	IV	2	Santiam Memorial Hospital, Santiam
48	IV	2	Silverton Hospital, Silverton
49	IV	5	Southern Oregon Medical Center, Grants Pass (merged)
50	IV	2	Valley Community Hospital, Dallas
51	IV	9	Wallowa Community Hospital, Enterprise
52	IV	5	Sutter Coast Hospital, Crescent City, CA

A **Level I Trauma Center** provides the highest level of definitive, comprehensive care for the severely injured adult and pediatric patient with complex, multi-system trauma. A Level I facility is the regional resource trauma center in the system and has the capability of providing total patient care for every aspect of injury from prevention through rehabilitation. In addition to direct patient care, Level I trauma centers are responsible for resident training, research, regional quality assurance, education and outreach programs in trauma. Oregon's two Level I Trauma Centers are in the Portland metro area.

A **Level II Trauma Center** provides definitive care for severely injured adult and pediatric patients with complex, but not multi-system trauma. Clinically, the care rendered at a Level II facility is similar to that of a Level I trauma center and staffing requirements are also comparable. Level II trauma centers are also responsible for regional quality assurance, education and outreach programs in trauma. Oregon has designated six Level II facilities, three of which are in bordering states. None are in rural areas, but St. Charles Medical Center in Bend is a regional rural referral center.

A **Level III Trauma Center** provides initial evaluation and stabilization, including surgical intervention, of the severely injured adult or pediatric patient. A Level III trauma center will provide comprehensive medical and surgical inpatient services to those patients who can be maintained in a stable or improving condition without specialized care. Critically injured patients who require specialty care are transferred to a higher level trauma system hospital in accordance with criteria established by the Area Trauma Plan. Of the 19 Level III designated hospitals, 10 are rural hospitals and two (Bay Area Hospital in Coos Bay and Merle West Medical Center in Klamath Falls) are regional rural referral centers.

Level IV Trauma Centers provide resuscitation and stabilization of the severely injured adult or pediatric patient prior to transferring the patient to a higher-level trauma system hospital. Resuscitation and stabilization may require surgical intervention. Trauma trained nursing personnel are immediately available to initiate life-saving maneuvers. Physicians trained in ATLS are promptly available to provide patient resuscitation and in most cases are present upon patient arrival to the hospital. Ancillary personnel are also in-house or promptly available at all hours of the day. Level IV Trauma Centers have all of the appropriate equipment and diagnostic capabilities to resuscitate the severely injured patient. Oregon has 25 Level IV Trauma Centers; all of them are in rural communities and five are in frontier counties.

In 1995 and 1996, 10,460 patients utilized the services of the trauma care system: 54.4% received care from a Level I trauma facility; 21.4% from a Level II facility; 17.2% from a Level III facility and 7.1% from a Level IV trauma center.

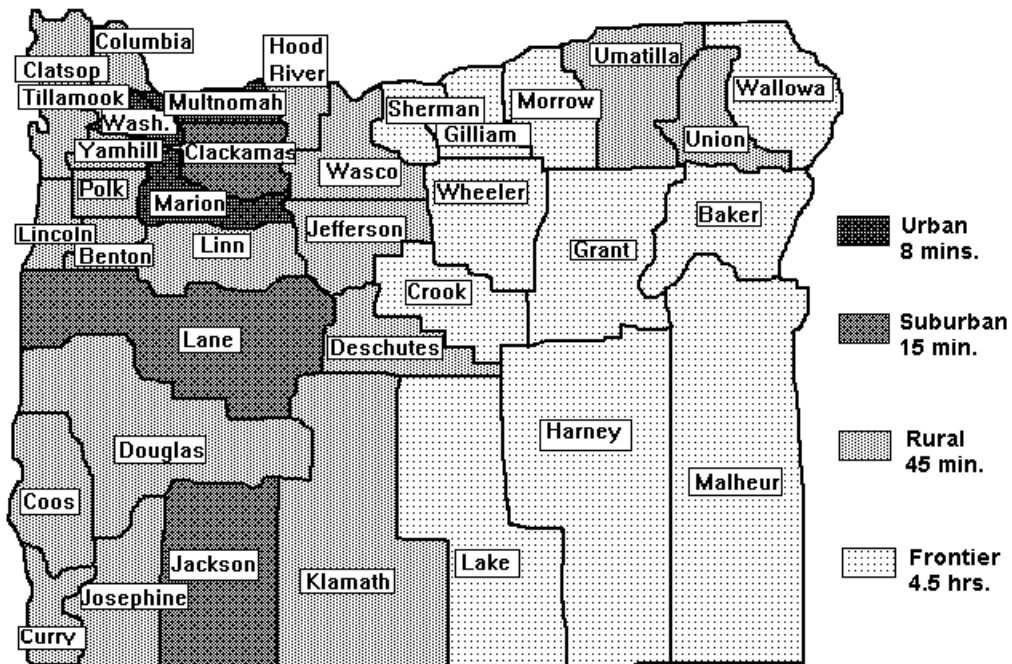
Prehospital transport: Dispatching of public safety resources is a matter of local control in Oregon. 9-1-1 calls are received at primary public safety answering points (PSAP) around the state, which are either local or multi-jurisdictional in

nature. These calls are either handled directly by the primary PSAP or transferred to a dispatch-only (a secondary PSAP) for activation of resources. Multnomah County has one integrated PSAP, but rural counties with small populations may have up to nine PSAPs.

The Health Division’s EMS section acknowledges that there is room for improvement in the present system. Radio communication in some areas of the state is quite poor due to remoteness and ruggedness of terrain. Because there is no state-level funding for communications projects, the most difficult communications challenges must be addressed by the most poorly funded local jurisdictions.

The following map illustrates prehospital response times, i.e., the time 9-1-1 dispatches a prehospital care unit to the time emergency medical personnel respond to the scene of the injured patient, by county:

Prehospital Response Time by County
 Source: Oregon Health Division, 1996



Delayed prehospital response times in the frontier counties are a function of the EMT workforce, i.e., even first responders in the most rural areas are likely to be volunteers. Expedient care of emergency patients is additionally complicated in rural areas by transport problems. In very rural communities, ambulances are likely to be owned and maintained by special tax-supported jurisdictions, i.e., health, and fire or ambulance districts. Declining tax revenues and diminished ability to access local tax bases have compromised the viability of many rural ambulance services.

Additionally, Oregon does not have statewide air ambulance coverage. Helicopter scene coverage within a 30-minute flight radius leaves most of Eastern Oregon without service. There are, however, an undetermined number of fixed wing aircraft supplied by the timber industry, Air Force and Coast Guard that periodically provide air medical evacuation, rescue and recovery.

Although Oregon's trauma system is innovative and exemplary, basic emergency medical services in very rural areas leave much room for improvement from a systems perspective. The previously referenced National Highway Traffic Safety Administration (NHTSA) report published in 1992 identified the following weaknesses in Oregon's EMS system which have not yet been corrected:

- Oregon's lead EMS agency does not have the authority and resources to adequately address a comprehensive and integrated approach to EMS system development.
- No EMS transportation needs assessment has been undertaken.
- A comprehensive EMS database for non-trauma patients needs to be developed.
- There is a lack of a statewide EMS communications system in Oregon.
- Oregon does not meet national standards for public information and education regarding EMS issues.
- The absence of a statewide EMS medical director results in lack of medical direction to EMTs in the field and inconsistent medical standards and protocols from one jurisdiction to the next, especially in rural areas.
- The current trauma system is on a separate course from that of a statewide EMS system and is not a cohesive component of that system.
- There is currently no statewide plan for EMS system evaluation in Oregon.

Oregon's EMS deficiencies cannot be addressed and resolved solely by implementation of a Critical Access Hospital System. For those facilities that are designated, however, a high and consistent standard of emergency medical care will be required, thereby improving access to emergency care for some rural citizens of the state.

Oregon's Public Health System: Three core functions form the infrastructure for public health in Oregon. The Oregon Health Division (May 1998) provides the following explanation of Oregon's core public health functions.

- **Review and assessment of community health conditions and the adequacy of health resources and systems to deal with problems that are identified.**

The state's role in this function includes responsibility for establishing and maintaining surveillance systems, collecting and assembling health status and utilization information and performing analysis. Expertise is provided at the state level for comparative analysis and forecasting regional and state trends. The capacity to provide technical assistance to local health agencies for community forecasting and interpretation of data also emanates from the state health agency.

Local health agencies are responsible for collecting data needed to assemble a picture of the health status of people in their community. In addition to data, local health departments assess the public's perceptions of community health status or what the public believes to be the most important issues facing their community.

- **Develop and evaluate health policy, and recommend programs to carry out these health policies.**

The state plays several roles in policy development. It is responsible for assembling and providing periodic health reports, as well as identifying statewide priorities and goals that reflect a series of local community planning efforts. Through community assessment and collaborative leadership, health policy is developed and evaluated with program recommendations to carry out those policies.

Local health departments recognize that many health policy issues first emerge on the local level. Regional or state policy development is more effective and efficient when local communities are active participants in its development. This approach is based on the assumption that the strongest public health policy is developed and owned at the local level.

- **Monitor and assure that necessary, high quality and effective services are available and accessible.**

The state Health Division's goals in this area include having adequate legal authority, resources, trained leadership and staff to provide a broad range of services, including maintenance of emergency response capacity

at the state level, enforcement of standards and laws and maintenance of quality assurance and technical assistance in the service delivery system. Health Division also attempts to assure that there is adequate provision of essential population-based services throughout the state, and must provide direct services where local delivery is economically impractical.

Local health departments attempt to coordinate priority needs in their own areas. They respond to regional or local emergencies, enforce regulations and, according to their capacity, provide essential outreach services to people experiencing barriers to necessary health care services.

Oregon's 34 local health departments vary considerably in their abilities to perform the ideal functions listed. With the exception of Multnomah County, few have the resources to provide primary care services. Although health departments have historically been regarded as "providers of last resort" for uninsured populations, the growth of managed care coverage under the Oregon Health Plan has complicated their ability to participate in the Medicaid reimbursement system. As private sector capacity has responded to the growing Oregon Health Plan, most rural health departments have discontinued offering primary care services.

According to the Health Division⁶, strengthening the public health system will require further examination in specific areas. In **conducting community diagnoses**, Health Division has a vast database. However, there are gaps in areas of information needed to complete essential activities necessary to promote and maintain healthy communities. These gaps include various chronic disease rates, as well as private sector health care services. Improvements must be made in disseminating information back to those people and organizations that can make a difference in planning programs to promote healthy communities. There have been many instances where data have been instrumental for developing specific policy, legislation, or community action. Until recently, however, little attention has been given to developing a comprehensive strategy for information collection, analysis and dissemination. Work must continue on the development and implementation of a plan for sharing data at both the state and local level.

- In **providing a safe and healthy environment**, state and local health departments must complete an emergency disaster plan. In the event of major, natural disaster (earthquake, tsunami) coordination with other government agencies, such as with DEQ, Emergency Management, and Department of Agriculture is critical.
- In **measuring performance, effectiveness and outcome** of health services there is no evaluation of the health care system in Oregon.

⁶ "Areas to be Strengthened," Oregon's Public Health System, Oregon Health Division, February 5, 1998.

Current outcome information focuses on evaluation of public health services only. The Health Division has not fully participated in monitoring or setting standards for the Oregon Health Plan.

- In **promoting healthy lifestyles**, the Health Division is just beginning to develop a plan. Until it is further evolved, there will be some difficulties integrating information into other services. Some local health departments have made progress with program development in such areas as combining prenatal care and smoking cessation. In some parts of the state funding sources need to be developed, in other areas funding sources need to be strengthened.
- An important area needing improvement is **providing targeted outreach and forming partnerships**. In most instances, the Health Division knows who the target groups are, but needs to further develop strategies for reaching them. This includes strengthening efforts to reach out to additional non-profit groups and private organizations to resolve public health problems. For instance, establishing a formal partnership with the Commission on Children and Families will require executive leadership and a "healthy community" vision.
- One of the most successful public health efforts has been achieved by developing a system to provide preventive health care services for individuals living from 58% to 185% Federal Poverty Level. This was accomplished because Oregon made it a priority. Once there are adequate primary care providers to deliver preventive services in underserved rural areas of the state, we may not need to address this issue. However, until that time, Health Division's efforts to assure **provision of personal health care services** will continue.
- **Research and Innovation** areas need to be examined and a focus developed. These activities are crucial to efficient and effective programs, and are critical in a climate of declining resources and increasing emphasis on outcomes. Traditionally, these functions have been among the most undervalued in the public health system. An increased appreciation of the essential nature of these functions must develop, along with better integration of these activities into all aspects of program design and delivery.

Finally, a strategy to **mobilize the community for action** must be developed. Improving and strengthening Oregon's public health infrastructure will depend on assuring accurate community diagnosis, providing targeted outreach and forming partnerships so that communities can be mobilized for action.

The Oregon Health Plan: No description of Oregon's health care environment would be complete without a discussion of the Oregon Health Plan, a state-wide health care reform effort that was begun in 1989. The Oregon Health Plan includes the following elements:

- A Medicaid expansion program that extends Medicaid coverage to all Oregonians living in poverty and to children under six and pregnant women up to 133 percent of the federal poverty level (FPL).
- Small business and individual market reforms that makes it easier and more affordable for small employers--nearly 97% of all employers in Oregon--to provide insurance coverage for their employees.
- A small business insurance pool to assist small companies in purchasing health insurance coverage for their employees.
- A high-risk insurance pool for individuals turned down for coverage in the commercial market because of their health status; and
- Reliance on managed care to control costs and improve service delivery.

An additional component of the plan passed by the 1989 legislature, mandating that employers either provide health insurance coverage for their employees or make payments into a state insurance fund, was to have taken effect beginning in 1994. However, the 1991 legislative session deferred its effective date to 1995, and the 1993 legislative session deferred it to 1997 (for businesses with 26 or more employees) and 1998 (for those with 25 or fewer.) Enabling legislation that would have been required for this part of the Plan to take effect, however, was not passed by the Congress of the United States by the beginning of 1996. Under the terms of the bills passed by Oregon's legislature, this means that the employer mandate will not take effect.

Phase I of the Medicaid expansion portion of the plan began on February 1, 1994, with coverage of most people below the federal poverty level (FPL), as well as pregnant women and young children up to 133% of the FPL. Phase II, beginning in January 1995, added seniors, persons with disabilities and foster children to the new program. It is managed by the Department of Human Resources (DHR) Office of Medical Assistance Programs (OMAP). The Medicaid program has extended a basic health benefit package to a monthly average of more than 115,000 newly eligible persons (who do not qualify for traditional Medicaid) as well as approximately 265,000 Oregonians who qualify for Medicaid because they are eligible for welfare, disability and other state benefits.

The five-year demonstration project required waiver of federal Medicaid rules and is monitored by the Health Care Financing Administration (HCFA). Revenues for the OHP Medicaid demonstration project are approximately 60% federal and 40% State General Fund, including a tobacco tax enacted in 1997.

The High Risk Insurance Pool provides benefits similar to those offered Medicaid recipients. With premiums limited to 150% of private insurance rates (due to decline to 125% in October 1996) and all health insurers doing business in the state required to participate in funding the program, the pool now insures more than 4,300 state residents. To make health insurance available to people working for small businesses, a state Insurance Pool Governing Board was established in 1987 and began making insurance available in 1989. Currently it provides coverage to 27,000 people working for nearly 9,000 small businesses. Another set of insurance reforms targeted at small employers took effect in 1993, with revisions that became operational in October 1996.

The Oregon Health Plan Progress Report, published by OMAP in January 1997, noted that satisfaction with health care among their clients has increased, and that access has improved. More respondents to their satisfaction survey (83% in 1996 vs. 73% in 1994) reported improved health status and satisfaction with dental care (a new component of the Medicaid program) increased from 48% to 65%. The average wait for mental health services declined from eight weeks to two weeks and mammogram rates, a measure of access to preventive services, increased from 21% to 52%.

As a result of the OHP, Oregon has seen substantial declines in the proportion of individuals who are uninsured, from 18 percent in 1990 to less than 11 percent in 1997, according to the Office for Oregon Health Plan Policy and Research (1997).

Within a year of Phase I implementation, hospital charity care had decreased by 35%, a savings of \$31.8 million. Improved access to primary care providers may have also contributed to a 6.5% decline in emergency room visits statewide:

Changes in Charity Care/ER Visits (Calendar years) ⁷			
	1993	1994	1995
Emergency visits	947,786	897,181	886,069
Charity Care	\$91.9 million	\$74.7 million	\$60.1 million

Oregon's Office for Health Plan Policy and Research notes that it is important to recognize that not all of the progress made in the growth of insurance coverage can be attributed directly to the OHP. Oregon has enjoyed a remarkably strong economy during the 1990s, which has fueled employment growth, particularly in

⁷ Oregon Health Plan Progress Report, Oregon Office of Medical Assistance Programs (OMAP), June 1997

high-tech sectors of the economy, which are more likely to offer health benefits to employees. However, a preliminary examination of other states with similarly strong economies suggests that this factor alone is insufficient to reduce the numbers of uninsured people, since none have experienced the same decline in uninsurance rates seen in Oregon. It appears then that the OHP has indeed been a major contributor to improvements in the health insurance status of Oregonians.⁸

Because of its reliance on managed care, the Oregon Health Plan has also had a profound impact on the health care delivery system in Oregon. Perhaps more than any other state, Oregon has significant statewide penetration of managed care plans:

- 87% of Oregon Medicaid clients (294,000) are now enrolled in managed care, compared with 33% (90,000) before the OHP.
- In 1997, 34 of Oregon's 36 counties had managed care health plans vs. 15 counties before the OHP.
- In 1997, 35 Oregon counties had managed care dental plans vs. six counties before the OHP.

Although early experience with this new delivery system appeared to be successful, recent months have witnessed the withdrawal of several managed health care plans from the OHP. Several factors have contributed to the health plans' growing lack of enthusiasm for Medicaid managed care, but the paramount factor is financial. Regence Blue Cross/Blue Shield of Oregon recently announced its withdrawal from Medicaid managed care in most of Eastern Oregon, citing heavy financial losses. Contract disputes between a physician-dominated IPA and area hospitals led to a loss of managed care services in two Oregon coastal counties. When managed care plans withdraw, payments in affected counties revert to lower fee-for-service reimbursement, with a subsequent loss in provider participation.

The impact of the OHP on Oregon's rural counties cannot be understated. On the one hand, the disproportionately uninsured populations in rural areas benefit from enrollment. On the other hand, rural providers have had difficulty adjusting to managed care delivery systems that were designed primarily for urban areas. Oregon's rural hospitals, guaranteed cost-based fee-for-service reimbursement as far back as 1987, have lost this guarantee under managed care, and must rely on contract negotiations to recover their costs.

⁸ The Uninsured in Oregon, 1997. Office for Oregon Health Plan Policy Research, April 10, 1998

Section V. Efforts to improve rural health care in Oregon

In 1987, a coalition of health care advocates led by the Oregon Association of Hospitals persuaded the Oregon legislature to begin adopting a series of rural health care initiatives that continued over the next several legislative sessions. As a first step, the legislature recognized the importance of maintaining essential hospital services:

ORS 442.515 Rural hospitals; findings. The Legislative Assembly finds that Oregon rural hospitals are an integral part of the communities and geographic area where they are located. Their impact on the economic well-being and health status of the citizens is vast. The problems faced by rural hospitals include a general decline in rural economies, the age of the rural populations, older physical plants, lack of physicians and other health care providers and a poor financial outlook. The Legislative Assembly recognizes that the loss of essential hospital services is imminent in many communities. [1987 c.918 s.1]⁹

The Office of Rural Health was granted authority to categorize rural hospitals into three classifications:

- (1) Type A hospitals are small and remote, have 50 or fewer beds and are greater than 30 miles from another acute inpatient care facility;
- (2) Type B hospitals are small and rural and have 50 or fewer beds, and are 30 miles or less from another acute inpatient care facility; and
- (3) Type C hospitals are considered rural and have more than 50 beds, but are not a referral center.

The state Medicaid program was directed to reimburse Type A rural hospitals “for the cost of covered services based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report, provided by the hospital to a person entitled to receive medical assistance.” In 1989, Type B hospitals were added to this benefit. This provision has required clarification as managed care has become more prevalent in rural areas, and in 1995 Oregon’s Attorney General issued an advisory opinion to OMAP absolving them of oversight responsibilities with managed care organizations. Hospitals that negotiate managed care contracts were not, therefore, entitled to this benefit.

Senate Bill 507, passed in 1997, directed health plans to reinstate cost-based Medicaid reimbursement for Type A and Type B rural hospitals. Although the state Medicaid agency has dedicated funds to health plans for offsetting those costs, the issue remains controversial.

⁹ Oregon Revised Statutes, updated 1997 version

The 1989 legislative session also witnessed activity from a larger and more diverse rural health coalition that prevailed upon legislators to pass an even broader rural health omnibus bill, Senate Bill 438. This bill laid the groundwork for the well-established rural health care infrastructure that Oregon now enjoys.

The following programs/services were created by SB 438 in 1989, and continue to succeed:

Area Health Education Centers (AHEC): \$250,000 in “seed” money was provided to initiate Oregon’s participation in this federal-state partnership. Oregon’s AHEC program is organized around a program office based at Oregon Health Sciences University and includes five regional private nonprofit Area Health Education Centers.

The mission of the statewide AHEC Program is to:

- Improve the availability, continuity and quality of health care for communities and populations in need through education.
- Develop distance learning capabilities to serve health professions students and resident physicians, local health care providers and community residents.
- Maintain a statewide system of five AHECs that link OHSU to communities, health care facilities and health care professionals.

Each regional AHEC provides:

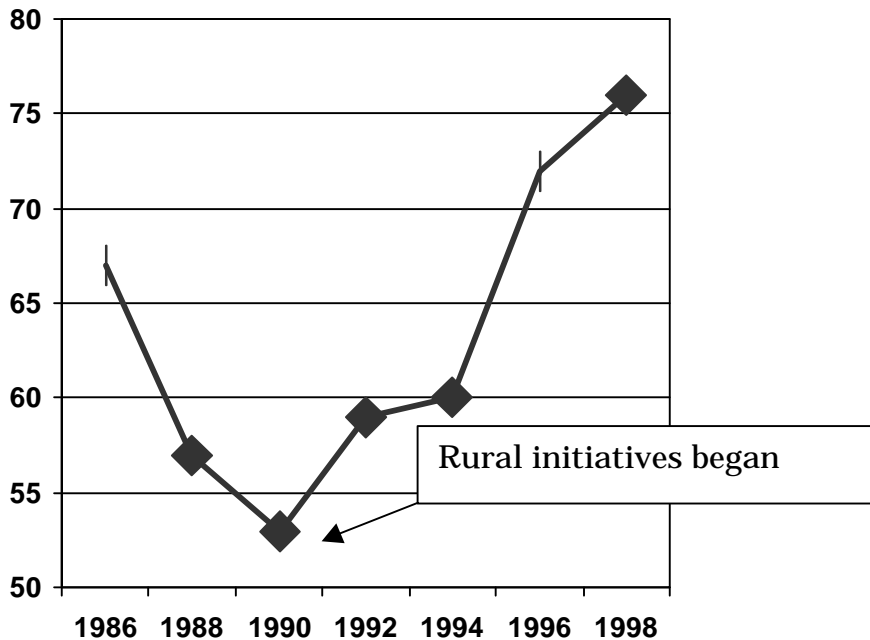
- Rotations for physician residents in family medicine;
- Education and training for medical, nursing, dental and allied health students;
- Health information and education programs for the public;
- Assessment of the education and training needs of area health professionals;
- Continuing education for practicing health professionals; and
- Encouragement to students, beginning in the early years of school, to enter a health profession.

Tangible results from the AHEC program to date include increased numbers of medical students choosing primary care residencies, students from remote and disadvantaged areas entering OHSU’s health professions programs and proven practitioner retention strategies.

Practitioner tax credits: More than a thousand rural practitioners in Oregon enjoy a personal income tax credit of up to \$5,000. Requirements for eligibility vary by professional group, but the following rural practitioners may potentially

qualify: physicians (MD or DO), nurse practitioners, physician assistants, certified registered nurse anesthetists, dentists, podiatrists and optometrists. Initiated in 1989 by a legislature alarmed by the exodus of physicians from small Eastern Oregon counties, this program is administered by the Office of Rural Health, which makes a determination of eligibility, then forwards that information to Oregon's Department of Revenue. The program is generally regarded as highly effective, both as a recruitment tool and a reason for retention. The small Eastern Oregon counties, which stimulated development of the program, have especially benefited:

Numbers of physicians in remote eastern Oregon counties, 1986-1998



Overall, the following net gains in practitioners in eligible rural areas have occurred since inception of the program in tax year 1990:

- 159 new physicians
- 137 new nurse practitioners
- 25 new physician assistants
- 9 new dentists
- 6 new CRNAs
- 1 new podiatrist

Oregon is generally credited with having taken a multi-faceted approach to improving access to health care for its rural citizens. In addition to the programs cited in this document, the state has initiated and maintained a successful practitioner recruitment program in the Office of Rural Health and made additional resources available to rural communities in the form of technical assistance. Oregon's Rural Development Council (ORDC), a federally funded program, has focused attention on the economic development aspects of rural health care. ORDC leadership from the state Office of Rural Health's Technical Assistance Program has helped direct millions of federal and state economic development and US Forest Service dollars to rural communities.

Oregon's rural communities have also profited from federal grant programs. Rural Health Outreach Grants offered by the Federal Office of Rural Health Policy have funded new health clinics in Union, Jackson, Josephine and Douglas counties, mobile medical vans in Wasco and Linn counties and an innovative mental health telecommunications project in 11 Eastern Oregon counties. Twelve rural Oregon hospitals received Rural Hospital Transition Grants from the Health Care Financing Administration (HCFA) prior to the recent demise of this program.

And finally, the Oregon Rural Health Association (ORHA), which was created in 1992, has helped to keep the issues of rural health visible among Oregon's legislators and policymakers. All rural health care provider groups are represented on the ORHA Board of Directors and participate actively in policy development and advocacy for rural health issues.

Section VI. Oregon's Hospitals

Oregon has 61 licensed hospitals; 38 are classified by the Office of Rural Health as "rural." As noted earlier, the state Legislature adopted a classification system for rural hospitals in 1987 that is unique to Oregon:

"ORS 442.470 Definitions for ORS 442.470 to 442.505. As used in ORS 442.470 to 442.505:

- (5) "Rural hospital" means a hospital characterized by one of the following:
- (a) Type A hospitals are small and remote, have 50 or fewer beds and are greater than 30 miles from another acute inpatient care facility;
 - (b) Type B hospitals are small and rural and have 50 or fewer beds, and are 30 miles or less from another acute inpatient care facility;
 - (c) Type C hospitals are considered rural and have more than 50 beds..."

Oregon's hospital marketplace: Any discussion of Oregon's rural hospitals must be placed in context with the overall health care environment. According to the most recent edition of the Oregon Hospital Report, published by the Office of Health Plan Policy and Research in January 1999, Oregon's hospital marketplace is characterized by:

- Creation of organizations of formerly independent physicians to avoid being excluded from managed care networks. Independent Practice Associations (IPAs) may act solely as a single source contracting mechanism or may expand to operate referral and utilization management programs, quality improvement and/or medical management systems.
- Consolidation and integration of hospitals and physician clinics that traditionally were compartmentalized. Since primary care physicians are in a position to determine how most of the total health care dollars are spent, hospitals have increasingly joined with IPAs on managed care contracts through Physician Hospital Organizations (PHOs).
- The organization of hospitals, physicians and health insurance companies into Integrated Delivery Systems (IDS). IDSs combine health care delivery, and sometimes financing, under one umbrella organization that owns or contracts for health care across a spectrum of settings, e.g., doctor's offices, ambulatory care settings, hospitals, nursing homes, etc.
- Financial risk-sharing that blurs the distinction between the financing and delivery functions of health care. Hospitals and physicians who seek greater control over the administration of health care delivery and retention of local health care dollars in their communities may merge into Provider Sponsored Organizations (PSOs) which offer their own health plans and assume all risk.

The effects of these organizational changes on the hospital industry can be identified as four distinct trends:

1. An expansion of outpatient services;
2. Closer contractual relationships among hospitals, health systems and physicians;
3. Consolidation of hospitals into multi-hospital systems; and
4. Increasing involvement of hospitals in managed care.

Oregon's rural hospitals: Oregon's rural hospitals have experienced all of the above trends. Because of their inherent fragility and distance from other facilities, many have displayed disproportionate responses to Oregon's volatile health care marketplace. Since 1982, nine Oregon rural hospitals have closed their doors, leaving four Oregon counties (Sherman, Gilliam, Wheeler and Columbia) with no hospital. Several rural hospitals in Oregon are currently struggling, and are looking to the Medicare Rural Hospital Flexibility Program

as a potential prescription for survival. Following is a list of Oregon's rural hospitals:

Hospital	Location	County	# of licensed beds	# of staffed beds	Type
Albany General Hospital	Albany	Linn	106	71	C
Ashland Community Hospital	Ashland	Jackson	49	37	B
Blue Mountain Hospital	John Day	Grant	39	20	A
Central Oregon District Hospital	Redmond	Deschutes	48	48	B
Columbia Memorial Hospital	Astoria	Clatsop	49	37	B
Coquille Valley Hospital	Coquille	Coos	30	NA	B
Cottage Grove Healthcare Community*	Cottage Grove	Lane	31	26	B
Curry General Hospital	Gold Beach	Curry	24	17	A
Douglas Community Hospital	Roseburg	Douglas	118	88	C
Good Shepherd Community Hospital	Hermiston	Umatilla	49	45	A
Grande Ronde Hospital	La Grande	Union	49	49	A
Harney District Hospital	Burns	Harney	44	44	A
Holy Rosary Medical Center	Ontario	Malheur	92	74	C
Hood River Memorial Hospital	Hood River	Hood River	32	31	B
Lake District Hospital	Lakeview	Lake	21	21	A
Lebanon Community Hospital	Lebanon	Linn	49	42	B
Lower Umpqua Hospital	Reedsport	Douglas	18	18	B
Mercy Medical Center	Roseburg	Douglas	111	95	C
Mid-Columbia Medical Center	The Dalles	Wasco	49	49	B
Mountain View Hospital	Madras	Jefferson	38	36	B
North Lincoln Hospital	Lincoln City	Lincoln	37	37	B
Pacific Communities Hospital	Newport	Lincoln	48	43	B
Peace Harbor Hospital	Florence	Lane	21	21	B
Pioneer Memorial Hospital	Heppner	Morrow	12	12	A
Pioneer Memorial Hospital	Prineville	Crook	35	35	B
Providence Newberg Hospital	Newberg	Yamhill	35	35	B
Providence Seaside Hospital	Seaside	Clatsop	34	34	B
Santiam Memorial Hospital	Stayton	Marion	40	40	B
Silverton Hospital	Silverton	Marion	38	38	B
Southern Coos General Hospital	Bandon	Coos	24	14	B
St. Anthony Hospital	Pendleton	Umatilla	49	49	A
St. Elizabeth Health Services	Baker City	Baker	49	36	A
Three Rivers Community Hospital	Grants Pass	Josephine	87	81	C
Tillamook County General Hospital	Tillamook	Tillamook	49	49	A
Tuality Forest Grove	Forest Grove	Washington	45	45	B
Valley Community Hospital	Dallas	Polk	44	39	B
Wallowa Memorial Hospital	Enterprise	Wallowa	29	27	A
Willamette Valley Medical Center	McMinnville	Yamhill	80	67	C

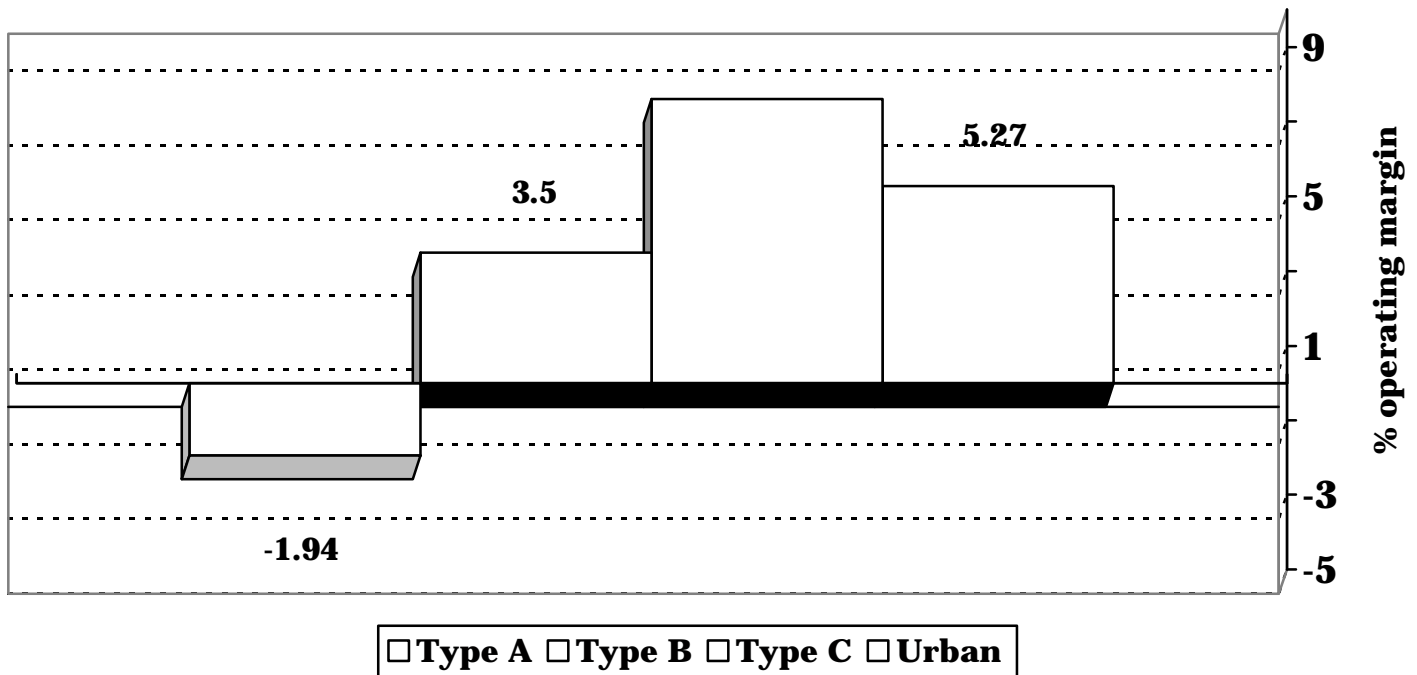
* Cottage Grove Healthcare Community surrendered its license in August 1998. Under Oregon law, the hospital can re-open within one year without a certificate of need (CON). Although the hospital is currently in bankruptcy, plans are underway to re-open this hospital in 1999, with a strong interest in conversion to a Critical Access Hospital.

Many statistical comparisons can be drawn between Oregon's rural and urban hospitals. Based on hospital category (A, B or Urban) the following differences are reported in The Oregon Hospital Report, published in January 1999 by the Office for Health Plan Policy and Research:

Hospital	Licensed Beds	Occupancy Rate	Total Inpatient Days	Average Daily Census	Total Charges
Type A	411	20.9%	31,334	85.8	\$63,668,544
Type B	866	27.9%	88,072	241.3	\$163,899,400
Urban	6,773	39.3%	972,127	2,663.4	\$198,652,461,101

The differences among Type A, Type B, Type C and urban hospitals are especially evident when operating margin¹⁰ is considered:

Operating Margins, Oregon Hospitals 1997



Additional instructive measures of rural hospital performance and stability are displayed in the following tables:

¹⁰ Operating margin is a more revealing characteristic than "bottom line" when considering rural hospitals because of frequent fluctuations in non-operating revenue, e.g., one-time bequests, varying tax revenues, etc.

Rural Hospital Utilization Data¹¹

Hospital	Type	Type County*	# of Discharges	Average Census	Average LOS
Albany General Hospital	C	M	3482	32	3.34
Ashland Community Hospital	B	M	1424	14	3.63
Blue Mountain Hospital	A	F	537	4	3.45
Central Oregon District Hospital	B	M	1685	12	2.58
Columbia Memorial Hospital	B	R	2318	20	2.76
Coquille Valley Hospital	B	R	392	2	2.34
Cottage Grove Community	B	M	1272	9	2.85
Curry General Hospital	A	R	376	2	3.34
Douglas Community Hospital	C	R	3528	25	3.82
Good Shepherd Community Hospital	A	R	2316	20	3.17
Grande Ronde Hospital	A	R	2260	18	4.08
Harney District Hospital	A	F	438	3	2.82
Holy Rosary Medical Center	C	F	3784	17	3.27
Hood River Memorial Hospital	B	R	1632	13	3.00
Lake District Hospital	A	F	502	2	2.26
Lebanon Community Hospital	B	M	3180	26	3.27
Lower Umpqua Hospital	B	R	722	2	3.16
Mercy Medical Center	C	R	6948	58	3.18
Mid-Columbia Medical Center	B	R	2334	20	3.56
Mountain View Hospital	B	R	1151	7	2.77
North Lincoln Hospital	B	R	1409	12	3.59
Pacific Communities Hospital	B	R	1656	15	3.26
Peace Harbor Hospital	B	R	1140	11	3.57
Pioneer Memorial (Heppner)	A	F	136	1	4.26
Pioneer Memorial (Prineville)	B	F	1036	7	3.27
Providence Newberg Hospital	B	M	1493	10	2.76
Providence Seaside Hospital	B	R	890	8	3.76
Santiam Memorial	B	M	869	7	3.81
Silverton Hospital	B	M	3140	18	2.63
Southern Coos General Hospital	B	R	184	1	4.79
St. Anthony Hospital	A	R	1916	2	3.23
St. Elizabeth Health Services	A	F	1449	11	3.34
Three Rivers Community Hospital	C	R	3039	18	3.27
Tillamook County General Hospital	A	R	1798	17	3.15
Tuality Forest Grove Hospital	B	M	942	6	2.49
Valley Community Hospital	B	M	1217	11	3.42
Wallowa Memorial Hospital	A	F	629	4	3.31
Willamette Valley Medical Center	C	M	2784	25	3.03

*F= frontier; R = rural; M = mixed urban and rural

¹¹ Data from Oregon Association of Hospitals and Health Systems, most recent (1997) audited financial reports, and Oregon Hospital Report, Office of Health Plan Policy and Research, January 1999

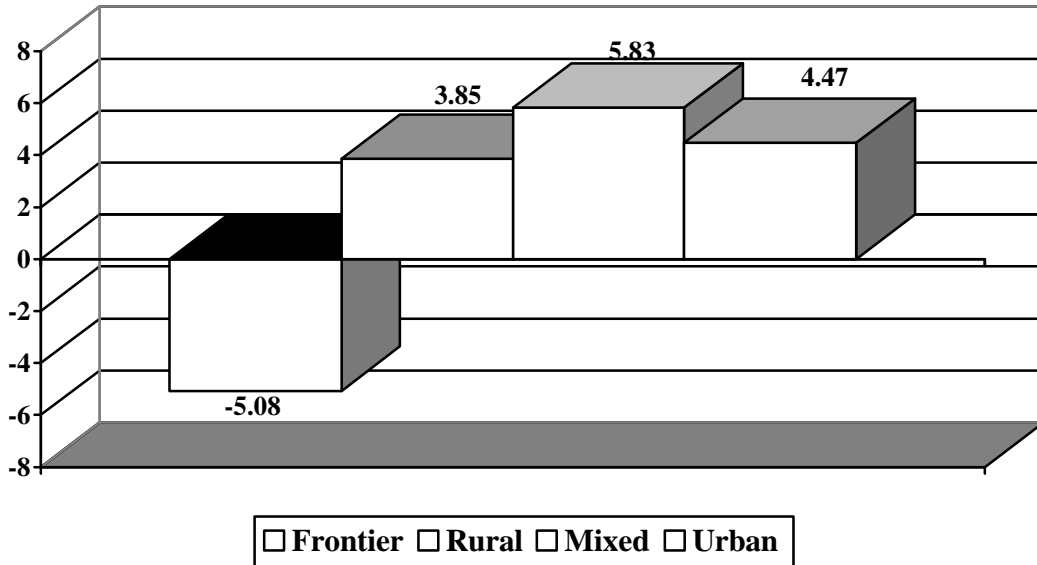
Rural Hospital Financial Data¹²

Hospital	Net operating revenue	Operating Expense	Net Operating Income	Operating Margin %	Bottom Line %
Albany General Hospital	\$31,951,072	\$29,667,569	\$2,283,503	7.15%	10.53%
Ashland Community Hospital	\$15,846,875	\$14,668,289	\$1,178,586	7.44%	9.32%
Blue Mountain Hospital	\$4,734,620	\$4,895,821	(\$161,201)	(3.40%)	7.97%
Central Oregon District Hospital	\$14,600,077	\$13,739,406	\$860,671	5.89%	9.77%
Columbia Memorial Hospital	\$18,967,557	\$16,528,773	\$2,438,784	12.86%	15.04%
Coquille Valley Hospital	\$3,743,972	\$3,801,000	(\$57,028)	(1.52%)	10.90%
Cottage Grove Community	\$18,233,524	\$18,611,091	(\$377,562)	(0.44%)	0.87%
Curry General Hospital	\$3,976,207	\$4,349,824	(\$373,617)	(9.40%)	(0.68%)
Douglas Community Hospital	\$28,122,924	\$27,911,320	\$211,594	0.75%	0.75%
Good Shepherd Community Hospital	\$19,540,270	\$18,356,528	\$1,183,742	6.06%	16.06%
Grande Ronde Hospital	\$22,289,837	\$19,236,367	\$3,053,470	13.70%	17.26%
Harney District Hospital	\$4,059,644	\$4,506,271	(\$446,627)	(11.00%)	0.91%
Holy Rosary Medical Center	\$31,183,030	\$28,769,496	\$2,413,534	7.74%	12.56%
Hood River Memorial Hospital	\$14,452,514	\$13,797,262	\$655,252	2.46%	5.15%
Lake District Hospital	\$3,845,184	\$4,316,860	(\$471,676)	(12.27%)	(3.73%)
Lebanon Community Hospital	\$23,694,930	\$22,330,463	\$1,364,467	5.76%	12.59%
Lower Umpqua Hospital	\$7,024,189	\$7,549,692	(\$525,503)	(7.48%)	9.71%
Mercy Medical Center	\$51,723,263	\$44,642,306	\$7,080,957	13.69%	13.00%
Mid-Columbia Medical Center	\$25,606,053	\$24,828,766	\$777,287	3.04%	3.94%
Mountain View Hospital	\$10,048,068	\$9,606,843	\$441,225	4.39%	7.45%
North Lincoln Hospital	\$19,269,400	\$20,040,612	(\$771,212)	(4.00%)	1.13%
Pacific Communities Hospital	\$20,147,818	\$19,735,379	\$412,439	2.05%	6.73%
Peace Harbor Hospital	\$15,810,917	\$13,892,792	\$1,918,125	12.13%	12.29%
Pioneer Memorial (Heppner)	\$4,263,395	\$4,999,140	(\$735,745)	(17.26%)	(5.11%)
Pioneer Memorial (Prineville)	\$8,899,991	\$8,904,552	(\$4,561)	(0.05%)	(0.05%)
Providence Newberg Hospital	\$14,161,119	\$14,078,475	\$82,644	0.58%	5.20%
Providence Seaside Hospital	\$10,474,837	\$10,441,898	\$32,939	0.31%	0.89%
Santiam Memorial	\$6,599,393	\$6,329,434	\$269,959	4.09%	4.19%
Silverton Hospital	\$15,538,282	\$13,531,073	\$2,007,209	12.92%	14.37%
Southern Coos General Hospital	\$2,611,326	\$2,613,785	(\$2,459)	(0.09%)	12.75%
St. Anthony Hospital	\$21,393,640	\$19,142,714	\$2,250,926	10.52%	15.97%
St. Elizabeth Health Services	\$12,033,154	\$12,508,729	(\$475,575)	(3.95%)	(1.84%)
Three Rivers Community Hospital	\$46,127,000	\$45,121,000	\$1,006,000	1.69%	2.18%
Tillamook County General Hospital	\$17,764,066	\$16,676,329	\$1,087,737	6.12%	6.13%
Tuality Forest Grove Hospital	\$10,041,013	\$11,213,053	(\$1,172,040)	-11.67%	-11.67%
Valley Community Hospital	\$12,934,842	\$12,306,962	\$627,880	4.85%	4.85%
Wallowa Memorial Hospital	\$4,456,981	\$4,477,043	(\$20,062)	(0.45%)	13.64%
Willamette Valley Medical Center	\$28,497,363	\$24,003,032	\$4,494,331	15.94%	15.94%

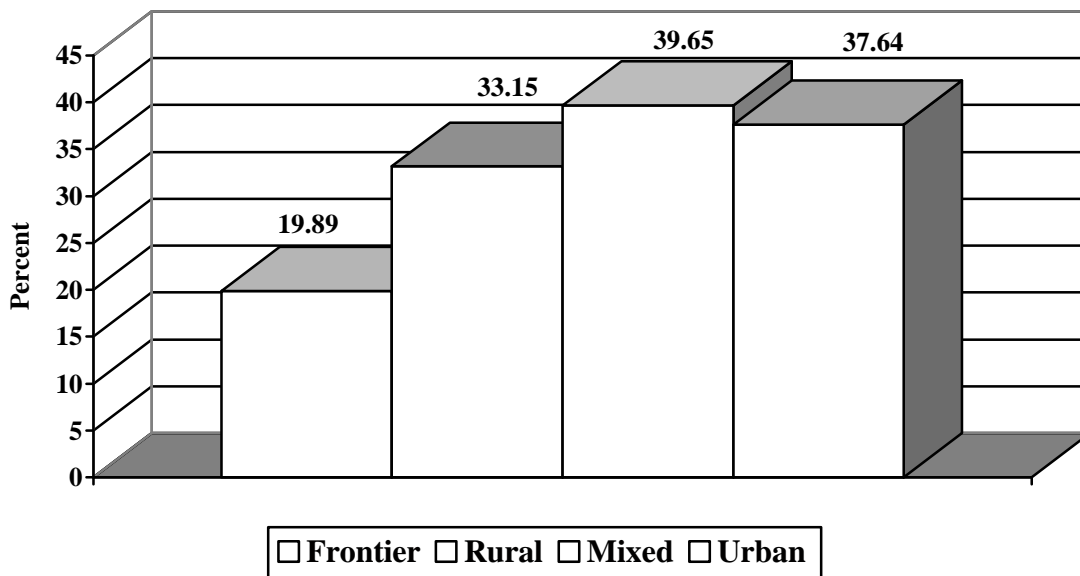
¹² Data from Oregon Association of Hospitals and Health Systems, most recent (1997 in most cases) audited financial reports

A more persuasive means of illustrating the differences among Oregon's hospitals is to compare hospitals located in frontier, rural, mixed urban/rural and urban counties:

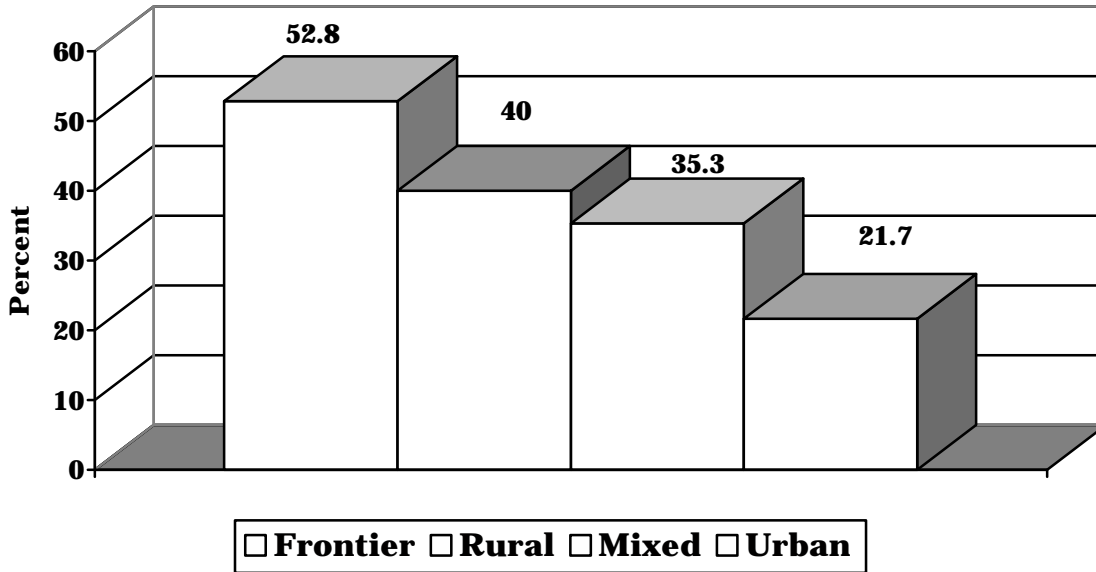
**Operating margin
by type of county, 1997**



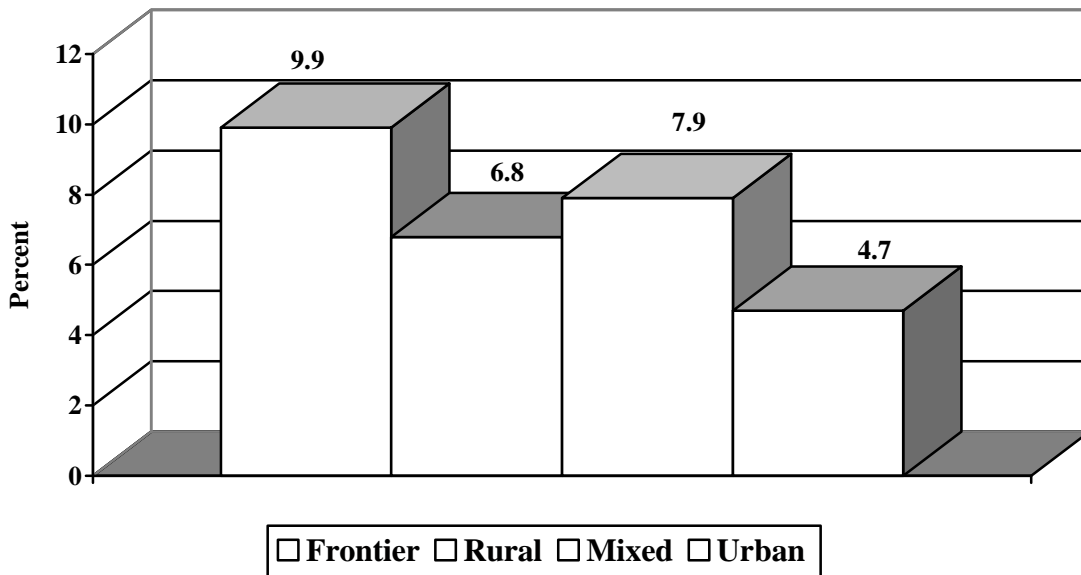
**Occupancy rate
by type of county, 1997**



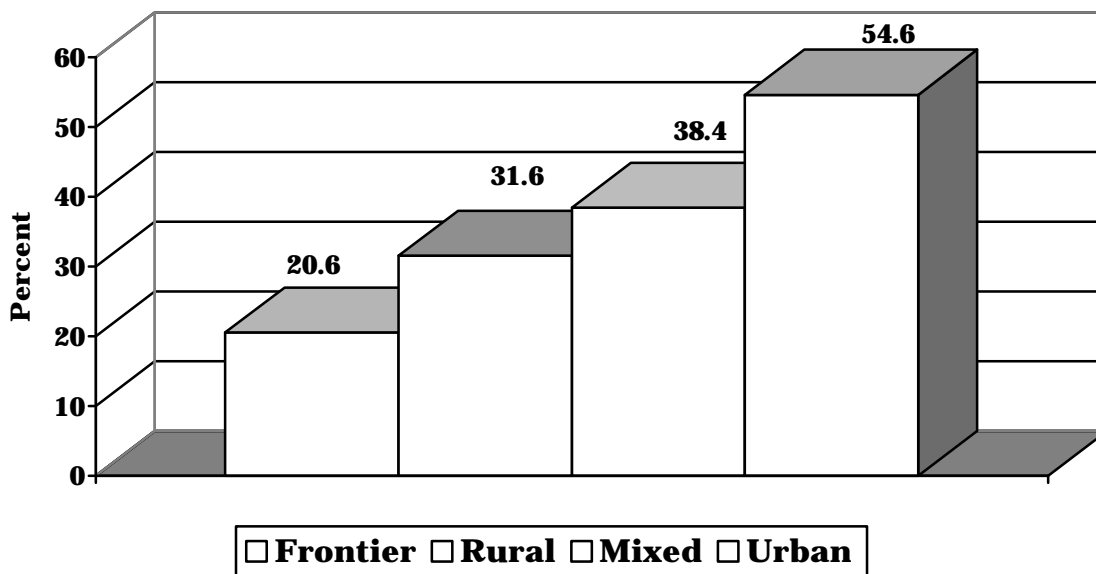
**Percent Medicare hospital inpatients
by type of county, 1994-96**



**Percent "self-pay" or non-sponsored hospital inpatients
by type of county, 1994-96**



Percent insured hospital inpatients by type of county, 1994-96



In conclusion, Oregon's hospitals face distinctively different challenges, depending on the type of county in which they are located:

- Hospitals located in frontier and rural counties have *lower operating margins*.
- Hospitals located in frontier and rural counties have *lower occupancy rates*.
- Hospitals located in frontier and rural counties have a *higher percentage of Medicare patients*.
- Hospitals located in frontier and rural counties have a *lower percentage of insured patients*.
- Hospitals located in frontier counties have a *higher percentage of self-pay or non-sponsored patients*.

According to the Office of Health Plan Policy and Research,¹³ “some rural hospitals have managed to survive on what appears to be sheer will. Coquille Valley Hospital was on the verge of closing in 1990 but has a much more optimistic future after combining a strategic plan, aggressive recruiting and a realistic assessment of what services were feasible for a small hospital. Lower Umpqua also faced closure following the collapse of the lumber and fishing industries and the resultant loss of population. Unwilling to give up their hospital, the community passed a bond issue to keep it open, physicians began actively recruiting for more doctors and a rural development bond was used for a major building project.”

¹³ Oregon Hospital Report, 1994-1996, Office for Oregon Health Plan Policy and Research, January 1999

Section VII. Affiliations, networks, mergers and acquisitions

Oregon's competitive health care market, coupled with the state Medicaid agency's determination to extend managed care statewide, has created dozens of new, and ever-changing, relationships among physicians, hospitals and health plans. Rural providers have been no less active than their urban counterparts in forming new affiliations. The following update on the most recent market activity has been duplicated verbatim from the Office for Health Plan Policy and Research report on Oregon hospitals, published in January 1999:

Excerpt from *Oregon Hospital Report*:

"There is at least one Independent Physician Association (IPA) in all but two of the state's 36 counties. Most were formed around 1993 to contract for OHP Medicaid clients. Since then, a growing number of IPAs are assuming responsibility for referral and utilization management programs, quality improvement and/or medical management systems. Not surprisingly, the relationships between hospitals and IPAs around the state are as diverse as the IPAs themselves.

- In Union County, the IPA and Grande Ronde Hospital have piloted their own managed care plan for hospital employees - Pioneer Health Assurance. Depending on the success of that venture, the PHO may become an integrated health network to expand its managed care plan and to challenge the entry of third party HMO organizations into Union County.
- In Umatilla County; Good Shepherd Community Hospital and the Oregon Trail IPA are discussing the formation of their own community health plan. They have organized themselves as Cascade East Health Plan and are applying for a license as a health services contractor.
- Hood River and Wasco Counties have been moving steadily toward creation of an inter-state Provider Sponsored Organization. A beginning step is the Columbia Gorge Community Health Network - a consortium made up of the Mid-Columbia Medical Center, Hood River Memorial Hospital and two hospitals on the Washington side of the Gorge. In addition to sharing administrative functions, the four hospitals now jointly invest merged savings, apply for grants, purchase medical and non-medical supplies and share a common formulary, re-credentialing forms, laundry, reference lab and common capital equipment budgets. (The pending purchase of Hood River Memorial Hospital by Providence Health Systems may affect this growing relationship.)
- In Lincoln County, North Lincoln Hospital, Pacific Communities Hospital and the Central Coast IPA formed Coastal Health Net, Inc. originally to contract for OHP Medicaid clients. However, the PHO anticipates expanding its functions to include referral and utilization management programs and quality improvement development.
- In Clatsop County, Columbia Memorial Hospital associated with Columbia Pacific IPA as Coastal Health Assurance. Providence Seaside Hospital has its own PHO with its physician employees.

- In Klamath County, Merle West Medical Center, Cascade Comprehensive Care (primary care physicians) and Klamath County IPA (specialists) are negotiating the joint purchase of the management company for the capitated Cascade Comprehensive Plan. The intent of the hospital and IPAs is to evolve into a PSO.
- In Josephine and Jackson Counties, Asante Health System (Three Rivers Community Hospital and Rogue Medical Center) have formed a for-profit business corporation with Ashland Hospital and the area's largest IPA, PrimeCare - Southern Oregon Health System, Inc. - to provide single signature authority on negotiations with managed care health plans.
- Douglas County has no formal PHO but with most of the physicians belonging to the Provider Sponsored Organization - Roseburg Health Enterprises, Inc. - there is a *defacto* integrated network of Mercy Hospital, and RHEI as both an IPA and insurer. Recently, a new 12-member physician group formed and is located at Roseburg's other hospital, Douglas Community Health Center. One of the stated intents of the new physician's group are to ensure that both hospitals remain viable.
- In Linn County, Lebanon Community Hospital and Mid-Valley Medical Group created a fully integrated network in 1995 - Mid-Valley Health Care, Inc.
- In Marion and Polk Counties, all primary care and specialist physicians belong to the Mid-Valley Independent Physicians Association. With no real competition between physician groups or between the four hospitals, Salem, Santiam, Silverton and Valley Community, no formal PHO relationship has been deemed necessary. Instead, they are all loosely affiliated in the Mid-Valley Health Consortium, which is a vehicle to provide better access to the full continuum of care and to achieve cost efficiencies.
- In the Portland Metropolitan area, most hospitals are linked in some way to the three largest delivery systems. The Legacy System, with four hospitals and a strategic link to a fifth, contracts with physician groups. The Providence Health System's three hospitals and Kaiser Hospital employ their physicians. Oregon Health Sciences University (OHSU) welded together a group practice from existing faculty practices to create five new primary care centers.
- Two suburban hospitals, Willamette Falls in Oregon City and Tuality Community Hospital in Hillsboro, have formidable PHOs which provide administrative support to physicians, contract with insurers and handle billing, utilization review and quality assurance functions.

The struggle for power and decision-making control in Oregon's managed care market took a new direction in 1996 with the creation of the 'homegrown' physician management company – Physician Partners Incorporated (PPI). PPI is jointly owned by the 291 member physicians of the Medford, Corvallis and Healthfirst (Portland) Clinics who transferred their 1600 person staff and all

assets to the new corporation. PPI made it clear from its inception that it intends to make “the doctor a driving force in managed care.” PPI’s influence may be matched by a new physician management company with a similar goal of ensuring that physicians “have an equal seat at the table” in healthcare decision-making. The merger of PhyCor and MedPartners has joined two national physician groups that will have nearly 200 physicians in Oregon with an affiliated network of more than 1000 doctors in the northwest area. It would appear that the relationship between Oregon’s hospitals and physicians will be even more complex as the struggle for the organizational, clinical and financial control of healthcare continues.

Oregon hospitals increasingly are associating themselves with other hospitals although generally not through full-blown mergers or acquisitions.

Today, 51 of the state's 60 general hospitals are part of larger network. Twenty-four hospitals are part of regional or multi-state health systems including Legacy Health System (four hospitals), Providence Health System (six hospitals), Adventist Health System (two hospitals), Catholic Health Initiatives (four hospitals), Columbia/HCA (two hospitals), PeaceHealth (three hospitals) and New American Healthcare Corporation (two hospitals). The other twenty-seven hospitals are part of very different regional associations.

- The Asante Health System is an integrated health network involving Rogue Valley (Medford) and Three Rivers (Grants Pass).
- The Central Oregon Hospital Network (CONet) is a loose association of hospitals in seven counties that began as a vehicle for risk sharing with HMOs but is increasingly developing telemedicine capacity for the smaller rural hospitals. Although CONet is dominated by St. Charles Medical Center (Bend) by virtue of its size and capacity, each member hospital retains its community identity.
- Columbia Gorge Health Network includes two Washington hospitals across the Columbia River from Hood River Hospital and Mid-Columbia Medical Center. The network aspires to become a provider-sponsored organization for the gorge community.
- The Inter-Community Health Network (Albany, Good Samaritan and Lebanon Hospitals) manages OHP Medicaid contracts for Linn and Benton counties as well as mental health contracts and workers compensation.
- Samaritan Health Services is an integrated health network that includes Lebanon Community Hospital, Good Samaritan Hospital and Pacific Communities Hospital.
- Southern Oregon Health Systems is a for-profit business corporation to negotiate managed care contracts for Ashland Hospital, Rogue Valley Medical Center and Three Rivers Community Hospital.
- Tuality Health Care is an integrated health network that includes Tuality Community Hospital (Hillsboro) and Tuality Forest Grove Hospital.

Most of the remaining unaligned hospitals are rural hospitals that have created hospital districts.”

The willingness of Oregon health care providers to affiliate and the relative sophistication employed to develop new organizations, even in the most rural parts of the state, are reliable predictors of success for the Medicare Rural Hospital Flexibility Program. Oregon's hospitals are aware of the benefits to be derived from networks and the MRHFP networking requirement will not be a barrier to successful participation in and implementation of this program.

Following is a list of all currently identified hospital networks in the state and makes note of their rural participants.

Oregon Hospital Systems with Member Hospitals

Adventist Health System

- Adventist Medical Center
- Tillamook County General Hospital*

Asante Health System

- Rogue Valley Medical Center
- Three Rivers Community Hospital*

Catholic Health Initiatives Western Region

- St. Elizabeth Health Services*
- St. Anthony Hospital*
- Mercy Hospital*
- Holy Rosary Medical Center*

Columbia/HCA

- Douglas Community Hospital*
- Willamette Valley Medical Center*

Central Oregon Hospital Network

- Blue Mountain Hospital*
- Central Oregon District Hospital*
- Harney District Hospital*
- Lake District Hospital*
- Mountain View Hospital*
- Pioneer Memorial Hospital (Prineville)*
- St. Charles Medical Center

New American Healthcare Corp.

- Eastmoreland General Hospital
- Woodland Park Hospital

PeaceHealth Oregon Region

- Sacred Heart Medical Center
- Peace Harbor Hospital*
- Cottage Grove Comm. Hospital*

Providence Health System

- Medford Medical Center
- Milwaukie Hospital
- Portland Medical Center
- Newburg Hospital*
- Seaside Hospital*
- St. Vincent Medical Center

Samaritan Health Services

- Lebanon Community Hospital*
- Good Samaritan Hospital
- Pacific Communities Hospital*

Southern Oregon Health Systems

- Asante Health System
- Ashland Hospital*
- PrimeCare

*rural hospital

Columbia Gorge Health Network

- Mid-Columbia Medical Center*

Tuality Health Care

- Tuality Community Hospital

Hood River Memorial Hospital*	Tuality Forest Grove Hospital*
Skyline Hospital (White Salmon, WA)*	<u>Willamette Health Care Alliance</u>
Klickitat Valley Hospital (Goldendale, WA)*	Salem Hospital
<u>Inter-Community Health Network</u>	Santiam Hospital*
Good Samaritan Hospital	Silverton Hospital*
Albany Hospital*	Valley Community Hospital*
Lebanon Community Hospital*	
<u>Legacy Health System</u>	
Emanuel, Good Samaritan	
Meridian Park, Mount Hood	

*rural hospital

In summary, Oregon may be a bell weather for other states in the rapid transition of its health care environment from a series of mostly independent entities to a series of health systems. The word which best describes the last five years in the Oregon health care market is “affiliation,” in both urban and rural areas.

These affiliations have obviously been stimulated by the rapid growth of managed care, which in rural markets, is mostly confined to the Oregon Health Plan. Oregon is currently in the midst of a debate over the workability of managed care in rural areas, as health plans dispute the feasibility of continuing to reimburse rural hospitals on a cost basis, and at the same time, offer physicians reasonable capitation rates and/or fees. While rural hospitals and their medical staffs have historically enjoyed an amicable relationship in Oregon, dissension over reimbursement is straining that relationship, both professionally and politically.

While the legislature considers either abolishing cost-based reimbursement, especially for Type B hospitals, the Governor has appointed a task force to consider options for insuring the continued fiscal sustainability of rural hospitals. Additionally, the Office for Oregon Health Plan Policy and Research has announced its intention to explore alternatives to capitated managed care for rural areas.

Section VIII. Oregon's Rural Hospital Flexibility Program

Background: Oregon began planning for the Medicare Rural Hospital Flexibility Program in July 1998, when the first meeting of the MRHFP working group was held at the offices of the Oregon Association of Hospitals and Health Systems (OAHHS). Members of the working group include OAHHS staff, Office of Rural Health staff and members of the OAHHS Small and Rural Hospital Committee. Other partners during the planning process have included staff from the Department of Human Resources, Oregon Health Division (OHD) and Oregon Medical Professional Review Organization (OMPRO).

During the planning process, it became clear that several rural Oregon hospitals might potentially benefit from conversion to a Critical Access Hospital (CAH). Oregon's highly competitive managed care environment, coupled with a political climate that values efficiencies in health care delivery, places additional stressors on small rural hospitals. Modifications in hospital Medicare reimbursement enacted by the Balanced Budget Act of 1997 have also lent a sense of urgency to seeking long term solutions for some of Oregon's troubled rural hospitals.

The working group reached consensus that, in addition to the federal requirements for Critical Access Hospital certification, Oregon should develop state-based criteria for designation as a "necessary provider" of health services.

Statutory/Regulatory Issues:

Early meetings with the Oregon Health Division's Office of Health Care Licensure and Certification resulted in the conclusion that statutory changes would not be necessary to implement the Oregon Medicare Rural Hospital Flexibility Program. Oregon's hospital licensing procedures provide for a unique facility, the "special inpatient care facility," which is defined in both statute and administrative rule as a "hospital." The relevant administrative rule is cited below:

"OAR 333-071-0000 Licensing Procedures and Definitions

As used in OAR Chapter 333, Division 71, unless the context requires otherwise, the following definitions apply:

- (1) "Health Care Facility" (HCF) has the meaning given the term in ORS 442.015, and includes but is not limited to the following classifications:
 - (a) "Hospital" means an establishment with an organized medical staff with permanent facilities that include inpatient beds, and with medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for, but not limited to, acutely ill patients and accident victims, or to provide treatment for the mentally ill or to provide treatment in special inpatient care facilities. "Special inpatient care facilities" are facilities with inpatient beds and other facilities designed and utilized for special health care purposes, to include but not be limited to: Rehabilitation center,

college infirmary, chiropractic facility, facility for the treatment of alcoholism or drug abuse, freestanding hospice facility, infirmary for the homeless, or inpatient care facility meeting the requirements of ORS 441.065, and any other establishment falling within a classification established by the Division, after determination of the need for such classification and the level and kind of health care appropriate for such classification.”

A special task force was formed by the Health Division to draft the necessary modifications to Oregon administrative rules, and its first meeting was held on January 26, 1999. The following issues were matters of special concern to the Oregon Health Division staff, and were considered and discussed:

- *If Medicare Conditions of Participation (CoP) require that all Medicare and Medicaid beneficiaries be admitted to the hospital by a physician, then how can a nurse practitioner, advanced practice nurse or physician assistant admit a patient to a CAH?*

Resolution: Consultation with HCFA staff clarified that “a nurse practitioner or PA can admit a patient to a CAH, but the physician must be notified (by phone or other appropriate means) and be aware of the admission and in agreement with it.” (E-mail from Marjorie Eddinger, HCFA, 1/25/99)

- *Are surgical services mandatory for a CAH? The rules seem to imply that they are not optional.*

Resolution: “Surgical services are optional in a CAH. If a CAH decides to provide surgical services, they must meet the CoP. They are not required to offer surgical services and, in fact, many facilities will not.” (Eddinger)

- *Hospitals in Oregon are required to have 24-hour nursing services unless a waiver has been granted. CAHs, however, must have nurses on duty only when patients are present.*

Resolution: No resolution of this issue has yet been reached. OHD licensing staff has expressed concern regarding quality of care in a CAH if a patient presents with no nursing staff on duty. Oregon may choose to adopt more stringent requirements than those imposed by HCFA and require 24-hour nursing services in those facilities that do not have an adjacent nursing home.

- *The CAH regulations at 485.618(d) state that a practitioner must be on-site within 30 minutes when a patient arrives for emergency care. Who calls the practitioner? If there are no inpatients, there is no requirement for nurses to be on duty.*

Resolution: OHD staff remains concerned regarding the potential for emergency patients to arrive at a non-staffed CAH. Members of the task force suggested that calling 911 would “activate” the system and result in a practitioner being called. This would not, however, address the issue of a patient who does not call 911 before arriving. No resolution of this issue has been reached, but if 24-hour nursing were required by state rule, then it would be resolved to the Health Division’s satisfaction.

Further meetings of the task force have produced the necessary modifications to administrative rule and the OHD is in the process (7/99) of distributing the proposed rules for public comment. Given the required time lines for publication and comment, rules could conceivably be in place by September 1, 1999.

Potential candidates for CAH conversion that are also participants in the statewide trauma system have expressed concerns regarding their status as designated Level IV trauma hospitals. Meetings with Oregon Health Division trauma system staff have resulted in a commitment to preserve the state’s trauma system by (1) allowing waivers to CAHs; or (2) establishing a new Level V category to allow continued participation by CAHs.

State Criteria for Determining Necessary Providers of Health Care Services: The following criteria are proposed for determining a “necessary provider of health care services.”

A rural hospital that does not otherwise meet the Federal mileage requirements to be certified as a Critical Access Hospital and is otherwise eligible to become a CAH will be certified by the State as a “Necessary Provider of Health Services” if the facility meets the following criteria:

- The hospital is located in an area that is defined as “rural” by the Office of Rural Health; and
- The hospital is located 20 or more highway miles from another acute inpatient care facility; and the hospital meets one of the following criteria:
- The Office of Rural Health has determined that the facility is located in an “area of unmet health care need” through its authority granted by ORS 442.555(4); or
- The hospital is located in an area that meets the criteria for designation as a Health Professions Shortage Area (HPSA) or Medically Underserved Area (MUA).

In addition, any hospital determined to be a “necessary provider” must demonstrate that it is substantially at risk for imminent closure due to loss of physician staff or fiscal crisis.

Justification for “necessary provider of health care” criteria: Oregon is a very rural state. The majority of its population and its health care workforce is clustered around the Interstate 5 corridor, which bisects the western half of the state from

the north to the south. In considering issues of access to health care, one must review not only the adequacy of health care workforce, but also the geographic, topographic and climatic challenges that may exist. While 20 miles' distance may appear easily attainable when viewing a map, Oregon's coastal and mountainous communities often experience sudden and prolonged isolation during seasonal rain and snowstorms. At the same time, fragile rural hospitals within 20-35 miles of one another may be most at risk of closure because of market share, selective contracting practices and other economic pressures. Maintaining access to basic hospital services in these areas is a high priority of Oregon's Office of Rural Health.

The Office of Rural Health also recognizes that the intent of Congress was to make this program available to those facilities and populations that are most at need. Consequently, the Oregon criteria contain additional safeguards to assure that congressional intent will be honored, and that no abuses of this program will occur.

Critical Access Hospital Designation Criteria: As outlined in the 1997 Balanced Budget Act, to be eligible as a CAH, a facility must be a rural public or nonprofit hospital located in a state that has established a MRHFP, and must be either located more than a 35-mile drive from any other hospital or CAH or certified by the state as being a necessary provider of health care services to residents in the area. In mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles.

In addition, the facility must make available 24-hour emergency care services, provide not more than 15 beds for acute (hospital-level) inpatient care, and keep each inpatient for no longer than 96 hours, unless a longer period is required because of inclement weather or other emergency conditions, or a PRO or other equivalent entity, on request, waives the 96-hour restriction. An exception to the 15-bed requirement is made for swing-bed facilities, which are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or SNF-level care, provided that not more than 15 beds are used at any one time for acute care. The facility is also required to meet certain staffing and other requirements that are enumerated in CFR Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs).

The BBA defined a rural health network as an organization consisting of at least one CAH and at least one acute care hospital, the members of which have entered into agreements with at least one other member regarding patient referral and transfer, the development and use of communications systems, and the provision of emergency and nonemergency transportation. In addition, each CAH in a network must have an agreement for credentialing and quality assurance with at least one hospital that is a member of the network, or with a PRO or equivalent entity, or with another appropriate and qualified entity identified in the rural health care plan for the state.

State-specific criteria: In order to satisfy Oregon state requirements for designation as a CAH, a hospital must first agree to meet all Federal requirements for designation. Additionally, the facility must agree to the following state-specific criteria:

- The hospital must be able to demonstrate that a thorough fiscal assessment has determined that conversion to a CAH will be fiscally appropriate.
- The hospital must demonstrate that a community needs assessment has occurred, and indicated that conversion to a CAH is in the best interests of the community.
- The hospital must demonstrate that public notice of the intent to convert to a CAH has occurred, and that the community substantially agrees with the plan.

State Designation Process:

1. Hospitals interested in designation as a CAH will forward an application to the Office of Rural Health, where staff will determine the applicant's ability to meet all federal and state criteria for designation as a CAH. Deficient applicants will receive technical assistance to meet necessary criteria.
2. The Office of Rural Health will forward completed applications to the Oregon Health Division, Health Care Licensure and Certification. Applicants will be notified that their applications have been forwarded.
3. Upon determination that all state and federal requirements have been met, the Health Division will then survey the hospital. Within 60 days, recommendation for acceptance or denial of the application will be made and the hospital notified by the Health Division.
3. If deficiencies are noted in the survey, the Health Division will notify the applicant of specific concerns, and with the participation of state Office of Rural health staff, will assist applicants in correcting deficiencies where possible.
4. The Health Division will forward documentation to HCFA that verifies that the hospital meets all CAH eligibility criteria.

Federal funds available in July 1999 from the Federal Office of Rural Health Policy to the State Office of Rural Health will allow SORH/MRHFP staff to:

1. *Inventory prospective program participants.*

Facilities with an average daily census of less than 10 patients and an average length of stay of approximately 96 hours, or eligible facilities that have been determined to be in financial crisis will be identified as potential candidates for conversion to a CAH.

2. *Work with communities to inform them of the CAH option.*

SORH staff will promote the program by preparing written information and dedicating space to the program on the office's web page. Staff will be available to present information to hospital staff and boards, and at professional association and service club meetings. Assistance will be provided to communities wanting to organize local planning sessions.

3. *Provide technical assistance to potential applicants.*

SORH program staff will work directly with hospitals interested in establishing CAH networks. Technical assistance will be provided in conducting community needs assessments and fiscal analyses, as well as meeting all state and federal assurances.

Monitoring and Evaluation: SORH staff, in consultation with the Health Division and the Oregon Association of Hospitals and Health Systems (OAHHS), will develop a monitoring/evaluation tool.

On an annual basis, program staff will assess each CAHs performance and provide technical assistance to meet MRHFP goals if necessary. Results of monitoring activities will be published in an annual report, which will be distributed to program participants, OAHHS, Health Division and other interested parties.

Assurances:

In a memo dated November 4, 1997, the HCFA Director instructed regional offices that MRHFP state plans must contain at least the following assurances:

- That the State has developed, or is in the process of developing, a State rural health care plan that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the State, and improves access to hospitals and other health services for rural residents of the State.
- that the State has developed the rural health care plan in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such a plan, assurances that the State will consult with these organizations); and
- That the State has designated or is in the process of designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals.

Assurance #1: This plan has identified existing rural health networks in the state of Oregon and has noted that several rural hospitals remain unaffiliated. In the event that an unaffiliated rural hospital applies for CAH status, the application will not be approved without written evidence of the existence of a networking relationship with another hospital, as defined in the BBA. The planning process for each individual CAH will include, as part of the community needs assessment, identification and facilitation of new network relationships that meet BBA criteria and the hospital's participation in regional delivery of health care services. The purpose of the CAH program is to insure that rural residents continue to have access to quality health care. By participating in and promoting this program, Oregon will have another tool at its disposal to assist rural Oregonians in

stabilizing their health care systems, including primary care, emergency care, preventive care and hospital services.

Assurance #2: Appendix Number Two lists OAHHS staff and rural hospital administrators who participated on the MRHFP planning work group.

Assurance #3: This plan proposes a mechanism through which Oregon hospitals may become certified as Critical Access Hospitals. Hospitals that have been tentatively identified as potential candidates for conversion include:

- Pioneer Memorial Hospital in Heppner (Morrow County)
- Southern Coos Hospital in Bandon (Coos County)
- Wallowa Memorial Hospital in Enterprise (Wallowa County)
- Cottage Grove Hospital in Cottage Grove (Lane County)
- Curry General Hospital in Gold Beach (Curry County)
- Harney District Hospital in Burns (Harney County)

Timelines: Oregon planners expect to have the necessary administrative rules in place to implement this program by September 1, 1999. Federal funds released in July 1999 will allow the SORH to hire program staff to assist hospitals in their application process by September 1, 1999. A detailed time line for SORH/MRHFP staff is included as an appendix to this report.

Appendix One
Rural Health Coordinating Council Roster

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Appendix Two
Roster of Members, RHFP Planning Work Group

Dan Field, General Counsel, Oregon Association of Hospitals and Health Systems

Karen Whitaker, Director, Oregon Office of Rural Health

Randy Scholten, Administrator, Curry General Hospital

Kim Dahlman, Administrator, Wallowa Memorial Hospital

Susan Brock, Administrator, Pioneer Memorial Hospital, Heppner

Dan Grant, CFO, Pioneer Memorial Hospital, Heppner

Jim Wathen, Administrator, Southern Coos General Hospital, Bandon

APPENDIX THREE: TIMELINES FOR IMPLEMENTATION OF RURAL HOSPITAL FLEXIBILITY PROGRAM			
ACTIVITY	RESPONSIBLE PERSON	ACTIVITY INITIATED	ACTIVITY COMPLETED
Respond to HCFA comments on plan	Karen Whitaker	5/15/99	8/15/99
Distribute copies of approved plan to interested parties, post to website	Karen Whitaker Marilyn Grendele	9/1/99	ongoing
Recruit for project coordinator position	Linda Pepler, Office Manager, ORH	7/15/99	9/15/99
Hire project Coordinator	Linda Pepler Karen Whitaker	8/15/99	9/15/99
Inventory emergency medical resources in rural areas	Andrew Jannsen (student intern)	7/1/99	8/30/99
Notify rural hospitals of program and availability of assistance	project coordinator	10/1/99	12/1/99
Identify prospective participants by reviewing hospital data and responses from notification	project coordinator	10/15/99	ongoing
Begin face-to-face meetings with organizational stakeholders	project coordinator	10/20/99	ongoing
Develop necessary application materials in consultation with Health Division	project coordinator	10/20/99	11/15/99
Make initial site visits to interested communities, meet with stakeholders	project coordinator	11/1/99	ongoing
Issue "RFQ" to solicit interested consultants, review responses	project coordinator	11/1/99	11/30/99
Develop needs assessment tool	project coordinator	11/15/99	11/30/99
Begin community meetings and needs assessments	project coordinator	12/1/99	ongoing
Develop evaluation instrument for program	project coordinator	12/1/99	12/30/99