Rural Health Coordinating Council (RHCC)
January 15, 2015, 8699 SW Sun Place, Wilsonville, OR

Roll Call & Introductions
Andrea Fletcher, Chair, began the meeting at 10 AM.

Members in Attendance
Gary Brooks, DMD, Oregon Dental Association (ODA); Bruce Carlson, Oregon Medical Association (OMA); Pam DeViss, FNP, Oregon Nurses Association (ONA); Wayne Endersby, Oregon EMS Association; Andrea Fletcher, Consumer – Eastern Oregon HSA #3; Heather Lewis, Consumer – Eastern Oregon HSA #3; Candye Parkin, Oregon Association for Home Care; Michael Patrick, Oregon State Board of Pharmacy; Judy Peabody, Oregon Association of Naturopathic Physicians; David Robinson, Oregon Health and Science University (OHSU)[by phone]; and Troy Soenen, Oregon Association of Hospitals & Health Systems (OAHHS).

Oregon Office of Rural Health (ORH) Staff
Robert Duehmig, Scott Ekblad and Eric Jordan.

Q = Question, A = Answer, C = Comment

Approval of January 2015 Agenda
The January 2015 Agenda, with the addition of an Oregon Rural Health Association (ORHA) update, was moved by Mr. Endersby, seconded by Mr. Patrick, and approved unanimously.

Approval of October 2014 Minutes
The October 2014 minutes were moved by Mr. Patrick, seconded by Ms. Parkin, and approved unanimously as corrected: on page 6, the limitation answer should read: “No, the limitation on narcotics should be on non-malignant pain only.”

ORH Updates

Apple a Day Update
Mr. Ekblad relayed an update on the Apple A Day Grant Program. The annual fundraiser raised just shy of $10,000. That money plus rollover funds from the previous year amounts to almost $17,000, which will go toward three cycles for 2015: two individual EMT cycles (Cycle 14 – Monday, January 5, 2015 to Friday, February 6, 2015, and Cycle 15 – Monday, August 3, 2015 to Friday, September 4, 2015) and one agency cycle (Cycle 5 – Monday, March 2, 2015 to Friday, April 3, 2015).

Q: [Dr. Carlson] Is that amount raised at the event lower than previous years?
A: [Mr. Ekblad] Yes. We had fewer auction items this year. In addition, the office was in flux over the spring and summer, so we had less time and fewer resources to spend on the event. We hope to be able to hire someone to organize this and the annual conference.

Personnel and Rural Needs
Mr. Ekblad gave an overview of the Field Services Team’s history and where the scope of their work is headed based on grant requirement, specifically the Medicare Rural Hospital Flexibility Program (Flex grant). There is a new 3-year Flex grant submission underway. The scope of this grant has
changed considerably since its last cycle, and this needs to be reflected in our staff’s focus. Our recently hired Clinical Technical Assistance (TA) person found that the position does not match his interests, and has given lengthy advance notice of his resignation. With this position opening, we will be revising the two TA staff’s positions and duties. One will be focused on quality and other benchmark measures, the other on community engagement.

Mr. Ekblad has reached out to the other State Offices of Rural Health (SORHs) regarding these changes and how they are handling their staffing needs. It turns out that the concept of having a dedicated Flex grant coordinator is an antiquated one among some SORHs. Many of the Offices are also aligning their workforce based on the work that is currently expected of us. He brought this item to the RHCC to see what technical assistance needs there might be in their areas of the state.

C: [Ms. DeVisser] I’d like to see that ORH is coordinating with other rural health bodies that might be providing services to the state.
A: [Mr. Ekblad] We are doing a better job of that than we ever have before. For instance, OHSU has moved several statewide outreach departments physically under one roof at the South Waterfront District in Portland, where we are all now meeting more regularly.

C: [Dr. Carlson] Working with Rural Health Clinics (RHCs). The RHC Workshop has always been a huge resource for as long as it has been held. There has always been a tremendous thirst for information and resources by these clinics.
A: [Mr. Ekblad] That is one of the things I am struggling with in this potential change in staff: I see the value in maintaining a position that focuses on the clinics and their needs. We’re just going to have to think a bit broader than that with the position description.

C: [Troy Soenen] With the recent uptick in RHCs, this might be a great time to reengage the RHC group. There are almost 80 of them now, so the landscape is different from when there were only about half of that and we could not get them engaged in the rural listserv.

Q: [Mr. Endersby] Are there states similar to ours that are rearranging their TA in the same way?
A: [Mr. Ekblad] It’s a mixed bag. Most SORHs are in state government, so they have really small staff. I got great feedback from Michigan and Kansas.

C: [Dr. Carlson] Having gone to a lot of national meetings, I see Oregon as being a leader in what has to be done. While you could always do better, I see Oregon as ahead of the curve.

C: [Mr. Soenen] I want to stress that one should not minimize the amount of work that clinics need, just the basic program, nuts and bolts type of practice help is what I’d stay mindful of. Even with all of the transformation work that needs to be done, they still need help with the basics of running a successful practice.

Q: [Ms. Fletcher] Following up on Dr. Carlson’s and Mr. Soenen’s comments – is it clinic turnover that leads to these basic operational problems?
A: [Dr. Carlson] I think it is two-fold. Finding people from a community’s employment pool who are
“quick studies” is very important. But often times it is the providers who have the training for running a practice, who then have to train their office staff on things such as billing, etc.

Mr. Ekblad went on to describe the early planning process for the Annual Oregon Rural Health Conference. The ORH is planning to issue a call for presentations. It will be made clear that this is not a call for sales pitches. Please keep your eyes open for the announcement via email and help us spread the word.

C: [Dr. Carlson] I would suggest sending a questionnaire to just the RHCs for what they might want and/or need at the RHC workshop.

C: [Mr. Soenen] I would definitely make sure you are asking clinic administration and the practitioner specific questions relating to their professions. One set will not fit both ends of a clinical practice.

C: [Ms. DeVisser] I've always liked a best-practices session. Perhaps asking the clinics to present 5- to-10 minutes on theirs would be a great topic.

C: [Dr. Brooks] I'd like to see a community medic program session.

**Clinicians for Rural Track Students**

Julie Hoffer, ORH's Workforce Services Specialist, is working with students enrolled in rural tracks at OHSU's Schools of Medicine and Nursing, COMP-NW School of Medicine and Pacific University's PA Program. She wonders if RHCC members know of rural practitioners who would be appropriate and willing to speak to these students. The presentations need not be in person; they can be done through the Internet or by video conference.

Q: [Ms. Fletcher] Any particular discipline or specialty?
A: [Mr. Ekblad] Just about any.

Q: [Mr. Endersby] Is there a timeline?
A: [Mr. Ekblad] We welcome these suggestions anytime. The ORH Workforce team is already working with the various schools.

Q: [Ms. DeVisser] Are you all working with the University of Portland's School of Nursing?
A: [Mr. Duehmig] No, they do not have a rural training track.

C: [Ms. DeVisser] But they have to place the students into rural for rotations. They do not have enough urban preceptors to work with them otherwise.

If you know of anyone who would be a great presenter, please contact Julie Hoffer | hoffer@ohsu.edu, or Bob Duehmig | duehmigr@ohsu.edu, both at 503-494-4450 or toll-free 866-674-4376.
Oregon Rural Health Association Update
Mr. Duehmig provided a brief update on recent changes at the ORHA. There are two new board members: one is the Dean of Instruction at Clatsop Community College, the other is an administrator from Grants Pass Women’s Health Center. There might be one more seat opening up in the summer. The ORHA recently received a National Rural Health Association (NRHA) grant. At the next meeting we’ll look at the legislative agenda for the members.

Mr. Ekblad clarified the difference between ORH and ORHA. ORH is a statewide public service organization located at OHSU, while the ORHA is a 501(c)6 non-profit membership organization that advocates for rural health policy at the state level.

Old Business

Preauthorization Paper
Dr. Miller spoke at the October RHCC meeting about the idea of using quality measures put forth by the National Committee for Quality Assurance (NCQA) to forego pre-authorization requirements. Dr. Miller cannot be here today but will draft a paper for the RHCC.

C: [Dr. Carlson] As a provider, we deal with pre-authorization for different situations, be it durable goods, drugs, or surgery. There are certain things the Oregon Health Plan (OHP) doesn’t cover. For instance, an adult hernia patient with no complications, that patient is not covered. If that patient is under the age of 18, they are covered. Most physical therapy is also not covered by OHP.

C: [Ms. DeVisser] I remember the conversation also being along the line of referrals, so that past experience or work could minimize future work by establishing a protocol based on previous work.

C: [Dr. Brooks] We have the same thing in dentistry with commercial insurance companies. With employers changing plans to save money, we have to start all over again, as the covered individual has had their plan changed on them.

Legislative Session

ORH Legislative Report
The Oregon Legislature convened earlier this week, and is now out until early February. Our top agenda item is the rural incentive programs. One legislator, Representative Nancy Nathanson, is frustrated that reauthorization and/or funding recommendations for the various programs are done in different committees. She has drafted a legislative concept to create a singular fund, merging multiple incentive programs, that would enable ORH to distribute the monies according to need each year.

Conceptually it makes sense, but the logistics are another matter. It could prove that merging these programs under a single fund will negate the intended purposes of individual programs, as they were initially created to meet different needs and goals. For instance: Loan Forgiveness is for communities to be able to grow their own practitioners to meet their localized needs, while Loan Repayment is to attract out-of-state practitioners who want to serve Medicaid patients. The Rural
Practitioner Tax Credit really works best as a retention tool for rural communities, while Liability Reinsurance assists those specialties for whom malpractice costs can be prohibitive.

Mr. Ekblad, Mr. Duehmig and Doug Barber, lobbyist for ORHA, met with Representative Nathanson to discuss what the wording of this legislative concept would actually do. She was agreeable to proposed changes and is also willing to work with us on any proposed changes to the tax credit program.

C: [Ms. DeVisser] There are two things that bother me. One is that, with the Ways and Means Committee, there is an awful lot of power in too few people. The other is that usually it is senior Legislators that end up on Ways and Means, but if there is turn-over, that leads to a great burden for its members to know what is going on, all the while being lobbied by special interest groups.

Speaking to these frustrations, Mr. Duehmig illustrated the path for these proposals. Loan Repayment first goes to the Health Committee, as it is specific to health providers. The policy discussion will happen there, if approved it goes to the Way and Means Health Subcommittee, before moving on to the full Ways and Means Committee. With Loan Forgiveness, as it is student-centric, it goes to the House Education Committee, then to the Ways and Means Education Subcommittee, then to the full Ways and Means. That these two bills begin in different Committees means that they will not be debated or discussed together. That will not happen until they are both at the full Ways and Means. One of Representative Nathanson's points is that, as a result, there is not a comprehensive view of these programs and decisions regarding them are made individually as sunsets and requests for funding come before the Legislature.

The Oregon Health Policy Board’s Workforce Committee was tasked with determining which incentive programs provide the best results. The committee determined that we do not collect enough data or conduct the structured evaluation necessary to determine which program(s) derive the best return on investment. We propose that there be a true data collection and analysis period before any changes are made, but it seems some Legislators are not patient enough to wait for that.

Take the Loan Forgiveness Program for instance. We won’t know the impact of that program until the students have completed their training and are practicing rurally, and that won’t happen for several years. The Legislators are not interested in maintaining status quo for another four years.

Q: [Mr. Soenen] Does each loan program have equal demand?
A: [Mr. Duehmig] Looking back, we could have combined the funds for both Loan Repayment and Loan Forgiveness and used it all for Loan Repayment. But that program is for importing people, whereas Loan Forgiveness is intended to cultivate the employment pool from within the state, so you would miss out on the long-term investment opportunity. We need both strategies.

The good news is that the motivation behind these bills does not appear to be fiscal. That will likely change if we get into a kicker scenario this year.
Mr. Duehmig went on to note that there will also be a bill that expands the telehealth services that insurance companies must pay for; specifically, a visit wherein the patient is at home rather than in a clinic setting.

**RHCC Member Legislative Report**

Mr. Ekblad asked the assembled RHCC Members to highlight their organization’s legislative agendas.

Ms. DeVisser noted that the ONA’s legislative agenda is:

- Safe nurse staffing in hospitals. This issue has been ongoing for some time now.
- Maintaining Registered Nurses (RNs) on blood drives. The Red Cross wants to do away with RNs on blood drives, which the ONA sees as a public health safety issue.
- Public health sick days: getting low-wage workers to be able to accrue sick days if they are not already.
- Improving access to school nurses. In 2009, the Legislators mandated a ratio of 1 nurse to 700 students. 1:4000 is the current nurse-to-student ratio.

**Q:** [Mr. Ekblad] Does the school district pay for the school nurse?

**A:** [Ms. DeVisser] Yes.

- The practitioner incentive programs previously mentioned are also on the agenda.
- Equal payment for services: bill for the diagnosis not the license is something that continues. Insurance companies are finding loopholes, so are still paying some license holders more than others. We hope to close those loopholes and get to a place where we have payment parity.

Dr. Carlson reported that the OMA is just getting started. They are looking at the over 1,800 bills introduced to see what all is being proposed. Their specific agenda items are:

- Financial incentives for providers; and
- Looking for ways to fund the Oregon Healthcare Workforce Institute to be able to collect data.

There is a new physician legislator, Representative Knute Buehler from Bend, who will hold a conference call for OMA members.

Dr. Carlson also reported that he heard there is a payment parity piece for Naturopaths being forwarded.

Ms. Parkin noted that Home Health has filed a lawsuit against face-to-face requirements. This is moving forward.

Mr. Robinson reported that OHSU is analyzing and looking for impacts. It seems to be a quiet year so far. There is a student health interest policy group on campus, and they will try to get sunscreen
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to not be viewed as a drug for K-12 schools. Currently sunscreen is not allowed on school grounds as it is viewed as a drug. This bill is an effort to allow the OHSU students a sampling of the state legislative process.

Q: [Mr. Ekblad] Is OHSU requesting continued funding for Scholars for a Healthy Oregon Initiative (SHOI)?
A: [Mr. Robinson] Yes, it's already in the OHSU general fund, with a two-year recommended funding.

Q: [Mr. Ekblad] Is Public Health included in SHOI?
A: [Mr. Robinson] It is not at this point, although we'd like to add it in the future, once the new school has opened. Currently, it is legislatively restricted to MD, DMD, PA, and NP licenses.

Federal Policy
Mr. Ekblad reported that the ORH attends the annual NRHA Policy Institute. This year Mr. Ekblad will be joined by Mr. Duehmig and Meredith Guardino. The NRHA has asked that members speak to their members of Congress about a recent bill co-sponsored by Senator Walden, concerning the 96-hour stay rule for Critical Access Hospitals (CAHs). Centers for Medicare & Medicaid Services (CMS) has begun interpreting it very narrowly, in opposition to the intent of the rule. The bill will hopefully clarify the rules so that they will not be misread. In addition to this, we will also ask for support for continued rural health funding streams in the Federal budget.

ORH Staff Reports
Mr. Ekblad called out a few highlights for the ORH Staff reports. Noted were:

- Linda Peppler has secured Sunriver Resort for the 2017 Oregon Rural Health Conference.
- Robert Duehmig is finishing up the annual State Offices of Rural Health (SORH) grant submission. The National Organization of State Offices of Rural Health (NOSORH) will ask for a funding increase for the SORH grants.
- David Senft is restructuring the clinical technical assistance information on our site.

Q: [Dr. Carlson] What if there is a practice that is rural but is not an RHC? Does the ORH help them as well?
A: [Mr. Ekblad] Yes, we can and do help them.

- Lindsay Flick, our new Office Specialist, is working out well for our office.
- Emerson Ong is working on the latest Areas of Unmet Need Report. The purpose of the methodology is to determine how to distribute and focus resources. Of the five variables, 'distance to nearest hospital' causes those with a hospital in their community to rank lower, even if there is still unmet need. We are considering throwing out that variable and adding in a poverty variable, or using all six variables. Adding in poverty and using all six variables does not change the rankings much, but removing distance to a hospital changes them dramatically. We are still considering all angles, and will convene a group of partner
organizations to weigh in on the methodology.

C: [Dr. Carlson] I am aware of two hospitals which do no maternity care. So for those communities, that becomes another need. That might be another variable to look at.
A: [Mr. Ekblad] We already use low birth weight as a variable, so might be factoring them in already.

• Hilary Henderson reports an additional nine practitioners for the Medicaid Primary Care Loan Repayment Program (MLRP), as well as getting the Behavioral Health Loan Repayment Program up and running.

Q: [Dr. Carlson] Regarding MLRP, are you still looking for applicants, or have you awarded all of the funds?
A: [Mr. Ekblad] We already have more applicants than money to award at this point.

Q: [name] I understand it is competitive. Does it matter where you are working?
A: [Mr. Duehmig] It is competitive. It depends on where the practice is, what your license type is, your Medicaid patient numbers as compared to the county’s numbers, among other factors.

C: [Dr. Carlson] I get the impression that MLRP seems to skew towards Federally Qualified Health Centers (FQHC), as they generally have a higher percentage of Medicaid patients.
A: [Mr. Duehmig] We do have an Oregon Primary Care Association (OPCA) person on our advisory board. However when the FQHCs that had really high HPSA scores applied, they were not awarded because their HPSA scores were so high, they were eligible for National Health Service Corp loan repayment.

Q: [Ms. DeVisser] Is there an area or region of Oregon that has had more awards?
A: [Mr. Duehmig] It is a bit of a mix, but more urban due to the larger Medicaid population.

The Oregon Partnership State Loan Repayment program is entirely obligated until September.

• Julie Hoffer is strengthening direct contact with schools.
• Eric Jordan has gotten our website up to date before OHSU launches new site templates. The tax credit applications and renewal forms were rolled out and are coming back with the usual heavy volume for this time of the year.
• Maeve Trick is busy with MBQIP reporting and helping hospitals report their data. Ms. Trick, Troy Soenen, and Kelly Ballas (CFO from OHA), visited 28 of the 37 rural hospitals. They will publish their findings in a report.
• Meredith Guardino has been active in the administration of the OHA SIMS Telehealth Pilot Grant Project.
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Q: [name] Could telehealth mean putting monitoring devices in a patient’s home?
A: [name] Yes, it could be exactly that. There were no real parameters for what telemedicine means in the grant’s guidelines.

RHCC Member Reports

Heather Lewis, Consumer - Community <3500

Ms. Lewis reported a new provider is in place at the Vernonia Health Center, which is in partnership with Pacific University. Rotations will continue to come from Pacific University’s PA program.

Candye Parkin, Oregon Association for Home Care

NP referrals for Home Health will be refiled with the new Congress. The 2015 priorities will be settled in time to discuss at the next RHCC meeting.

Wayne Endersby, Oregon EMS Association

Donna Wilson from Oregon EMS/Trauma is retiring at the end of the month. She will be sorely missed.

Eagle Valley had seven calls in the first 9 days of 2015, which is high.

Mr. Endersby relayed a community-medic story regarding an elder that resulted in a positive outcome in the elder’s home and not a re-admission to the hospital.

Gary Brooks, DMD, Oregon Dental Association

Willamina has implemented a community medic program, named as such as the work need not be done by paramedics, an EMT-I will certainly suffice. This will hopefully cut down on hospital re-admissions. There will be grant money coming in from two CCOs to help fund this. Payments will be on a capitation basis, as the CCOs operate on that model.

Q: [Mr. Duehmig] Is the capitation paid on the full time 1,800 full-time residents, or the 27,000 transitory populations?
A: [Dr. Brooks] It depends on the individual’s insurance.

Dr. Brooks noted that Community Medics might make a great conference session.

CompNW in Lebanon has a DO resident in seemingly every medical office in McMinnville.

Dr. Brooks is retiring this year. He has had little success in selling the business to another practitioner. He is looking for a charitable organization to which he can donate his dental hardware.
Beryl Fletcher has retired from the ODA.

**Andrea Fletcher, Consumer - Eastern Oregon HSA #3**

The EOCCO came up with Eastern Oregon Healthy Living Alliance, a not-for-profit to seek additional funding globally over the 12 counties. A Kickstarter campaign is already under way.

**Michael E. Patrick, Oregon State Board of Pharmacy**

The Board will be going to a bi-annual license. Autofill prescriptions will need to have some revisions made.

Q: [Dr. Brooks] Is there any pharmacy rule that keeps me from mailing a narcotic prescription to a patient?
A: [Mr. Patrick] No, it is legal for you to do that.

**Bruce Carlson, MD, Oregon Medical Association**

Prices on older generic drugs are on the rise. Physicians are finding that insurance companies are pushing back on some generics being prescribed, and are publishing approved/non-approved generics lists.

**Eastern Oregon CCO**

This past fall, all CCOs received a care incentive measures list from the State of Oregon. Measures are things like screening for drugs or alcohol; follow-up on ADHD patients; etc. Each CCO was ranked and paid accordingly. EOCCO rewarded the providers based on patient census. The new list includes dental, contraception, smoking cessation. This means one’s practice is becoming a healthier population.

**Pendleton**

Pendleton Independent Practice Association is now Eastern Oregon IPA. They are contracting with Moda for a Case Manager. There is now a 700-person census at the Pendleton Clinic. They will soon be open a 4th day a week.

**North Lake**

There are two providers at the North Lake Clinic. Recently while one was in Guam, the other had a death in the family. They scrambled and found a retired doctor to fill in. Staffing for rural is not as easy as it is in urban. Electronic Health Record user interface discrepancies is a really big issue for obtaining coverage. The next closest clinic is 63 miles away, that one being under a different CCO.
Hermiston

Lately, 30% of visits are on OHP. Previously it had been at 15%. Private pay numbers are down significantly.

Oregon Medical Board

The OMB is looking for autonomous status from the state. Their budget is derived from licensing fees, not the general budget.

C: [Dr. Brooks, Mr. Patrick, Ms. DeVisser] Pharmacy, nursing, and dentistry boards are all either already autonomous, or are working towards that status.

There seems to be a lot of interest in autonomous cars for elder patient delivery.

Stephen Brill wrote a couple of pieces for Time Magazine and has now published a book, all named *Bitter Pill*, which are well worth reading.

Pam DeVisser, FNP, Oregon Nurses Association

North Coast

Clatsop County was awarded a Road to Wellsville Grant. The Clatsop County team met with Esther Dyson, an angel investor, who started HICCUP. This team is managed through the CCO and Clatsop County Health Department. They want to work on community health issues and hope to not duplicate services already available. Leaders county-wide were asked to participate, which resulted in a huge turn-out.

Providence Seaside just established a tele-nocturnist program by partnering with St. Vincent’s Hospital in Portland.

Q: [Mr. Ekblad] The ED doc can’t admit?
A: [Ms. DeVisser] They are ER only. They hand off the admit to the tele-nocturnist.

Q: [Ms. Fletcher] How did you find them?
A: [Ms. DeVisser] They are through St. Vincent’s, whoever might be on call there.

Providence is starting a medical home in their costal clinics.

As of last week, I have semi-retired.

Troy Soenen, Oregon Association of Hospitals & Health Systems

Oregon healthcare is looking better than it has since I arrived here 15 years ago.

OHA, ORH, and OAHHS visited most of the rural hospitals for a listening tour. The issues seem to be the same as they were 15 years ago: behavioral health, drugs and alcohol abuse, access to care, CCO issues both good and bad, telehealth adoption, HIT incompatibility, data black holes, etc. I think we
need to do a better job on distinguishing between health systems vs. community health status. We are working on a transformation assessment tool with ORH for the 32 small rural hospitals. It will launch this Monday, with a report out in March.

Q: [Dr. Carlson] What do we do about transformation with hospitals under different utilization realities? There are some small rural hospitals that have $10,000,000 excess in their budgets and like-hospitals that have a $2,000,000 deficit.

A: [Mr. Soenen] I think we have some smaller frontier hospitals that might need to look at their designations to see if their current status still makes sense. I think there needs to be a federal designation that can allow for these changes, which is something the American Hospital Association is working toward.

Another area that is interesting along these lines, Brookings, which has no hospital, is looking at the ORS to see if they can have a free-standing ER operated by a CAH elsewhere.

There is a new frontier definition on its way, which will have four levels of frontier. This will potentially impact funding and programs that hinge on the frontier definition for small rural sites.

C: [Mr. Ekblad] Along these lines, Ted Molinari faxed to the ORH a story on small rural hospital closures that are occurring nationwide. The NRHA is also tracking this frontier definition change.

New Business/Public Input
There was no new business nor was there any public input.

Adjourn
Ms. Fletcher adjourned the meeting at 2:45pm.