Oregon Federally Certified Rural Health Clinics
2011

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The Oregon Office of Rural Health

The mission of the Oregon Office of Rural Health (ORH) is to improve the quality and availability of health care for rural Oregonians. The ORH was created and funded by the Oregon Legislature in 1979. The office partnered with Oregon Health & Science University in 1989 to increase its ability to bring statewide resources to rural areas. ORH engages in the following activities to fulfill its mission:

- Coordinates statewide efforts to provide health care in rural areas;
- Builds stronger relationships among organizations and individuals interested in rural health care;
- Serves as a clearinghouse for information on rural health care;
- Provides consultation to rural communities and health care providers;
- Assists rural communities to recruit and retain health care practitioners;
- Supports the training and education of health care practitioners in rural practice settings;
- Initiates and participates in policy development that improves delivery of health care to rural Oregonians;
- Advocates for rural populations and health care providers in legislative and regulatory forums;
- Encourages development of innovations to improve delivery of rural health care.

Technical Assistance Provided By ORH Field Services

The ORH offers assistance to rural communities, often on-site, to strengthen their health care delivery systems. Assistance is offered with:

- Hospital financial issues and access to federal programs;
- Strategic planning;
- Hospital and clinic board training;
- Health district formation;
- Needs assessment and analysis;
- Rural Health Clinic and Federally Qualified Health Center development and certification requirements;
- Community health development.

For additional information regarding technical assistance or other rural health questions please go to the ORH web site at www.ohsu.edu/orh or contact us at 503 494-4450.

Acknowledgements

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Executive Summary

The McKenzie River Clinic became Oregon’s first Federally Certified Rural Health Clinic (RHC) in 1978. Since that time RHCs have been providing rural Oregonians with health care services throughout the state; some serving as the only source of health care in their community. The number of RHCs has continued to increase. In 1999 there were 22 RHCs, which increased to 47 by 2004, 52 by 2008, and to 60 by the end of 2010. RHCs currently exist in 25 of 36 Oregon counties. While the overall increase in RHCs has been moderate, the majority of new RHCs are private, for-profit clinics.

Except for pediatric clinics, all Oregon RHCs see Medicare patients, and all RHCs see Medicaid and uninsured patients. The average payer mix for Oregon’s RHCs is 35% private insurance, 29% Medicare, 18% Medicaid, 9% other and 9% uninsured. Without RHCs, many publically insured as well as uninsured people, and even those with private insurance, would have nowhere to go to receive primary care.

The financial benefit to being an RHC is enhanced Medicare and Medicaid reimbursement. Independent RHCs currently received a capped Medicare reimbursement rate of $78.07 per encounter (the 2011 rate). These same RHCs have an average adjusted cost per visit of $130.68, leaving an average deficit of $52.61 per Medicare encounter. The Medicare Economic Index (MEI), which determines the yearly increase of the Medicare cap rate, has failed to keep pace with the actual cost of providing care in Oregon’s RHCs. Since 1999, the average adjusted cost per visit has increased by 98%, but the MEI has only increased 29% during that same time.

An area of improvement is in the implementation of Electronic Health Records (EHR). In 2007, only 37% of RHCs had implemented an EHR. That number increased to 56% by 2010, with another 13% planning to implement within the next two years. However, due to the high purchase and implementation costs, that still leaves 31% of Oregon’s RHCs without the use of an EHR.

Recruitment and retention continues to be a major challenge facing RHCs; 43% of RHCs are currently recruiting and half of those are recruiting for multiple positions. Rural communities are not only competing with urban areas, but are forced to compete with other rural communities as well. It is important that local communities and medical providers collaborate in their recruitment efforts to create a Recruitment and Retention plan to ensure they have a unified strategy. Rural Oregonians rely on state and federal programs that incentivize primary care providers to practice in rural communities. These incentives include loan repayment, tax credits and malpractice subsidies and help to attract medical providers to practice in rural communities. It is imperative that these programs continue to receive funding. Advocating for legislative policy that increases the primary care work force and increases work force exposure to the rural experience is also a priority.

Health care has seen many changes the last several years and RHCs are no exception. In 2003 the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) was passed to help seniors pay for prescription drugs. This law also made other changes to Medicare, including the Hospital Inpatient Quality Reporting and Physician Quality Reporting programs implemented in 2005 to improve quality measures. In 2009 the Health Information and Technology for
Economic and Clinical Health (HITECH) Act—passed as part of the American Recovery and Reinvestment Act (Public Law 111-5)—defined measures for meaningful use of electronic health records.

Now it appears that national health care reform is occurring. In 2010 the Patient Protection and Affordable Care Act (Public Law 111-148) was signed into law, laying out several iterations of change to how health care will be provided and paid for. The implications of this law for RHCs are still unclear. What is known is that there will be a shift in how health care is delivered and reimbursed. The Patient Centered Primary Care Home is being promoted by both federal and state initiatives; again, it is unclear how the model will work in Oregon’s smallest RHCs. Under this model the burden of controlling quality and costs will be shifted to the provider. Fee-for-service reimbursement methodology will transition to paying for healthy outcomes of a population. It is hard to know for sure what changes the future holds for Oregon’s RHCs but it should be an interesting time for all involved.

Figure 1: Map of Oregon RHCs, February 2011
Introduction

This report provides an update on the Federally Certified Rural Health Clinic program in Oregon. Previous versions of this report were released in 2005 and 2008, copies of which can be found on the ORH website, www.ohsu.edu/orh. This edition provides a time trend analysis from previous reports, and updates clinic benchmarks.

This report is intended to serve as an educational tool to inform communities, health care professionals, policy makers, and other stakeholders about the RHC program. RHC designation is a federally recognized program that will be detailed throughout this report.

Our hope is that clinics will be able to use information in this report to improve their business practices and overall financial performance. This paper shares information that should allow comparisons, yet still protect the individual clinics’ anonymity. Market shares, productivity, hours of operation, access to technology and financial operations are presented.

The Office of Rural Health (ORH) will use these findings to continue to improve the services it provides. By listening to the qualitative responses and analyzing the data, we hope to create tools and programs that are responsive to clinic needs. We will look to take what we learn from this report and translate it into action.

There is no one-size-fits-all RHC model. Oregon RHCs show a great diversity in community size, scope of service, business practices and ownership. That diversity, combined with the relatively small number of participant study clinics, makes it hard to draw any definitive generalizations about the program as a whole.

What is a Rural Health Clinic?

In 1977, Congress passed Public Law 95-210, the Rural Health Clinics Act, to increase the availability of primary healthcare services to Medicare patients in rural communities. This program, titled the Certified Rural Health Clinic Program, is more commonly known today as “the RHC program.” Rural providers have to meet certain criteria before they can be certified by the Centers for Medicare and Medicaid Services (CMS) as a rural health clinic. The clinic must be a predominantly primary care practice (family practice, general internal medicine, pediatrics, or obstetrics and gynecology) and meet the following criteria to be eligible for certification:

- Clinic must be located in an area defined by the US Census Bureau as NOT an Urbanized Area
- Clinic must be located in an area that is federally-defined as either a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA); or in an area designated by the State’s Governor as underserved. See: www.ohsu.edu/xd/outreach/oregon-rural-health/data/health-care-shortage.cfm.
- Clinic must employ a mid-level provider (Nurse Practitioner, Physician Assistant, or Certified Nurse Mid-Wife) at least 50% of the time the clinic is open.
• Clinic must have physician oversight from a physician who is on site once every two weeks, available to see patients, consult with the mid-level and review medical practices when necessary.
• Clinic must offer six basic laboratory tests on site:
  • Pregnancy Test
  • Examination of stool occult
  • Glucose
  • Primary culturing for transmittal
  • Hemoglobin or Hematocrit
  • Urine
• The shortage area designation must have been updated within last four years

This is only a summary of criteria. For more detailed information review “Starting a Rural Health Clinic – A How-To Manual.” This manual and other resources may be found at www.narhc.org/resources/resources.php.

What distinguishes RHCs from other primary care practices is how the clinic is reimbursed for Medicare and Medicaid patient visits. Federally certified RHCs receive reimbursement rates for Medicare and Medicaid patients that are set based upon the clinic’s cost to provide care. The Medicare reimbursement rate is based on the clinic’s allowable costs for core services under the Medicare RHC program divided by the number of patient Medicare encounters for a fiscal year. This rate is calculated every year using a CMS cost report form. Examples of RHC non-allowable costs include cosmetic surgery, dental treatment, inpatient hospital services, EKGS, radiology and contracted lab services. After calculating cost, Medicare applies an upper limit rate cap that is adjusted annually. In 2010 Medicare paid a maximum of $77.76 per encounter while the average cost per encounter for all Oregon RHCs (independent and provider-based) was actually $138.42. Each year the Medicare cap is adjusted using the Medicare Economic Index (MEI). In 2011 the Medicare cap rate increased to $78.07 per encounter.

A provider-based RHC is an RHC that is affiliated with a hospital, skilled nursing facility, or home health agency and operates under common licensure and governance. If an RHC is a provider-based RHC owned by a hospital with fewer than 50 beds, then the rate cap does not apply and the clinic is reimbursed at a 100% of allowable costs for Medicare patients.

Medicaid payments are also based upon a cost-per-encounter ratio calculated from the clinic’s financial and encounter data from 1999-2000. This rate is called the clinic’s Prospective Payment System (PPS) rate and, once established, is also adjusted each
year using the MEI. Clinics that entered the RHC program later than 2000 are able to use more current financial and encounter data to calculate their PPS rate, or they can base their initial rate upon that of a neighboring RHC. The PPS rate is not capped and therefore more accurately reflects the cost of doing business than the Medicare rate but, for many RHCs, the MEI rate of increase has not kept up with the true increase in the cost of providing care.

To start the application process, clinics may contact the Office of Rural Health at 503-494-4450 to verify that necessary RHC eligibility requirements are met. For RHC survey and certification questions, clinics must contact the Oregon Department of Human Services, Health Care Licensure & Certification office at 971-673-0540.

Who is eligible to be an RHC?

Shortage Designations

The following maps show which areas had a Primary Care HPSA, MUA or Governor’s Shortage designation in 2010. A provider located in any of the following areas and not in an urbanized area may be eligible to apply for RHC status.

HPSA

HPSAs may be designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups or medical or other public facilities.

Geographic Areas must:

- Be a rational area for the delivery of primary medical care services
- Meet one of the following conditions:
  - Have a population to full-time-equivalent primary care physician ratio above 3,500:1
  - Have a population to full-time equivalent primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and have unusually high needs for primary care services or insufficient capacity of existing primary care providers
- Demonstrate that primary medical professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to the population under consideration.

Population Groups Must:

- Reside in an area that is rational for the delivery of primary medical care services as defined in the Code of Federal Regulations.
- Have access barriers that prevent the population group from use of the area's primary medical care providers.
- Have a ratio of persons in the population group to number of primary care physicians practicing in the area and serving the population group greater than 3,000:1
  - Be members of federally recognized Native American tribes, who are automatically designated, or other defined groups who meet the criteria described above.
To learn more about HPSAs please visit http://bhpr.hrsa.gov/shortage/hpsadesignation.htm.

**MUA**

Medically Underserved Areas (MUA) may be a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services.

Calculating MUAs involves application of the Index of Medical Underservice (IMU) to data on a service area to obtain a score for the area. The IMU scale is from 0 to 100, where 0 represents completely underserved and 100 represents best served or least underserved. Under the established criteria, each service area found to have an IMU of 62.0 or less qualifies for designation as an MUA.

The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The value of each of these variables for the service area is converted to a weighted value, according to established criteria. The four values are summed to obtain the area’s IMU score. To find out more about MUAs visit http://bhpr.hrsa.gov/shortage/muaguide.htm.
Governor’s Shortage Designation

A third shortage designation, the Governor’s Shortage Designation, is available for RHC eligibility. As of 2005 the State of Oregon had not taken advantage of the Governor’s Designation option. After compiling the 2005 RHC report, the ORH realized that the sparsely populated areas mentioned in the above paragraph, such as Wallowa county and Southern Lake county, remained ineligible using the HPSA and MUA designations. The ORH, the DHS Office of Health Systems Planning and the Governor’s office then crafted new designation criteria to be used by the state for a Governor’s Shortage designation. To find out more about the Governor’s Shortage Designation visit the ORH website at www.ohsu.edu/ohsuedu/outreach/oregonruralhealth/data/hcare_shortage.cfm.

After the implementation of this designation in 2007, clinics from Wallowa County and southern Lake County have applied and been approved for RHC designation.
Should You Become an RHC?

This is an important question for any rural provider or a community/public board considering RHC status. What is the benefit? What are the costs? Why do it? Once the basic criteria for program participation are met, the clinic must determine whether the change in reimbursement will improve the financial situation of the facility and improve access for patients. Certified rural health clinics differ from other rural primary care clinics; they are reimbursed using a cost-based methodology for Medicaid and Medicare patients.

According to the Medicare claims processing manual, www.cms.gov/manuals/downloads/clm104c09.pdf, an “encounter” is: a face-to-face visit between a patient and a physician, a mid-level provider, clinical psychologist, or clinical social worker that takes place in the patient’s place of residence, nursing home, in the clinic, or at the scene of an emergency. Every Medicare encounter is reimbursed at the same rate.
regardless of the level of service. The 2011 Medicare encounter rate for independent RHCs is $78.07. However, actual reimbursement from Medicare is 80% of the interim rate (also known as capped rate) and patients are responsible for coinsurance and deductible if applicable (Bell, 2005). Medicare patients are required to pay a 20% coinsurance in the RHC program and to meet an annual deductible. In addition, Medicare applies an annual productivity standard to physicians (4200 encounters) and mid-level providers (2100 encounters). Productivity is discussed in more detail on page 25 of this report.

A Medicaid “encounter” is defined as: a face-to-face or telephone contact between a health care professional and an eligible Oregon Health Plan (OHP) client within a 24-hour period ending at midnight, as documented in the client’s medical record. An encounter includes all services, items and supplies provided to a client during the course of an office visit except as excluded in Section (11) of the rule. Medicaid encounters are reimbursed at 100% of reasonable allowable cost to provide Medicaid services. Therefore, depending on the clinic’s overall costs to see patients, every clinic will have a different reimbursement rate. It is important to include direct and indirect costs (including malpractice insurance and reasonable physician compensation for the clinic’s location) and to remember that no productivity standards for Medicaid services are imposed when calculating the Medicaid encounter rate. Each RHC encounter includes the average of all clinic costs, so even if a client is seen at the RHC for a mere flu shot, DMAP pays the encounter rate. However, the same encounter rate is also paid for more complicated procedures. The average Medicaid reimbursement for Oregon RHCs in 2003 was approximately $81.26 per encounter. In 2007 it went up to $123.06 per encounter, and in 2011 it has increased to $140.73. Medicaid allowable and reasonable costs are defined in the Division of Medical Assistance Programs (DMAP) billing guide, www.dhs.state.or.us/policy/healthplan/guides/fqhc-rhc/main.html.

Clinics with a payer mix at or above 35% combined Medicaid and Medicare may benefit from RHC certification. The current average Oregon RHC payer mix is 18% Medicaid and 29% Medicare clients. The “Starting a Rural Health Clinic – A How-To Manual” is available through the Health Resources and Services Administration (HRSA). This manual is a good starting point and outlines a number of questions to consider when determining whether or not to enter the program. The manual can be found through the Oregon Office of Rural Health website at www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/rhc-ta-resources.cfm or on the National Association of Rural Health Clinics website at www.narhc.org/uploads/pdf/RHCmanual1.pdf.
History of RHCs in Oregon

Figure 5: The number of RHCs in Oregon by year of certification

Figure 5 above displays the history of the RHC program in Oregon from its creation by Congress in 1977 with the passage of the Rural Health Clinics Act through 2010. As of December 2010, Oregon had 60 certified RHCs.

The uptake of the RHC program has varied widely by state; current RHC numbers from CMS for the lower 48 states are shown in Figure 6. This variety may reflect differences in both state policies and in local medical practice customs and arrangements as well as the distribution of rural populations. Western state RHC counts vary from only seven RHCs in Nevada to 129 in Washington and 274 in California. Nationwide the highest numbers of RHCs are found in the Midwest with over 300 RHCs in both Texas and Missouri and more than 100 in many other states of the region.

As the above graph shows, the net number of RHCs in Oregon increased slowly from the program’s inception in 1977 through 1998. There were only 16 Oregon RHCs in 1998. The implementation of the Medicaid Prospective Payment System and more widespread knowledge of the RHC program likely both contributed to the significant program growth seen from 1999 to 2004 as a net of 33 clinics joined the
program over those five years. In the last six years a number of new RHCs have joined the program while several existing clinics have either closed their doors or withdrawn from the RHC program—this turnover is not reflected in the graph which only shows aggregate changes. The total number of RHCs has continued to increase in recent years, but the rate of increase has been much lower than in the early 2000s. Since 2004 the Oregon RHC program has seen a net increase of 13 clinics.

As Figure 7 shows, Oregon is among the states which show a greater percent increase in number of RHCs since the 2008 RHC Report was released. However given the significant variations in RHC adoption from one state to another, it is unclear if these state-to-state differences are very meaningful.

**Figure 6: Number of RHCs by state as of January 2011 (CMS, 2011),**
(Alaska and Hawaii only have 2 certified RHCs each and are not shown on this map)
Isolated Rural Health Facility

One of the purposes of past editions of the Oregon Federally Certified Rural Health Clinics Report has been to identify how isolated rural health facilities (IRHF) are faring and what may be done to help sustain primary care delivery in areas that otherwise would have no locally-available services and therefore no reasonable access to health care (Soenen, Clemens, and Ong, 2005; Soenen, Tranchese, Johnson, Ong, and Clemens, 2008).

The Oregon definition of Isolated Rural Health Facility: IRHF’s are private non-profit or public primary care clinics located in rural Oregon communities. These organizations are the sole source of access to primary care in the community, do not receive any Public Health Service Section 330 monies, and are not school-based clinics.

“Isolated Rural Health Facility” is currently a conceptual designation used to identify a specific type of rural safety net health care provider. The definition was proposed by the Oregon Office of Rural Health in 2005 and adopted by the Health Care Safety Net Advisory Council in 2008. Additional information on IRHFs as one type of safety net provider can be found in the 2008 report, Oregon’s Healthcare Safety Net, at www.oregon.gov/OHPPR/SNAC/index.shtml.
There is no targeted benefit or support provided to facilities identified as IRHFs so the designation is currently only used conceptually. Should subsidies or other financial benefits for IRHFs be proposed in the future, formal designation criteria could be developed and might include:

- Board governance training on roles and responsibilities
- Private nonprofit or governmental unit, e.g., health district status
- Development of an annual strategic plan
- Providing quarterly uniform data sets to the Oregon Office of Rural Health for monitoring and evaluation purposes [ORS 442.500 (5)]. Reports would monitor the following:
  - Health service utilization
  - Financial status
  - Progress toward strategic plan implementation
  - Implementation of a community oriented primary care practice methodology
- Participating fully in Medicare and Medicaid programs
- Operating a schedule of discounts
- Maintaining existing federally certified Rural Health Clinic status or Federally Qualified Health Center look-alike status (if applicable).
  
  If a clinic wants to become a RHC but cannot obtain the required qualifying survey due to temporary federal budget constraints, but otherwise meets the IRHF criteria, the clinic could be considered an IRHF during the interim.

The Office of Rural Health would, given the resources to do so, provide the technical assistance necessary to meet these qualifications and maintain their IRHF designation.

A map of current IRHFs is on page 12. Please note that this map is subject to change.

**Changes among IRHFs since 2008**

In the 2008 RHC report, 20 potential IRHFs were identified (Soenen, et al., 2008); eighteen of these sites were certified RHCs at the time while two were not. Since that report, two of the identified clinics have withdrawn from the RHC program—one transitioned to a Federally Qualified Health Center and receives funding from the Health Resources and Services Administration (HRSA) under Section 330 of the Public Health Service Act, and the other has withdrawn from the RHC program (although it continues to meet all of the other criteria for IRHF status).

The two clinics that were not certified in 2008 had successfully gained RHC status by 2010. However two of the clinics that were identified in 2008 have closed in the past two years leaving Yachats and Powers with no local providers of health care. Finally, one clinic no longer meets IRHF criteria although it continues to operate as an RHC.

At the present time fifteen RHCs are identified as IRHFs. Of these clinics, nine are supported by health districts, a type of special tax district created by voters. In fact all but two of the 11 RHCs currently associated with health districts are IRHFs. This voter-approved support reflects the value that small rural communities place on their health care facilities. These communities have chosen to provide public support to maintain health care availability in places where unsupported commercial or even
independent not-for-profit operations would not be financially viable. The current distribution of IRHFs is shown in Table 1.

Table 1: Count of IRHFs categorized by ownership type, community size, and operation type (n = 15)

<table>
<thead>
<tr>
<th></th>
<th>Health District</th>
<th>Public</th>
<th>Not-for-profit</th>
<th>Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Small</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Rural</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Independent</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Provider-based</td>
<td>3</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>9</strong></td>
<td><strong>1</strong></td>
<td><strong>5</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

Figure 8: Map of IRHFs, n = 15

**ISOLATED RURAL HEALTH FACILITIES**
**Survey Methodology**

Each RHC in Oregon was mailed a survey packet (see Appendix A) requesting information on clinic operations, patient demographics, technology usage and electronic health record implementation, recruitment and retention, services offered, current fee schedule, hours of operation, and open-ended questions on opportunities and challenges facing the RHC.

The 56 RHCs in operation in July 2010 (the remaining four were newly certified or in the process of closing) were contacted by phone to arrange a meeting time in the clinic between a staff member from the ORH and a clinic representative. For their time and efforts in gathering information, each participating clinic was entered into a lottery for three awards of $2,500 each.

The most recent available Medicare cost reports were requested from the Medicare Administrative Contractors who process RHC payments. Medicaid Encounter rates were provided by the Oregon Department of Medical Assistance Programs. Service area demographic information was obtained from the ORH Primary Care Service Area Database. More information about this database and service area demographics is available at [www.ohsu.edu/xd/outreach/oregon-rural-health/data/index.cfm](http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/index.cfm).

**Participation Rates and Data Collection Instruments**

Sixty RHCs were registered in Oregon in mid-2010; three of these clinics were newly certified and one was in the process of closing, so no attempt was made to survey these four clinics. For this reason only 56 responses were expected in most categories. The number of responses by clinic type is shown in Table 2. Medicare cost reports are due five months after the close of a clinic’s fiscal year and are subject to review by the fiscal intermediary and by CMS following submission. Therefore they incorporate a greater time lag than other data sources, particularly for provider-based clinics. Reporting periods for the analyzed cost reports are shown in Figure 16 on page 39 in the cost report section of this document.

As Table 2 on page 14 shows, response rates were generally lower among provider-based clinics compared to clinics that operate independently. Therefore these results may describe provider-based clinics less accurately than independent ones. When grouped by ownership category (data not shown) 85% of public clinics completed the survey compared to 75% of not-for-profit and privately owned clinics. Lower response rates on some items, particularly the information about fee schedules, limits the completeness and generalizability of reported data. When possible the number of clinics that provided specific data will be represented by n.

Data were organized in Microsoft Access and mathematical analyses and construction of graphical presentations was done in Microsoft Excel. All information collected is confidential and is presented in this report in a manner that maintains clinic anonymity.
Table 2: Data received from clinics, response rate in parentheses

<table>
<thead>
<tr>
<th>Data Presentation Categories</th>
<th>Independent</th>
<th>Provider-based</th>
<th>Total received</th>
<th>Total expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHC Questionnaire</td>
<td>34 (87%)a</td>
<td>13 (76%)f</td>
<td>47 (84%)</td>
<td>56</td>
</tr>
<tr>
<td>Clinic Questionnaire (ORPRN)</td>
<td>36 (92%)a</td>
<td>15 (88%)e</td>
<td>51 (91%)</td>
<td>56</td>
</tr>
<tr>
<td>Office Hours</td>
<td>32 (82%)a</td>
<td>13 (76%)f</td>
<td>45 (80%)</td>
<td>56</td>
</tr>
<tr>
<td>Checklist of Services</td>
<td>30 (77%)a</td>
<td>13 (76%)f</td>
<td>43 (77%)</td>
<td>56</td>
</tr>
<tr>
<td>Fee Schedule</td>
<td>21 (54%)a</td>
<td>2 (12%)e</td>
<td>23 (41%)</td>
<td>56</td>
</tr>
<tr>
<td>Medicare Cost Reports</td>
<td>30 (94%)b</td>
<td>6 (35%)c</td>
<td>36 (73%)</td>
<td>49</td>
</tr>
</tbody>
</table>

Notes:
- a) 39 respondents expected: out of 43 independent clinics 1 was closing and 3 were opening
- b) 32 respondents expected: 4 pediatric clinics submit no-utilization cost reports without cost information and 7 clinics were established too recently to have completed cost reports.
- c) 17 respondents expected

Data Presentation Categories

Data are presented in peer groupings so that clinics can compare and contrast their own results with others in more similar situations. The categories used in this report are shown in Table 3.

Table 3: Peer groupings used for clinic comparisons

<table>
<thead>
<tr>
<th>Grouping Metric</th>
<th>Possible Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ownership type</td>
<td>Private / for-profit</td>
</tr>
<tr>
<td></td>
<td>Not-for-profit</td>
</tr>
<tr>
<td></td>
<td>Public and Health Districts</td>
</tr>
<tr>
<td>Operation type</td>
<td>Provider-based</td>
</tr>
<tr>
<td></td>
<td>Independent</td>
</tr>
<tr>
<td>Isolated Rural Health Facility</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Community size</td>
<td>Large town (≥ 10,000 people)</td>
</tr>
<tr>
<td></td>
<td>Small town (2,500–9,999 people)</td>
</tr>
<tr>
<td></td>
<td>Rural community (&lt;2,500 people)</td>
</tr>
</tbody>
</table>

Ownership type is divided into three categories:

- Clinics that are privately owned and operated for a profit, “private”.
- Clinics that are owned by not-for-profit organizations either independently or under a not-for-profit hospital, “not-for-profit”.
- Clinics that are owned by public entities and health districts, “public”.

Operation type is defined as part of a clinic’s RHC certification. RHCs may operate as freestanding entities, “independent” or under the licensure and governance of a hospital, skilled nursing facility, or home health agency, “provider-based”. See the discussion of provider-based clinics on page 2 for more information. All provider-based clinics in Oregon are affiliated with not-for-profit hospitals. Although the difference may not be noticeable to patients, the distinction between independent and provider-based RHCs is important for clinic management because of implications for reimbursement.
As described on page 10, **Isolated Rural Health Facility** is a conceptual designation used to identify a type of safety net provider in rural areas.

**Community size** is defined based on the population of the rural service area in which the RHC is located. Since Oregon’s counties vary widely in size, geography, and population, the Office of Rural Health has defined sub-county units called “Primary Care Service Areas” that more accurately reflect community use of primary health care services. Of the 131 identified service areas in Oregon, 105 are considered rural under current ORH definitions. More information on service area definitions and statewide maps can be found in the 2010-2011 Areas of Unmet Health Care Need in Rural Oregon Report on the ORH website at [www.ohsu.edu/xd/outreach/oregon-rural-health/data/health-care-shortage.cfm](http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/health-care-shortage.cfm). In addition, 6-page demographic, socioeconomic, and health status profiles can be requested from ORH for each of the 105 identified rural service areas. For the purpose of this report service areas are defined as large (service area population ≥ 10,000), small (service area population 2,500-9,999), or rural communities (service area population < 2,500). These categories follow the RUCA (rural-urban commuting area) guidelines developed by the WWAMI Rural Health Research Center which distinguish large towns, small towns, and rural communities. For more information on rural definitions see the Oregon Office of Rural Health rural definitions webpage at [www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm](http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm).

**Accomplishments and Impact of Oregon RHCs**

Evaluating the impact of the RHC program on access to health care in rural Oregon is complicated due to the wide variety of communities and situations served by rural health clinics. The oldest certified RHC in the state has provided services for 33 years, while, at the other extreme, several clinics were newly certified in 2010. Despite this range, some aggregate information is available from surveys and the Medicare cost reports that gives an idea of the scope of the RHC program in this state.

The ultimate goal of the RHC program is to enhance access to primary care services in rural areas where certified RHCs operate and to reduce health care treatment disparities between urban and rural populations. While differences in health care access and use between urban and rural populations has been extensively studied (for example see Casey, Thiede, & Klingner (2001) and Larson & Correa-de-Araujo (2006)) there is limited research on the effectiveness of RHCs in ameliorating this urban-rural disparity. Using 2002-2003 administrative claims data from the Oregon Medicaid program Kirkbride and Wallace (2009) reported that Medicaid patients in rural areas with RHCs received selected diabetes-related primary care services at the same rates as urban patients while those in rural areas without RHCs received these services at a lower rate. This study provides suggestive evidence that Oregon RHCs are improving primary care services in rural areas where they operate although, as the authors note, it is limited in scope and time and may not be generalizable beyond the population of Medicaid beneficiaries. Evaluating the overall impact of the RHC program in Oregon and nationwide will require more research.
One area for which aggregate indicators are not available is the community support provided to public and not-for-profit clinics. This ranges from cash donations and health district tax funding to substantial volunteer contributions including the work of board members as well as operational support, maintenance, even landscaping. Such community support shows the value that rural communities place on their local clinics.

Medicare cost reports provide some information on total visits to RHCs and provider employment. This is summarized in Table 4. For this section, only cost reports that included information for some part of the calendar year 2009 are included in the aggregate data. Therefore, Table 4 only includes information for 32 clinics, 30 independent clinics and two provider-based ones, as some of the available cost report data was quite old. See page 39 for more information on Medicare cost reports. Cost reports which cover fewer than 365 days are pro-rated to adjust the reported volume to the equivalent of a full year.\(^1\) The reporting periods are not entirely congruous as can be seen in Figure 16 on page 39, however as adjusted they all account for the same number of days. Also it is important to note that these volumes do not include all Oregon RHCs, only those for which data was available. Overall these RHCs fulfilled more than a third of the calculated primary care demand in the service areas where they are located.

<table>
<thead>
<tr>
<th>Table 4: Summary of RHC services in 365-day reporting period, n = 32 clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total visits provided by RHCs</td>
</tr>
<tr>
<td>Total primary care demand in service areas with RHCs</td>
</tr>
<tr>
<td>Service area primary care demand met by RHCs</td>
</tr>
<tr>
<td>Number of Medicare visits provided by RHCs</td>
</tr>
<tr>
<td>Number of service areas</td>
</tr>
</tbody>
</table>

Survey responses also provide some information on the overall impact of Oregon’s RHCs. Clinic responses to the questions: “How many patients do you see in a typical week?” and “What is the total number of individual patients seen at least once in the last 24 months?” are shown in Table 5 on the next page. A total of 51 clinics completed the clinic questionnaire but not every clinic responded to every question and these are not necessarily the same clinics as represented in Table 4, above. These data should be seen as another way to view RHC impact and not a direct comparison. Since only 43 of 60 clinics reported weekly visits, it is clear that Oregon RHCs are providing considerably more than 10,000 patient visits every week. This is a significant benefit for rural populations in the state. The “individual patient” count could potentially result in the same person being counted as a unique patient at different clinics; however, given the wide geographic distribution of Oregon’s RHCs, any double counting is unlikely to be very large or significantly influence the overall total.

In addition to providing medical services, RHCs provide employment in local communities. The total number of people employed by RHCs was not available. Clinics did report staff hours and the number of full-time-equivalent (FTE) positions is shown in Table 5. An FTE is calculated as 40 hours per week, but many RHC staff and providers work part-time. Therefore the total number of people employed by Oregon’s RHCs likely exceeds the calculated 364 staff positions and 130 medical provider positions by a

\(^1\) The calculation is: \((365/\text{actual days of report}) \times \text{reported visits} = \text{adjusted annual visits}\)
considerable amount. For this calculation, physicians, nurse practitioners, and physician assistants are all grouped as “providers.”

Table 5: Survey information on RHC impact: total patients, weekly patient visits, and employment

<table>
<thead>
<tr>
<th>Information</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of unique RHC patients in 24 months (n = 28 clinics)</td>
<td>146,580</td>
</tr>
<tr>
<td>Total number of RHC patient visits per week (n = 43 clinics)</td>
<td>10,704</td>
</tr>
<tr>
<td>Total reported staff FTE (n = 39 clinics)</td>
<td>364</td>
</tr>
<tr>
<td>Total reported provider FTE (n = 38 clinics)</td>
<td>130</td>
</tr>
</tbody>
</table>

Finally, RHC providers are engaged in their communities on many scales. Of the 47 clinics which completed the RHC survey, 30 reported that their providers volunteer health care services. Twenty-five clinics reported local volunteer work, two reported national volunteer work, and seven reported international volunteer work on the part of their providers. Also, 31 clinics reported some form of community outreach and prevention services including vaccination clinics, health fairs and screening events, education events, wellness programs, and collaboration with the local county health department.

Ownership and Governance of Oregon Rural Health Clinics

A unique aspect of the RHC program is the participants’ diverse governance structures. Certified RHCs may operate as any type of business structure available under the laws of their state. In Oregon, RHCs fall into three major ownership categories: privately owned and operated for a profit, not-for-profit organizations, and public entities. Public entities include county health departments, voter-approved health districts, and state-affiliated organizations. The distribution of RHCs by ownership type has not changed a great deal since 2007 although the proportion of RHCs that are privately owned and operated has increased steadily since 2004.

<table>
<thead>
<tr>
<th>RHC Ownership</th>
<th>2004</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>34%</td>
<td>41%</td>
<td>43%</td>
</tr>
<tr>
<td>Not-for-profit</td>
<td>38%</td>
<td>36%</td>
<td>35%</td>
</tr>
<tr>
<td>Public</td>
<td>28%</td>
<td>23%</td>
<td>22%</td>
</tr>
</tbody>
</table>

Table 6: Count of 2010 RHCs in Oregon by descriptive category (n = 60)

<table>
<thead>
<tr>
<th>Ownership Type</th>
<th>Large</th>
<th>Small</th>
<th>Rural</th>
<th>Subtotal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>19</td>
<td>7</td>
<td>-</td>
<td>26</td>
</tr>
<tr>
<td>Not-for-profit</td>
<td>15</td>
<td>3</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Public</td>
<td>1</td>
<td>7</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Independent</td>
<td>23</td>
<td>13</td>
<td>7</td>
<td>43</td>
</tr>
<tr>
<td>Provider-based</td>
<td>12</td>
<td>4</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>IRHF</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Not IRHF</td>
<td>33</td>
<td>12</td>
<td>-</td>
<td>45</td>
</tr>
<tr>
<td>Subtotal</td>
<td>35</td>
<td>17</td>
<td>8</td>
<td>60</td>
</tr>
</tbody>
</table>
Ownership and governance structure is an important component to consider when assessing RHCs because this determines how the business will operate and to whom it is accountable. The different governance structures reflect different focuses and missions of the individual clinics. As well as ownership, clinics differ in respect to community size and operation type. Due to this variety, it can be a challenge to identify areas of common concern for RHCs statewide. The only group of RHCs that shows some homogeneity on the dimensions of governance and location are the 26 private clinics which are all independent (not provider-based) RHCs in large or small, but not rural, service areas. The not-for-profit and public clinics display a variety of governance models, operation types, and service area sizes.

As shown in Figure 9, below, the total number of Oregon RHCs has increased by 13 clinics (or 28%) since 2004 for an average annual net increase of 2.2 newly certified RHCs per year. Some change has occurred in all three ownership categories although the number of private clinics has shown the greatest overall increase while public clinics have entered and left the program resulting in no net change in number. From 2004 to 2007 newly certified RHCs were predominately for-profit operations which reduced the proportion of public and not-for-profit clinics to from 66% in 2004 to 58% in 2007. The relative proportions remained nearly steady from 2007 to 2010 with 57% of the 60 RHCs identified in 2010 operating under some corporate structure other than as a for-profit business.

Figure 9: Number of Oregon RHCs by ownership type and year (totals shown at top of columns)
Community Size

Oregon’s RHCs can be found in a variety of communities around the state. The populations of primary care service areas containing RHCs range from the Jordan Valley area with an estimated population of 466 in 2010 to the Grants Pass service area, population 70,294 (ORH, 2011; population data from Claritas). See page 15 for more information on service area community size categories.

The number of RHCs in Oregon by community size is shown in Figure 10 and more details on 2010 RHC distribution is in Table 6. The net growth in numbers of RHCs statewide has occurred in larger communities.

The eight clinics in rural communities in 2010 are all designated as IRHFs. Due to low patient volume these clinics often need assistance to supplement operating revenue. No private, for-profit RHCs are found in these service areas.

Although the number of clinics in the smallest rural service areas has not changed significantly in the last six years, the proportion of rural RHCs continues to decline as RHCs are added in more populated areas.

The 17 clinics in small town service areas include five designated IRHFs. Most of these clinics operate as independents with only four provider-based RHCs in small towns. Private clinics make up 41% of the RHCs in small towns.

The 35 RHCs in large town service areas include two IRHFs (service areas may include multiple towns and these clinics are located in portions of the service area that lack other providers). There are no health districts and only one publically owned clinic located in large town service areas. Private clinics make up 54% of the RHCs in large towns. Nearly three-quarters of currently certified private RHCs in Oregon are located in large town service areas.

<table>
<thead>
<tr>
<th>Service Area:</th>
<th>2004</th>
<th>2007</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large (≥10,000):</td>
<td>51%</td>
<td>55%</td>
<td>58%</td>
</tr>
<tr>
<td>Small (2,500-9,999):</td>
<td>26%</td>
<td>30%</td>
<td>28%</td>
</tr>
<tr>
<td>Rural (&lt;2,500):</td>
<td>23%</td>
<td>15%</td>
<td>13%</td>
</tr>
</tbody>
</table>
Clinic Operations

Market Share

The ORH uses National Ambulatory Medical Care Survey statistics (Hsiao, Cherry, Beatty, and Rechtsteiner, 2010) to determine the demand for clinic visits in a given community based on the age and gender distribution of its service area population. The number of a clinic’s visits, expressed as a percentage of the community’s overall demand, is the clinic’s market share. The National Ambulatory Medical Care Survey reports that 60% of all medical visits are for primary care; therefore when calculating primary care market share the denominator used is 60% of the community’s projected total demand for medical care visits.

Market share is an important indicator when considering a clinic’s overall viability. If a clinic has 100% market share, it means the clinic is capturing the maximum number of primary care visits from the service area. When a clinic has less than 100% market share, it is an indication that people from within the service area are seeking primary care somewhere else—this is known as out-migration. Occasionally, a clinic will have more than 100% market share. This suggests that people from outside the service area are receiving primary care at the clinic.

Two key points to consider about market share are, one, out-migration moves health care dollars out of the local community, and two, increased market share means increased revenue. An important consideration for isolated facilities in particular is that, in areas with small populations, a high market share may not indicate sufficient volume to support a clinic. Market share should not be considered the only measure of clinic success.
As Figure 11 shows, market share is not a factor of ownership type. IRHFs have the highest average market share by a slight margin, but all ownership categories have a similar range.

<table>
<thead>
<tr>
<th>Ownership Type</th>
<th>Average</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Market Share for all Clinics</td>
<td>41%</td>
<td>3%-113%</td>
</tr>
<tr>
<td>Isolated Rural Health Facility</td>
<td>56%</td>
<td>11%-99%</td>
</tr>
<tr>
<td>Independent RHC</td>
<td>38%</td>
<td>3%-99%</td>
</tr>
<tr>
<td>Provider-Based</td>
<td>58%</td>
<td>19%-113%</td>
</tr>
<tr>
<td>Health District</td>
<td>55%</td>
<td>11%-99%</td>
</tr>
<tr>
<td>For Profit</td>
<td>32%</td>
<td>3%-113%</td>
</tr>
<tr>
<td>Not-for-Profit</td>
<td>49%</td>
<td>6%-99%</td>
</tr>
</tbody>
</table>

**Figure 11: Market share by ownership and operation type over time, n = 36**

**Recommendations: Market Share**

- Clinics should have a mission statement and market the clinic based upon their mission. “A modern health care organization today must decide whether providing high-quality medicine or improving societal or community health status should be the organizational goal. If community wellness becomes the mission, this might lead to the recognition of different trends in the environment and necessitate different responses from the organization.” (pg 39, Berkowitz, 2006)
- Create a website to advertise the clinic and its services.
- Follow the “four P’s” of marketing: Product, Price, Place, and Promotion.
- Be aware of how the clinic appears to the public. Consider the condition of internal and exterior surfaces, landscaping, signage and the cleanliness of the building.
- Healthcare is like any other business in that the public’s perception is key. A clean and tidy clinic gives a perception of quality and professionalism.
- Have clearly visible street and clinic signage.
Payer Mix

Rural Health Clinics often rely on the reimbursement they receive from Medicare and Medicaid under the RHC program. To be economically viable RHCs also need to have a large part of their reimbursement coming from private insurance. Figure 12 shows the current payer mix for RHCs, but payer mix can vary greatly among individual RHCs depending on their situation and community demographics.

![Figure 12: Average RHC payer distribution](image)

## Hours of Operation

Clinic hours are important from many perspectives. If a clinic is open more often than is justified by its number of patients, expenses can significantly exceed patient revenue. Alternatively, if a clinic is not open enough it may not be meeting the needs of patients, which can decrease market share.

There is a range of hours among Oregon’s RHCs; however, as seen in 2008, the majority of clinics are open five days a week. All of the 45 clinics who responded to this survey question are open Monday – Thursday and most of them are open on Fridays. Nineteen clinics reported closing at least one hour for lunch; the other 26 were open over lunch.

<table>
<thead>
<tr>
<th>Days per week</th>
<th>Number of RHCs open</th>
<th>Number with extended hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>33</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of RHCs open</th>
<th>Number with extended hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>45</td>
</tr>
<tr>
<td>Tuesday</td>
<td>45</td>
</tr>
<tr>
<td>Wednesday</td>
<td>45</td>
</tr>
<tr>
<td>Thursday</td>
<td>45</td>
</tr>
<tr>
<td>Friday</td>
<td>42</td>
</tr>
<tr>
<td>Saturday</td>
<td>9</td>
</tr>
<tr>
<td>Sunday</td>
<td>1</td>
</tr>
</tbody>
</table>
A total of 13 clinics reported some form of extended hours, defined as open later than 5:00 pm on at least one weekday or open at any time on Saturday or Sunday. Eight of those RHCs have extended hours most days of the week while the other five offer the service once a week. Offering extended (or shifted, e.g. open later and close later) hours at least once a week can be a good way for smaller clinics to enhance access to their services without overstretching their staff and resources.

Clinics in all categories offered extended hours with no clear trends observed in operation type (both provider-based and independent), service area size (varied from rural to large), or ownership (some but not all, private, not-for-profit, and health district clinics all offer these schedules).

Remaining open on holidays will increase a clinic’s total hours open over the course of a year. Holidays can be good days for clinics to remain open because many patients will not have to work and so may more easily access clinic services on these days. Only four RHCs reported no holiday hours. The other 41 are open some holidays although not necessarily the same days. Clinics with holiday hours may not be open the full day—on Christmas Eve in particular many clinics closed at noon.

### Table 10: Number of RHCs reporting some holiday service

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Number of RHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martin Luther King Day</td>
<td>37</td>
</tr>
<tr>
<td>Christmas Eve</td>
<td>32</td>
</tr>
<tr>
<td>President's Day</td>
<td>31</td>
</tr>
<tr>
<td>Day after Thanksgiving</td>
<td>19</td>
</tr>
<tr>
<td>New Years Eve</td>
<td>4</td>
</tr>
<tr>
<td>July 4th</td>
<td>3</td>
</tr>
<tr>
<td>Memorial Day</td>
<td>2</td>
</tr>
<tr>
<td>Thanksgiving</td>
<td>2</td>
</tr>
<tr>
<td>New Years Day</td>
<td>1</td>
</tr>
<tr>
<td>Labor Day</td>
<td>1</td>
</tr>
<tr>
<td>Christmas Day</td>
<td>1</td>
</tr>
</tbody>
</table>

The total hours open in a normal (non-holiday) week for RHCs varied from a high of 80.5 hours per week to a low of 22.5 hours per week. The distribution of hours per week is shown in Figure 13. Clinics in small and rural service areas tend to be open fewer total hours per week compared to clinics in service areas with larger populations. This likely reflects a tendency to align clinic hours with demand for primary care services.

**Key Findings: Hours of Operation (n = 45)**

- The majority of clinics are open Monday-Thursday during standard business hours.
- Thirteen clinics have extended hours beyond traditional 8:00-5:00 business hours.
- Larger RHCs average more hours per week.
Recommendations: Hours of Operations

- Match clinic hours to demand from the community. Clinics should be open sufficient hours to meet community needs yet not so long as to lead to expenses that are greater than revenues.
- Survey patients to see if current hours meet their needs.
- Clinic hours should be well publicized, particularly if they vary by day of the week.
- Clinics should explore ways to be open when schools and employers are closed. It may require trial and error to determine the best configuration of hours to meet a given community’s needs and primary care demand.

Physical Plant

The physical structure is important both to how customers perceive the clinic and to how the clinic functions. Cramped spaces and awkward movement can be a handicap to providers, staff, and patients. The external and internal physical space is the clinic’s first opportunity to make a good impression on everyone who visits. A pleasant physical work environment is also an advantage when recruiting medical providers and support staff. The buildings that house RHCs vary significantly in size and age, but 74% report their building currently meets their needs.
<table>
<thead>
<tr>
<th>RHC category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>16</td>
<td>80%</td>
</tr>
<tr>
<td>Public</td>
<td>7</td>
<td>64%</td>
</tr>
<tr>
<td>Not for Profit</td>
<td>12</td>
<td>75%</td>
</tr>
<tr>
<td>Rural service area</td>
<td>5</td>
<td>71%</td>
</tr>
<tr>
<td>Small service area</td>
<td>8</td>
<td>67%</td>
</tr>
<tr>
<td>Large service area</td>
<td>22</td>
<td>79%</td>
</tr>
<tr>
<td>Overall</td>
<td>35</td>
<td>74%</td>
</tr>
</tbody>
</table>

Key Findings: Physical Plant, n = 47

- The newest RHC building was completed in 2010, the oldest in 1916!
- 40% of RHCs own their building (19 of those reporting).
- The current building meets the needs of 74% of RHCs (35 of those reporting). Privately owned RHCs are more likely to report that the clinic meets their needs than public and not-for-profit operations, however the differences are not large.
- The 26% (12 clinics) whose building did not meet current needs overwhelmingly reported that they needed more space.
- Some clinics are unable to expand services to meet demand due to space limitations.
- Four clinics are currently planning or carrying out renovations.

Recommendations: Physical Plant

- Be aware of how the clinic appears to the public and to potential recruits. Take advantage of the opportunity to make a good first impression by insuring that internal and external appearance, landscaping, and signage are well-maintained.
- Ensure that signage is clear and plentiful so that potential patients, particularly visitors from out of town, can easily find the clinic and determine hours of operation.
- Post after-hours information in a location that can be accessed and read after hours and at night.
- Budget money for future capital expenditures, renovation, and expansion.
- Clinics should have wheelchair accessible sidewalks, doors, and hallways.
- Not-for-profit and publicly owned clinics may be able to access grant funding and/or low-cost loans for capital expenditures including buildings.

Productivity Standards

Productivity standards are the basis for an RHC’s Medicare encounter rate. CMS uses the following annual productivity standards: 4200 encounters for physicians (1 FTE); 2100 encounters for physician assistants, nurse practitioners; and certified nurse midwives (1 FTE). There is no history or other information regarding how these standards were established. For Medicare calculations one full-time-equivalent is considered 40 hours per week. The productivity standard is adjusted by FTE before it is applied to the actual number of encounters. For example, a 0.5 FTE nurse practitioner (20 hours/week) has a productivity standard of 1050 encounters. A clinic’s Medicare rate per encounter equals the total
allowable costs divided by either the actual number of encounters OR the productivity standard, whichever is higher. Medicaid pays a cost-based encounter rate as well, but does not use productivity standards to calculate that rate.

Productivity is tied closely to market share - if the market share is low, but the productivity standard is being met, then additional providers should be added to increase market share. If the market share is low and productivity standard is not being met, then increasing the productivity will increase the market share.

Medicare currently caps the payment for most RHCs. Because of this cap the incentive to stay at the productivity standard is minimal as long as the cost per encounter does not drop below the cap. At this point, many clinics actually benefit by exceeding the productivity standard due to the revenue generated by seeing additional encounters, while still receiving the maximum possible reimbursement from Medicare. It’s important for clinics to monitor their productivity to ensure they don’t fall below the Medicare Cap rate. In 2010, 100% of the clinics that reported their Medicare rate were above the 2010 cap.

If providers produce significantly higher or lower than the standard, it is likely that the clinic will lose money per encounter. Again, Medicare payments are based on allowable costs divided by the higher of either the number of encounters or the productivity standard. If a provider is above or below the productivity standard, the total allowable cost is divided by the higher number, making the average cost per encounter lower. It is counter-intuitive to work less in order to make more. However, that is exactly how RHC reimbursement is structured. Every encounter beyond the productivity standard means less money per encounter. In Table 12, by working below the productivity standard, the clinic is actually losing $16.09 per encounter. In Table 13, the clinic is working at the productivity standard and is receiving 100% of the allowable costs. In Table 14, by working over the productivity standard, the clinic is actually losing $19.05 per encounter. These examples do not take the Medicare Cap into consideration. Even though the calculated Medicare encounter rates vary depending on productivity, the actual reimbursement received by independent RHCs from Medicare is based on the Medicare Cap rate, $78.07 for 2011.

<table>
<thead>
<tr>
<th>Table 12: Example BELOW Productivity Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Encounters</td>
</tr>
<tr>
<td>Productivity Standard</td>
</tr>
<tr>
<td>Total Allowable Costs</td>
</tr>
<tr>
<td>Actual Cost Per Encounter</td>
</tr>
<tr>
<td>Encounter Rate at Productivity Standard</td>
</tr>
<tr>
<td>Dollar Difference Per Medicare Encounter</td>
</tr>
</tbody>
</table>
Fees

Fees vary widely among Oregon’s RHCs. Many clinics fear that raising fees will cause an undue burden on patients who are uninsured and/or unable to pay for medical services. A schedule of discounts is an effective way to provide for those who are uninsured and low-income. If fees are set too low, a clinic can fail to recoup all the money possible from third party payers if they are willing to pay more than was billed.

Table 13: Example AT Productivity Standard

<table>
<thead>
<tr>
<th>Actual Encounters</th>
<th>2100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity Standard</td>
<td>2100</td>
</tr>
<tr>
<td>Total Allowable Costs</td>
<td>$250,000</td>
</tr>
<tr>
<td>Actual Cost Per Encounter</td>
<td>$250,000/2100 $119.05</td>
</tr>
<tr>
<td>Encounter Rate at Productivity Standard</td>
<td>$250,000/2100 $119.05</td>
</tr>
<tr>
<td>Dollar Difference Per Medicare Encounter</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Table 14: Example ABOVE Productivity Standard

<table>
<thead>
<tr>
<th>Actual Encounters</th>
<th>2500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity Standard</td>
<td>2100</td>
</tr>
<tr>
<td>Total Allowable Costs</td>
<td>$250,000</td>
</tr>
<tr>
<td>Actual Cost Per Encounter</td>
<td>$250,000/2500 $100.00</td>
</tr>
<tr>
<td>Encounter Rate at Productivity Standard</td>
<td>$250,000/2100 $119.05</td>
</tr>
<tr>
<td>Dollar Difference Per Medicare Encounter</td>
<td>($19.05)</td>
</tr>
</tbody>
</table>

Table 15: Average Reported Fees, 2010, n = 23

<table>
<thead>
<tr>
<th>RHC TYPE</th>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
<th>99211</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Non-Profit</td>
<td>$68.45</td>
<td>$123.91</td>
<td>$178.96</td>
<td>$271.79</td>
<td>$348.98</td>
<td>$39.52</td>
<td>$74.26</td>
<td>$118.17</td>
<td>$177.95</td>
<td>$238.51</td>
</tr>
<tr>
<td>Independent For-Profit</td>
<td>$74.80</td>
<td>$123.19</td>
<td>$182.82</td>
<td>$273.60</td>
<td>$352.10</td>
<td>$42.51</td>
<td>$76.48</td>
<td>$120.45</td>
<td>$185.30</td>
<td>$249.08</td>
</tr>
<tr>
<td>Public/Health District</td>
<td>$68.13</td>
<td>$131.05</td>
<td>$191.73</td>
<td>$282.89</td>
<td>$326.63</td>
<td>$38.71</td>
<td>$77.06</td>
<td>$115.95</td>
<td>$177.59</td>
<td>$246.63</td>
</tr>
<tr>
<td>Low</td>
<td>$20.00</td>
<td>$98.00</td>
<td>$141.98</td>
<td>$183.20</td>
<td>$265.00</td>
<td>$17.77</td>
<td>$60.00</td>
<td>$80.00</td>
<td>$126.00</td>
<td>$184.00</td>
</tr>
<tr>
<td>Median</td>
<td>$75.00</td>
<td>$126.00</td>
<td>$183.26</td>
<td>$282.00</td>
<td>$353.45</td>
<td>$37.00</td>
<td>$75.00</td>
<td>$123.00</td>
<td>$185.00</td>
<td>$250.00</td>
</tr>
<tr>
<td>High</td>
<td>$91.80</td>
<td>$159.00</td>
<td>$236.00</td>
<td>$362.00</td>
<td>$455.00</td>
<td>$96.20</td>
<td>$102.70</td>
<td>$154.70</td>
<td>$233.00</td>
<td>$316.00</td>
</tr>
<tr>
<td>2010 Average</td>
<td>$73.87</td>
<td>$126.55</td>
<td>$186.10</td>
<td>$278.22</td>
<td>$350.93</td>
<td>$42.38</td>
<td>$77.23</td>
<td>$120.40</td>
<td>$184.19</td>
<td>$249.83</td>
</tr>
<tr>
<td>2008 Average</td>
<td>$70.69</td>
<td>$117.78</td>
<td>$170.67</td>
<td>$241.35</td>
<td>$304.93</td>
<td>$39.11</td>
<td>$69.40</td>
<td>$99.84</td>
<td>$152.96</td>
<td>$217.55</td>
</tr>
<tr>
<td>2005 Average</td>
<td>$60.13</td>
<td>$98.00</td>
<td>$142.00</td>
<td>$201.08</td>
<td>$264.95</td>
<td>$35.02</td>
<td>$59.46</td>
<td>$80.92</td>
<td>$124.89</td>
<td>$183.28</td>
</tr>
</tbody>
</table>

National Health Service Corps has examples of schedules of discounts on their website. [http://nhsc.hrsa.gov/communities/discountedfee.pdf](http://nhsc.hrsa.gov/communities/discountedfee.pdf)
Table 15 shows the reported fees for ten CPT codes (Current Procedure Terminology, the codes used to describe medical services for billing purposes) commonly used by RHCs. Only 23 clinics reported their current fee schedules and there was a somewhat higher response rate among independent clinics compared to provider-based ones. As expected, fees are higher for initial visits and for more complicated visits within both the initial and repeat visit categories. The range of fees reported is shown by the whisker bars in the graph in Figure 14. Individual clinics generally show the same relative trend in their fee schedules. A given clinic was generally consistently high or consistently low in the fee distribution, but there is considerable overlap from one code to another at different clinics. RHCs are distributed widely and the medical services market varies throughout Oregon so it is to be expected that fees will vary at different clinics in different areas.

Figure 14: Box plots showing distribution of current fee schedules for Oregon RHCs, n = 23
The Impact of Fees on Revenue

RHCs receive payment for Medicare services from two sources—one payment from Medicare and another from the patient. Medicare pays the RHC based on the interim rate (Medicare capped rate), $78.07 in 2011. The patient pays the clinic based on the actual charges for the service. Table 16 demonstrates the effect charges have on total reimbursement from Medicare in the RHC program.

Table 16 uses the low, average, and high fee for a 99213 from the data collected in the survey. As it shows, total reimbursement varies depending on the amount charged by the clinic. There is a difference in total reimbursement of **$8.08** between the low and average fee and a difference of **$6.86** between the average and high fee. The difference in reimbursement between the clinic with the lowest fee and the clinic with the highest fee is **$14.94**.

<table>
<thead>
<tr>
<th>Table 16: Example fees collected for CPT Code 99213</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge</td>
<td>$80.00</td>
<td>$120.40</td>
<td>$154.70</td>
</tr>
<tr>
<td>Medicare Reimbursement (capped rate)</td>
<td>$78.07</td>
<td>$78.07</td>
<td>$78.07</td>
</tr>
<tr>
<td>Actual Medicare Payment (80% of capped rate)</td>
<td>$62.46</td>
<td>$62.46</td>
<td>$62.46</td>
</tr>
<tr>
<td>Copayment From Patient (20% of charges)</td>
<td>$16.00</td>
<td>$24.08</td>
<td>$30.94</td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td>$78.46</td>
<td>$86.54</td>
<td>$93.40</td>
</tr>
</tbody>
</table>

Availability of Services

RHCs provide primary care services. As noted in the description of the RHC program on page 1, certified RHCs must be predominately a primary care practice (family practice, general internal medicine, pediatrics, and/or obstetrics and gynecology), employ a mid-level provider, and offer six basic laboratory tests on site.

The range of services available at an RHC varies considerably among the different clinics in Oregon. Table 17 gives a profile of RHC services based on the Checklist of Services on the 2010 RHC survey. Respondents were asked to report if a given service was provided in the clinic by RHC staff, in the facility by other providers who periodically visit the RHC site, and/or if it was locally available by referral within 30 minutes travel time. Note that respondents did not necessarily indicate that a service was also available locally if they provided it at the clinic although some did do so on their surveys. “Unavailable” shows the count of clinics that did not indicate any local option to access a specific service.
Table 17: Number of clinics providing specified services. Services may be offered by RHC staff, by visiting providers, and locally (n = 43).

Services are ordered from most to least frequent, categories are not mutually exclusive.

<table>
<thead>
<tr>
<th>Service</th>
<th>RHC Staff</th>
<th>Visiting</th>
<th>Locally</th>
<th>Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Primary Care</td>
<td>43</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Immunizations</td>
<td>37</td>
<td>1</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Sports Physicals</td>
<td>36</td>
<td>1</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Following Hospitalized Patients</td>
<td>33</td>
<td>0</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Family Planning</td>
<td>30</td>
<td>3</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Employment Physicals</td>
<td>30</td>
<td>0</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Urgent Medical care</td>
<td>29</td>
<td>1</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Gynecological Care</td>
<td>27</td>
<td>2</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Diagnostic Laboratory</td>
<td>23</td>
<td>4</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>Diagnostic Tests/Screenings</td>
<td>21</td>
<td>1</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>24-hour Coverage</td>
<td>21</td>
<td>0</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>21</td>
<td>0</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Home Visiting</td>
<td>21</td>
<td>0</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>19</td>
<td>0</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>Interpretation/Translation Services</td>
<td>19</td>
<td>0</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>Health Education</td>
<td>18</td>
<td>0</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>18</td>
<td>0</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td>15</td>
<td>0</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>Postpartum Care</td>
<td>14</td>
<td>2</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td>Diagnostic X-ray Procedures</td>
<td>13</td>
<td>1</td>
<td>22</td>
<td>7</td>
</tr>
<tr>
<td>Nursing Home &amp; Assisted Living Placement</td>
<td>12</td>
<td>0</td>
<td>21</td>
<td>12</td>
</tr>
<tr>
<td>Parenting Education</td>
<td>11</td>
<td>1</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>Prenatal Care/Maternity Case Management</td>
<td>9</td>
<td>2</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Antepartum Fetal Assessment</td>
<td>9</td>
<td>1</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Nutrition Services other than WIC</td>
<td>8</td>
<td>1</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>Eligibility Assistance</td>
<td>8</td>
<td>0</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Case Management</td>
<td>8</td>
<td>0</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>Labor and Delivery Professional Care</td>
<td>7</td>
<td>1</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Hospice</td>
<td>7</td>
<td>0</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
<td>7</td>
<td>0</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>6</td>
<td>0</td>
<td>26</td>
<td>12</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>5</td>
<td>1</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>5</td>
<td>0</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>Outreach</td>
<td>5</td>
<td>0</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Directly Observed TB Therapy</td>
<td>5</td>
<td>0</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>Dental Care</td>
<td>4</td>
<td>3</td>
<td>30</td>
<td>8</td>
</tr>
<tr>
<td>WIC Services</td>
<td>4</td>
<td>1</td>
<td>29</td>
<td>9</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>4</td>
<td>0</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>Food Bank/Delivered Meals</td>
<td>3</td>
<td>1</td>
<td>30</td>
<td>12</td>
</tr>
</tbody>
</table>
Table 17, continued

<table>
<thead>
<tr>
<th>Service</th>
<th>RHC Staff</th>
<th>Visiting</th>
<th>Locally</th>
<th>Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational or Vocational Therapy</td>
<td>2</td>
<td>0</td>
<td>26</td>
<td>15</td>
</tr>
<tr>
<td>Other Specialty Care</td>
<td>1</td>
<td>2</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>Podiatry</td>
<td>1</td>
<td>1</td>
<td>27</td>
<td>14</td>
</tr>
<tr>
<td>Genetic Counseling and Testing</td>
<td>1</td>
<td>1</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>1</td>
<td>0</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>Child Care</td>
<td>1</td>
<td>0</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td>1</td>
<td>0</td>
<td>21</td>
<td>22</td>
</tr>
<tr>
<td>Environmental Health Risk Reduction</td>
<td>1</td>
<td>0</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>0</td>
<td>1</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>24-hour Crisis Intervention/Counseling</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>10</td>
</tr>
<tr>
<td>Massage</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>10</td>
</tr>
<tr>
<td>Transportation</td>
<td>0</td>
<td>0</td>
<td>28</td>
<td>15</td>
</tr>
</tbody>
</table>

All RHCs provide general primary care. The majority provide related services including immunizations, sports and employment physicals, family planning, and diagnostic tests and screenings. While many communities have services available locally, both within and apart from the RHC, it does not always mean that patients can get appointments for these services or can pay for them. Mere availability provides little information on quantity and affordability of services, the types of insurance accepted, or assistance available for those without insurance or unable to pay. **It is important to distinguish between availability of care and feasible access to care.**

Under the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), Medicare payments for mental health services will increase over the 5-year period from 2010-2014 as the outpatient mental health treatment limitation is phased out. This will result in Medicare paying for mental health treatment provided by RHCs at the same encounter rate as for other health services, or 80% of the capped encounter rate. This increased payment level may provide an opportunity for more RHCs to offer mental health services.
Key Findings: Availability of Services (n = 43)

- Only five clinics report on-site pharmacy services, yet 81% have local pharmacy services in some form.
- Specialty care, including TB therapy, genetic testing, fetal assessment, and amniocentesis were the services least likely to be locally available from any provider.
- Immunizations, physicals, urgent care, and routine primary care were all available in more than 80% of communities.
- Urgent care was provided by 67% of clinics and locally available (including from the RHC) for 91%.
- Dental care is available in 16% of clinics and locally available for 81% of clinics.

Recommendations: Availability of Services

- Establish and maintain referral systems and relationships with specialty care providers.
- Consider bringing specialty providers and services into clinics through the use of visiting specialists or telemedicine.
- Learn how to successfully establish and bill for mental health services within an RHC.
- Conduct a needs assessment of the service area to assure the services offered meet the services demanded.
Recruitment and Retention

The recruitment and retention of qualified clinical and administrative staff is essential to the survival of an RHC. Many RHCs report that their dedicated staff and medical providers are among their greatest strengths. Recruitment and retention plans are essential tools for recruiting appropriate providers and administrative staff who in turn provide access to services, stability, and promote long-term survival of the RHC.

One very successful community model of provider recruitment is the Rimrock Health Alliance (RHA) in Crook County. This community group grew out of a Community Health Improvement Partnership (CHIP) community development process that began in 2007. One of their ongoing projects is community-based provider recruitment and retention. RHA seeks to recruit providers to the community, for the community, using community-wide strategies. Their successful strategy was/is to involve a range of community businesses and organizations within and outside of health care fields. Board members who have a vested interest in success of the alliance include FQHC, RHC, and CAH administrators as well as business leaders and private practice interests. RHA recruited four new hires to Crook County in 2010 alone.

http://www.rimrockha.org/

The entire nation faces a health care workforce shortage, particularly in primary care. Shortages are further exacerbated in rural areas because of the maldistribution of available providers (Agency for Health Care Research and Quality, 2005). As rural providers age along with the populations they serve, finding their replacements and meeting increasing community need is becoming challenging. This requires clinics to be more attentive and organized in their recruitment and retention efforts.

In 2009 the Oregon Department of Human Services found that 22% of physicians statewide plan to retire within five years; in Eastern Oregon nearly one third of physicians are over 60 years of age (Swendsen & Isgrigg, 2010). Factors such as perceived call hours, assumed income potential, and the small town lifestyle all reduce the number of providers willing to practice in rural areas. Limited supply and urban preference means that recruitment of physicians and other clinicians to rural areas can take years. Some RHCs report that they are essentially always recruiting medical providers as positions turn over.

The ORH recommends that, to ensure continuity of healthcare services in a community, the RHC develop an active Recruitment and Retention (R/R) plan. Even if the current practitioner does not plan to retire in the immediate future, there are many reasons to have a plan in place. A well executed R/R plan means the clinic reduces overall recruitment costs and limits revenue instability arising from retention problems. The A report from the Center for Studying Health System Change suggests that perceptions of lower income for rural physicians are inaccurate. When adjusted for specialty mix and local cost of living, rural physicians actually have higher incomes than their urban peers (Reschovsky & Staiti, 2005).
average recruiting time for Oregon RHCs was 16 months, less than the national average of 24 months. Recruiting times nationwide are expected to increase in the future.

2010 Key Findings: Recruitment and Retention (n = 47)

- 20 RHCs, or 43% are currently recruiting staff and half of those (10 RHCs) are seeking to fill multiple positions
- Recruiting time varied from less than a month to several years. The median recruiting time was 6 months and the mean was 16 months.
- 1 of the clinics currently recruiting was able to share their R&R plan
- 4 clinics not recruiting had an R&R plan and were able to share it
- Only 11% of clinics that responded had a recruitment and retention plan that they were able to share.
- 5 of 13 IRHFs currently recruiting (39%)
- 15 of 28 large service area RHCs currently recruiting (54%)
- 4 of 12 small service area RHCs currently recruiting (33%)
- 1 of 7 rural service area RHCs currently recruiting (14%)

Medical Staff Turnover

Reported medical staff turnover is summarized in Table 18. Two-thirds of clinics saw some change in their staff makeup in the last two years.

Table 18: RHCs experiencing Medical Staff Change, n = 47

<table>
<thead>
<tr>
<th></th>
<th>Loss</th>
<th>Gain</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>11</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>%</td>
<td>11%</td>
<td>23%</td>
<td>32%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Midlevel providers may be physician assistants or nurse practitioners under several different classifications such as pediatric NP or family NP. More clinics saw changes in their midlevel providers than in their physician makeup. The reasons may include: less turnover among RHC physicians than RHC midlevels, more midlevel providers than physicians providing RHC medical services, or a combination of the two. Table 19 lists the total number of providers gained and lost by provider type.

Table 19: Number of Providers added and lost by RHCs in the past two years, n = 47 clinics

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Number Added</th>
<th>Number Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td>Midlevel</td>
<td>32</td>
<td>20</td>
</tr>
<tr>
<td>Both</td>
<td>53</td>
<td>36</td>
</tr>
</tbody>
</table>
2010 Key Findings: Medical Staff Turnover (n = 47)

- Most RHCs saw some medical staff change—gain, loss, or both
- Slightly more clinics added staff than lost staff, although experiencing both was the most common situation
- RHCs are likely to experience staff turnover and should have a plan in place to manage it

Loan Repayment

Loan repayment programs are one recruitment tool available to RHCs. Table 20 shows the number of clinics with one or more providers receiving loan repayment through the various available programs. Some clinics had providers receiving funding under more than one program.

<table>
<thead>
<tr>
<th>Table 20. Loan repayment by program type, n = 47</th>
<th>Number of clinics</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more providers receiving loan repayment</td>
<td>20</td>
</tr>
<tr>
<td>State program</td>
<td>4</td>
</tr>
<tr>
<td>Federal program</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
<tr>
<td>Unspecified</td>
<td>10</td>
</tr>
<tr>
<td>None</td>
<td>27</td>
</tr>
</tbody>
</table>

Twenty clinics reported utilizing loan repayment incentives to recruit and/or retain providers. This appears to be an effective incentive for recruitment. If care is taken in determining professional and community ‘fit’ for recruited providers, retention can be positively impacted. R/R plans that focus on retention from the first encounter with a potential candidate can further enhance retention.

The Office of Rural Health has done the following analysis of the State Loan Repayment Program that was de-funded in the 2009 legislative session. The program may be re-funded in the 2011 session. The data demonstrates that the loan repayment program is hugely successful in recruiting and retaining providers. When reviewing this information, keep in mind that the more recent awardees have not had the opportunity for the longevity of service that those awarded in the early years of the program have had.
The type of loan repayment varies and is typically based on some number of years of obligated service in return for assistance with student loans. There are two state programs. The first is one that will hopefully be re-funded during this legislative session and has historically been based on unmet need status of the employment site and a competitive application process. If not funded, the program will continue to exist only to administer prior commitments. A second state program is partially funded by a federal grant. This second program requires that a community provide a 1:1 match of loan repayment funds. The full obligated amount, plus administrative overhead must be paid by the site at the time of application approval. Participation criteria in this program are similar to that of the National Health Service Corps (NHSC).

A federal loan option is the NHSC which requires site approved eligibility and awardee (provider) approved eligibility. Criteria and applications are available at www.nhsc.hrsa.gov. This program is dependent upon national budget allocations – so the annual dollars are fluid – as are the number of applications. When resources are scarce, distributions are made to eligible participants based on HPSA scores. If your score is not high, your providers may not be able to take advantage of this program.

Another option is a site-funded loan repayment contract, negotiated similarly to the other programs – some agreed upon assistance with loans in return for some set amount of service. If this becomes a topic of discussion, remember that there is a limited time period, established by negotiation, for loan repayment.
repayment assistance. Some facilities/providers would rather negotiate a higher salary to assist with loan repayment. Over the long run this will be more costly to the practice as there is no defined end point.

Oregon Office of Rural Health Recruitment Tool Box

- VISION – Consensus is critical – Educate board members about how to communicate with practitioners and promote the community. Utilize the talents in your growing retirement communities to teach marketing and coach on the fine art of recruitment – engaging a potential provider in a meaningful relationship.
- Needs assessment to validate current or predict future staffing needs – particularly important as the survey reveals a significant amount of activity in staff movement. The board members need to anticipate this change and provide incentives for early notification of impending departure for retirement or otherwise.

1. Website development - *continues to be a high priority as people increasingly utilize the web for the discovery of information.*
2. Build community (general and medical) support
   - Recognize the interconnectedness among healthcare, schools and economic development in vital communities.
   - Physicians know how to recruit other physicians – engage them.
   - Build loan repayment and retirement notification incentive resources into recruitment budget.
   - Community health resource guide – shows potential candidate that the community takes healthcare seriously.
   - Dedicated recruitment person – more critical than ever. Competition for candidates nationwide is at an all-time high. If you do not respond to an interested party within a few hours, someone else will. Quick response is essential to every communication.
   - Preplanning, organization, and follow-through are critical to success and require the full buy-in of the recruitment team.
   - R/R costs (including recruitment position) built into budgets and cost report
3. Take advantage of every available local, state and federal incentive
4. Gather examples of best R/R practices and use those that are applicable
5. Develop creative options:
   - Decreased interest on home mortgage loans
   - Offer housing to encourage health professions students to do clinical rotations in the community
   - Local gift baskets, newspaper subscriptions, etc. Base these on information gathered by all team members during the recruitment process.
Recommendations: Recruitment and Retention

- **Have a plan that meets your vision (and the perceived needs of your community):** This is the foundation of your recruitment effort and provides the map to a successful recruitment and long term retention.

- **Retention strategies must be stated in the R/R plan.** Create individualized retention plans for each newly recruited practitioner. This begins with each interviewer sharing tidbits or personal provider information captured during the recruitment process – from the first telephone conversation forward – so that personalized retention strategies can be developed. I.e., the provider’s favorite bottle of wine is?? A 2004 Garden Valley Merlot is presented for a special appreciation day. Favorite flower?? An orchid is delivered on another occasion. Time of the day?? Early morning?? Treat the provider to a few unexpected hours off to care for themselves.

- **Share the written plan with all parties involved so that all will be “on the same page” in the recruitment effort.** All members of the recruitment team must be able to share the same information with a candidate without variation and without hesitation.

- **Present your opportunity to candidates with confidence and clarity to assure them that they are joining a well-run operation.** If the recruitment process does not run smoothly when you are recruiting – the courting stage – the candidate will assume that things will only get worse with time and familiarity.

- **Stay tuned in to the needs of your community – real and perceived.** Regularly assess the current and anticipated needs of your community in order to determine what type of provider will most appropriately meet those needs and to make sure your facility is being responsive to these needs. The Oregon Office of Rural Health can provide information and resources for community and service area assessments.

- **Seek opportunities to develop relationships with students to encourage their interest in health professions and return to your community upon completion of their healthcare training.** This is important for physicians, mid-level providers, nurses, and allied health professions. Make opportunities for shadowing to reward a high-interest young person. Incentivize community participation in education and prevention activities. Participate in training for medical students and residency rotations. Take the time to reach out and develop connections that will engage people with your community.

- **Board members need to be fully engaged and thoughtful of current day facility activities – but also anticipate future needs in terms of both staffing and the community.** Their participation in R/R, as well as providing the connection between the health center and the community is essential to both the successful recruitment effort and a smooth running clinic.

- **Contact the Oregon Office of Rural Health for advice and assistance.**
Cost Report Data

The following information and figures highlight some of the data contained in RHC Medicare cost reports. The purpose of this information is to provide a benchmarking tool for clinics to compare themselves against other RHCs. RHCs may use a calendar year or fiscal year for their reporting period. RHCs file their cost report data with their Medicare Administrative Contractor (MAC). RHCs in Oregon are currently using one of two MACs, Noridain or CAHABA. The MACs will not release cost reports until they have been finalized. One challenge for data collection is that the MACs have different timeframes for reviewing cost reports; the ORH was able to obtain 2009 cost report data from one MAC and a mix of 2007 and 2008 data from the other. Figure 16 shows the timelines of the cost reports available and used in this report. The varied time periods of these cost reports are a limitation to consider when analyzing and drawing conclusions from cost report data. This is an example of the data and comparability challenges that can arise when assessing RHCs across the state.

**Figure 16: Time periods reported on Medicare cost reports (n = 36)**

<table>
<thead>
<tr>
<th>Time Periods of Cost Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider-based RHCs</td>
</tr>
</tbody>
</table>
Provider Salary

Provider salaries are reported by Full Time Equivalent (FTE) and shown only as averages. **It is important to note that provider salaries listed in the cost reports often include the cost of benefits for the provider.**

The Centers for Medicare & Medicaid Services (CMS) defines 1 FTE as 40 hours per week in Rural Health Clinics.

Table 21: Average Salary by FTE, n = 36 in 2009

<table>
<thead>
<tr>
<th></th>
<th>Physicians</th>
<th>Nurse Practitioners</th>
<th>Physician Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$295,457</td>
<td>$123,913</td>
<td>$106,302</td>
</tr>
<tr>
<td>2003</td>
<td>$121,045</td>
<td>$78,474</td>
<td>$54,413</td>
</tr>
</tbody>
</table>

Figure 17: Average Salary per FTE by provider type and year
Productivity

Provider productivity is fairly consistent among independent and provider-based RHCs. Only IRHFs as a group show a variance from the average. IRHFs have lower productivity across all provider types. This has more to do with a lack of patient demand than it does with providers not seeing enough patients.

Table 22: Productivity by FTE- All, n = 36

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Average Annual Encounters</th>
<th>RHC Productivity Standard</th>
<th>% of Productivity Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>4118</td>
<td>4200</td>
<td>98%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2883</td>
<td>2100</td>
<td>137%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>2714</td>
<td>2100</td>
<td>129%</td>
</tr>
</tbody>
</table>

Table 23: Productivity by FTE- Independent, n = 30

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Average Annual Encounters</th>
<th>RHC Productivity Standard</th>
<th>% of Productivity Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>4241</td>
<td>4200</td>
<td>101%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2839</td>
<td>2100</td>
<td>135%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>2786</td>
<td>2100</td>
<td>133%</td>
</tr>
</tbody>
</table>

Table 24: Productivity by FTE- Provider Based, n = 6

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Average Annual Encounters</th>
<th>RHC Productivity Standard</th>
<th>% of Productivity Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>3892</td>
<td>4200</td>
<td>93%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>3024</td>
<td>2100</td>
<td>144%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>2452</td>
<td>2100</td>
<td>117%</td>
</tr>
</tbody>
</table>

Table 25: Productivity by FTE- IRHF, n = 10

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Average Annual Encounters</th>
<th>RHC Productivity Standard</th>
<th>% of Productivity Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>3061</td>
<td>4200</td>
<td>73%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>2241</td>
<td>2100</td>
<td>107%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>2069</td>
<td>2100</td>
<td>99%</td>
</tr>
</tbody>
</table>
The RHC program is often thought of as having services provided predominately by NPs and PAs due to the midlevel provider requirement for certification. However, cost report data show that the majority of RHC visits in Oregon are provided by physicians.

Figure 19: Distribution of RHC encounters by provider type, from latest cost reports
Employee Hours

There is a wide variety of medical staffing patterns among Oregon’s RHCs. In part this likely reflects the variety of clinic configurations and communities within which they operate.

Table 26: Clinical staff hours, n = 36 in 2009

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2006</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clinics with regular physician hours</td>
<td>19</td>
<td>36</td>
<td>22</td>
</tr>
<tr>
<td>Average number of Physician FTE</td>
<td>2.75</td>
<td>1.59</td>
<td>1.58</td>
</tr>
<tr>
<td>Highest number of Physician FTE</td>
<td>10</td>
<td>5.34</td>
<td>5.57</td>
</tr>
<tr>
<td>Lowest number of Physician FTE</td>
<td>0.05</td>
<td>0.02</td>
<td>0.06</td>
</tr>
<tr>
<td>Clinics Using NPs as primary provider</td>
<td>10</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Average number of NP FTE</td>
<td>1.71</td>
<td>0.75</td>
<td>0.88</td>
</tr>
<tr>
<td>Highest number of NP FTE</td>
<td>1.5</td>
<td>2.33</td>
<td></td>
</tr>
<tr>
<td>Lowest number of NP FTE</td>
<td>0.25</td>
<td>0.13</td>
<td>0.03</td>
</tr>
<tr>
<td>Clinics using PA’s as primary providers</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Average number of PA FTE</td>
<td>1.25</td>
<td>0.79</td>
<td>0.82</td>
</tr>
<tr>
<td>Highest number of PA FTE</td>
<td>2.5</td>
<td>1.7</td>
<td>1.99</td>
</tr>
<tr>
<td>Lowest number of PA FTE</td>
<td>0.4</td>
<td>0.06</td>
<td>0.03</td>
</tr>
</tbody>
</table>

Figure 20: Provider FTE by provider type in 2009, n = 36
Other

The disadvantage faced by IRHFs is seen when comparing their cost per visit and total allowable cost to RHCs as a whole. The average total allowable cost of IRHFs is only 71% of the average RHC cost, but, due to their low encounters, their cost per visit is higher at 106% of the average for Oregon RHCs. Due to their small communities and low populations many IRHFs cannot achieve economies of scale.

Many independent clinics do not claim Medicare bad debt on their cost reports despite the fact that uncollectible Medicare debt 120 days past due will be reimbursed. Provider-based RHCs, possibly due to greater resources for and expertise in Medicare reporting, were more likely to claim bad debt on cost reports.

Overall, cost report data showed considerable variation, even in areas such as cost per influenza vaccination that might be expected to be relatively consistent from one clinic operation to another. This may reflect both real cost differences and/or variation in record keeping or reporting methodologies. It is not possible to determine the reason for cost variation solely from these reports but outlying data points may highlight areas for improvement.

**Table 25: Other cost report summary data, n = 36**

<table>
<thead>
<tr>
<th></th>
<th>All RHCs</th>
<th>Independent</th>
<th>Provider-Based</th>
<th>IRHF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Adjusted Cost Per Visit</td>
<td>$138.42</td>
<td>$130.68</td>
<td>$174.54</td>
<td>$146.61</td>
</tr>
<tr>
<td>Average Office Salary per Provider FTE</td>
<td>$78,521</td>
<td>$88,396</td>
<td>$25,195</td>
<td>$68,773</td>
</tr>
<tr>
<td>Average Total Allowable Costs Per Provider FTE</td>
<td>$527,119</td>
<td>$455,988</td>
<td>$698,575</td>
<td>$376,396</td>
</tr>
<tr>
<td>Average Facility Costs</td>
<td>$84,482</td>
<td>$51,926</td>
<td>$221,512</td>
<td>$22,946</td>
</tr>
<tr>
<td>Clinics that claimed Medicare Bad Debt</td>
<td>50%</td>
<td>43%</td>
<td>83%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Electronic Health Records

Survey data shows that 34 RHCs (out of 51 responding) currently have an EHR; eight others stated that they plan to implement an EHR system within the next two years. A few clinics that currently have an EHR may need to upgrade to a newer version to meet the meaningful use incentive requirements. Other clinics would like to have an EHR but due to the initial expense associated with implementation they cannot afford to do so without financial assistance.

The 34 RHCs who reported they currently have an EHR reported using 14 different EHR systems with no single EHR dominating the market. The wide range of EHRs currently in use demonstrates the challenge of health information exchange between clinics and hospitals.

<table>
<thead>
<tr>
<th>Name</th>
<th>Number Using</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allscripts</td>
<td>4</td>
</tr>
<tr>
<td>eClinical works</td>
<td>4</td>
</tr>
<tr>
<td>Nextgen</td>
<td>4</td>
</tr>
<tr>
<td>Centricity</td>
<td>4</td>
</tr>
<tr>
<td>Noteworthy</td>
<td>3</td>
</tr>
<tr>
<td>Sage Intergy</td>
<td>3</td>
</tr>
<tr>
<td>EPIC</td>
<td>3</td>
</tr>
<tr>
<td>Soapware</td>
<td>2</td>
</tr>
<tr>
<td>Practice Partner</td>
<td>2</td>
</tr>
<tr>
<td>Greenway</td>
<td>1</td>
</tr>
<tr>
<td>Amazing Charts</td>
<td>1</td>
</tr>
<tr>
<td>PracticeOne</td>
<td>1</td>
</tr>
<tr>
<td>E-MDs</td>
<td>1</td>
</tr>
<tr>
<td>Net Practice/Chart</td>
<td>1</td>
</tr>
</tbody>
</table>

In recent study (Avalere Health, 2009) researchers found that a solo or small group practice will spend $124,000 over the five year period of 2011-2015 to adopt EHRs, and will receive up to $44,000 in federal incentive payments. The resulting financial deficit would be $80,000, or an average of $16,000 a year. Although there may be less expensive options available, cost is the greatest barrier to EHR implementation for many RHCs.

Benefits of implementing an EHR include increased quality of care, improved access to medical record information, workflow, patient communications, and accuracy for coding evaluation and management procedures.

The use of an EHR will become essential as both federal and state mandates to move towards the Patient Centered Medical Home model increase. Such a model requires an EHR to track and manage the health of the clinic’s patient population.
It is also becoming necessary to have an EHR for a clinic to be able to recruit new providers. Providers just graduating from school may have never used a paper chart during their training and expect to practice with electronic records.

RHCs can receive guidance on selection and implementation of an EHR, as well as assistance with meeting Meaningful Use requirements from Oregon’s Health Information Technology Extension Center (O-HITEC). O-HITEC is partially funded by the ARRA legislation that funds the incentive payments and they are mandated to provide guidance, education and technical assistance to advance the meaningful use of an EHR. You can find more information on O-HITEC at http://o-hitec.org.

American Recovery and Reinvestment Act Implications for Rural Health Clinics

The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, contains more than $787 billion in spending and tax cuts, several of which are related to health care.

ARRA provides $2 billion in funding for Federally Qualified Health Centers (FQHC): $1.5 billion for FQHC Infrastructure Grants for clinic construction, renovation, equipment, and acquisition of health information technology. ARRA provides another $500 million for FQHCs to increase services. These funds are used to support new sites and service areas, to increase services at existing sites, and to provide supplemental payment for spikes in uninsured populations. All funds are made available through a competitive grants process.

ARRA, unfortunately, has no such funding provisions for RHCs. As demonstrated by this survey, Oregon’s RHCs also face the financial challenges of providing uncompensated care to the uninsured and have considerable infrastructure needs. The Oregon Office of Rural Health has been contacted by many existing RHCs seeking information regarding conversion to an FQHC to gain access to these funds. We believe this is a trend that is likely to continue.

ARRA also provides incentive payments for the adoption and “meaningful use” of a certified Electronic Health Record (EHR). Eligible provider types working in both RHCs and FQHCs are eligible to begin receiving incentive payments in 2011. Under ARRA, RHCs can receive an amount not in excess of 85% of the net average allowable costs for certified EHR technology and support services including maintenance and training that is for the adoption and operations of such technology.

The initiative will encourage hospitals and clinics across the nation to not only install EHR technology but to use it in ways that demonstrably improve patient care, lower costs, reduce errors and save lives. ARRA provides two ways in which practices can receive incentive dollars.
The first incentive option is through Medicare. Eligible providers may receive up to $44,000 in EHR incentives from Medicare. Eligible provider types for the Medicare program are:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Surgery or Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Doctors of Chiropractic Medicine

Eligible Providers receive the EHR incentive payment based on Medicare Part B billing using the CMS-1500 form. While RHCs are not specifically excluded from the Medicare program, they do not bill Part B for RHC services. Instead RHCs bill Medicare Part A using a UB-04 form. Unless an RHC can bill in excess of $25,000 per year to Part B they will not be able recoup the full $44,000. Providers with a large hospital practice may be able to meet the $25,000 Part B billing threshold.

The second method to receive EHR incentives is through Medicaid. Eligible Providers may receive up to $63,750 in EHR incentives from the Medicaid program. Eligible Provider types for the Medicaid program are:

- Physicians
- Dentists
- Certified Nurse Midwives
- Nurse Practitioners
- Physician Assistants (If practicing in an FQHC or RHC led by a PA)

It’s important to note that Nurse Practitioners and Physician Assistants are only eligible under the Medicaid program. To be eligible to receive the EHR incentives under the Medicaid program, Eligible Providers practicing in an RHC must have at least 30% (20% for pediatrics) of volume from patients considered “needy.” To qualify as “needy,” patients can be: Medicaid, SCHIP, provided uncompensated care, or receiving a reduction in charges from a formal schedule of discounts maintained by the clinic based on their ability to pay.

From the data collected during the survey, the ORH’s preliminary estimates are that approximately one-third of RHCs will definitely qualify for Meaningful Use incentives. Another one-third might qualify, and one-third will not qualify. For assistance with qualifying for Meaningful Use incentives RHCs should contact O-HITEC at http://o-hitec.org.
Qualitative Data and SWOT Analysis

The RHC survey asked all clinics some open-ended questions about their situations. These elicited a range of responses, but some major themes that emerged are listed below. In addition word clouds provide a way to visualization written responses. Word clouds were constructed using the online tool Wordle, [www.wordle.net](http://www.wordle.net), and are shown on the following pages.

Themes observed by question: \( n = 47 \)

- What are the strengths of the clinic?
  - Community location, connections, responsiveness
  - Staff quality, commitment, long-term experience

- What are the clinic’s weaknesses?
  - Lack of providers and staff
  - Not enough patients
  - Low reimbursements rates, problems with financial stability, collecting payment
  - Scheduling and access
  - Facilities and insufficient space in some cases

- What are your opportunities for the future?
  - Expansion in some cases
  - Implementing medical home model and new services including telehealth applications

- What are the threats to the clinic?
  - Recruitment, retention, and replacement of retirees, both clinical and support staff
  - External economic downturn
  - Decreasing reimbursement rates
  - Competition from other providers and from larger cities
Figure 22: Strengths

Figure 23: Weaknesses
Figure 24: Opportunities

Figure 25: Threats
Works Cited


Sharon Larson, and Rosaly Correa-de-Araujo. (2006). "Preventive health examinations: a comparison along the rural-urban continuum". Women’s Health Issues : Official Publication of the Jacobs Institute of Women’s Health. 16 (2).


Appendix A

Survey materials used to collect data for this report.

RHC Questionnaire, 2010

General RHC Questionnaire

Clinic Name:

Recruitment and Retention Questions

1. Are you currently recruiting for clinical or administrative staff?   Yes   No
   a. If yes, what positions are you recruiting for?
   b. How long have you been recruiting?
2. How many providers have you added or lost in the last 2 years?   Added: _______ MD   _______ Midlevel
   Lost: _______ MD   _______ Midlevel
3. Who handles your recruitment process?
4. Where are you posting your open positions?
5. What loan repayment programs are you aware of?   National Health Service Corp   State
   State   Federal   Other   No
6. Do you have providers receiving loan repayment?   Yes   No
7. If you’ve had loan repayment providers how long did they stay?
8. Will you share a copy of your written R&R plan with us?   Yes   No

Technology Questions

1. How old are most of your computers?   < 1 year   < 2 years   3-5 years   > 5 years
2. Is your provider able to access your patient records away from the clinic?   Yes   No
3. What type of Practice Management (scheduling, etc.) software do you use and how old is it?
4. Do you now use telehealth to provide service to your patients?   Yes   No
   a. If yes, what services are currently provided and from whom?
   b. If no, do you plan to do so in the next 2 years?   Yes   No
5. Are you aware of any telehealth services in your community?   Yes   No
   a. If yes, who is providing the service?

Billing and Fee Information

1. Do you bill electronically?   Yes   No
   a. If yes, for which insurance:   OHP   Private (please specify)
   b. If private, do you use a clearinghouse?   Yes   No
   c. If yes, which one?
2. Will you share with us your formal/published schedule of discounts?   Yes   No
3. How many uninsured ENCOUNTERS did you have last year?
4. What percentage of your practice revenue comes from self-pay patients?
5. Are there any services you do not bill for?   Yes   No
   a. If yes, which ones?

Physical Plant Information

1. When was the last time the building was remodeled and/or built?
2. Do you own your building?   Yes   No
3. Is the building meeting the needs of the practice?   Yes   No
   a. If no, please specify:
Administrative
1. Can you provide a copy of your Quality Improvement Plan? Yes No
2. Can you provide a copy of your Mission and/or Vision Statement? Yes No
3. How do you market clinic services to the community?
4. What types of community outreach and/or prevention services do you provide?
5. Do your providers volunteer health care services? Yes No
   a. __ Locally __ Nationally __ Internationally
6. Would you be willing to participate in a confidential online salary and benefits survey? Yes No

RHC Resource Questions
1. Do you participate in the RHC e-group? Yes No
2. What RHC resources do you use? Please list:
3. What types of Training do you need? Please list:
4. Do you have any topics for future RHC webinars?

General Questions
1. What are the strengths of the clinic?
2. What are the clinic’s weaknesses?
3. What are your opportunities for the future?
4. What are the threats to the clinic?

Collect the following:
   ____ List of current board members, including length of time served
   ____ A year’s worth of E&M Codes for new and established patients
   ____ Copy of current fee schedule
   ____ Copy of sliding fee scale/schedule of discounts
   ____ Copy of R&R Plan
   ____ Mission/Vision Statement
   ____ Copy of QI Plan
Oregon Clinic Practice Survey, 2010

This survey was developed and generously shared by ORPRN, the Oregon Rural Practice-based Research Network.

Practice Survey

Today's Date:  
Practice Name:  
Practice Address:  
City:  
State:  
Zip:  
Practice Main Phone:  
After Hrs Phone:  
Fax:  
Practice Website:  
Practice Manager:  
Email:  
Phone:  
Primary ORPRN Site Contact:  
Email:  
Phone:  
Primary Clinician:  
Email:  
Phone:  

Practice Information

1. Year the practice was established in this community?  
2. Who owns the practice?  
   o Hospital  
   o Physician or physician group  
   o Hospital system  
   o Other health organization  
   o Other - Please specify:  
3. What is the ownership status of the practice?  
   o Private For-Profit (private or corporate ownership)  
   o Not-for-Profit (community-based organization)  
   o Public (operated by a health district or county government)  
4. Do you have any satellite practice sites?  
   a. If yes, please list:  
5. Are there computer(s) in the exam rooms?  
6. Are there computer(s) at the nursing/work station(s)?  
7. Are the computers in your clinic networked to each other?  
8. Do you have videoconferencing capability at your practice site?  
9. Does your practice have an electronic health record (EHR) system?  
   a. If yes, what is the name of your EHR system?  
   b. If yes, when was it implemented?  
   Date:  

If NO to Q 9, answer Q 10. If YES to Q 9, SKIP to Q 11.  

10. Do you have plans to implement an EHR system in the next year?  
   a. If yes, what brand or brands of EHR are being considered?  
11. Does your practice have any patient registries?  
   (Registries are a list of all patients in your practice who share some characteristic, such as a certain condition or medical regimen.)  
   11a. If yes, which registries do you use and where are they stored? (Check all that apply.)  
   o Immunizations (e.g. ALERT):
- Diabetes:
- Asthma:
- Hypertension:
- Anticoagulation:
- Cancer Screening (e.g. PAP, mammogram):
- Mental Health:
- Chronic Pain:
- Other:

11b. If yes, which registries are populated directly from your EHR? (Check all that apply.)

- Immunizations
- Diabetes
- Asthma
- Hypertension
- Anticoagulation
- Cancer Screening
- Mental Health
- Chronic Pain
- Other

12. Please mark all that apply to this practice:

<table>
<thead>
<tr>
<th>Currently Receive Electronically</th>
<th>Currently Send Electronically</th>
<th>Expect to Add (send or receive) over the next year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Prescribing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Images (PACS)</td>
<td></td>
<td></td>
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<tr>
<td>Other Images (ECGs, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lab Data</td>
<td></td>
<td></td>
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<tr>
<td>Visit Reports/Progress Notes</td>
<td></td>
<td></td>
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<tr>
<td>Problem Lists</td>
<td></td>
<td></td>
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<tr>
<td>Medication Information</td>
<td></td>
<td></td>
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<tr>
<td>Emergency Department visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Patient Information (admission, H&amp;P, discharge note, procedure notes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registries</td>
<td></td>
<td></td>
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<tr>
<td>Email Communication with patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email Communication with other medical offices/outside physicians</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. How is your billing done?
- Within the practice
- By contract
  a. If within the practice, what billing software do you use?
    - Centricity
    - Medisoft
    - Medical Manager
    - NextGen
    - Prism
    - Mars
    - Carecast
    - EPIC
    - Other - Please specify:

14. How do you provide general information about your practice to your community and patients? (Check all that apply.)
- Newsletter
- Practice website
- Brochure
- Yellow Pages display ad
- Newspaper
- Other - Please specify:
15. Does your organization have a written strategic plan?  
   Yes  No
Last update?

**Patient Information**

16. What is the total number of individual patients (not visits) this practice has seen at least once in the office in the last 24 months?

17. In a typical week, how many patient visits do you have in your practice?

18. Are you currently accepting new patients into your practice?  
   Yes  No
   a. If yes, from these new patients, which of the following types of payment do you accept? (Please mark all that apply.)
   - Medicare
   - Medicaid
   - Commercial insurance
   - TriCare/Champus
   - Self pay
   - Other

19. What percentage of your practice revenue from patient care comes from:
   - Medicare
   - Medicaid
   - Commercial insurance
   - TriCare/Champus
   - Self pay
   - Other
   **100% Total**

20. What is the gender distribution of the practice's current patient panel?
   - Male
   - Female
   **100% Total**

21. What is the age distribution of the practice's current patient panel?
   - 0-1
   - 1-4
   - 5-11
   - 12-18
   - 19-44
   - 45-64
   - 65-74
   - 75-84
   - 85 and above
   **100% Total**

22. Estimate the proportion of the practice's current patient panel that is Hispanic:
   - Hispanic or Latino

23. Estimate the racial distribution of the practice's current patient panel: (Race is defined by biology—a group defined by genetically transmitted characteristics. Hispanic and Latino individuals may be of any race.)
   - White Self pay
   - Black/African American
   - Asian
   - Native Hawaiian/Pacific Islander
   - American Indian/Alaska Native
   **100% Total**

THANK YOU FOR COMPLETING THE SURVEY!
### Practice Staff

#### Practice Name:

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>Hours per week per Employee Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative staff</td>
<td></td>
</tr>
<tr>
<td>Business office</td>
<td></td>
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<tr>
<td>Managed care administrative</td>
<td></td>
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<tr>
<td>Information systems</td>
<td></td>
</tr>
<tr>
<td>Housekeeping</td>
<td></td>
</tr>
<tr>
<td>Other administrative support staff</td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td></td>
</tr>
<tr>
<td>LPN</td>
<td></td>
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<tr>
<td>Medical Assistants and other clinical support</td>
<td></td>
</tr>
<tr>
<td>Medical receptionists</td>
<td></td>
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<tr>
<td>Medical records</td>
<td></td>
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<tr>
<td>Medical secretaries/transcribers</td>
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<tr>
<td>Clinical laboratory</td>
<td></td>
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<tr>
<td>Radiology</td>
<td></td>
</tr>
</tbody>
</table>

Example: 1.5 FTE = 60 hours per week

### Names of Clinicians

#### Practice Name:

Please list the names of all the clinicians in your practice. Include physician, physician assistant, nurse practitioner, mental health clinician, dentist, social worker, or any other clinician who sees patients and may bill for professional services (including charting and follow-up).

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Discipline</th>
<th>Specialty</th>
<th>FTE*</th>
<th>Hrs per Wk**</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

*FTE of this clinician in this practice

**How many hours per week is this clinician scheduled to see patients in this office?
Office and Holiday Hours

Clinic Name: ________________________________

**Office Hours:**

If there is no Time Open we will assume you are closed; if the lunch space is left blank we will consider you open during lunch.

<table>
<thead>
<tr>
<th>Day</th>
<th>Time Open</th>
<th>Time Close</th>
<th>Closed for Lunch between</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
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<td>Monday</td>
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<tr>
<td>Saturday</td>
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</tbody>
</table>

**Holiday Hours:**

If there is no Time Open we will assume you are closed; if the lunch space is left blank we will consider you open during lunch. Please add any other holidays on which you are closed, or open for other-than-regular hours.

<table>
<thead>
<tr>
<th>Holiday</th>
<th>Time Open</th>
<th>Time Close</th>
<th>Closed for Lunch between</th>
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</thead>
<tbody>
<tr>
<td>New Year’s Day</td>
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<td>Presidents Day</td>
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<td>MLK Day</td>
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<td>Memorial Day</td>
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<td>Independence Day</td>
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<td>Labor Day</td>
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<tr>
<td>Thanksgiving</td>
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<td>Day after Thanksgiving</td>
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<tr>
<td>Christmas Eve</td>
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<tr>
<td>Christmas Day</td>
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<td>Other:</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

**Vacation Hours:**

Please indicate any periods of time that your clinic is closed for any reason other than holidays:

_______________________________ Dates: __________

_______________________________ Dates: __________
**Checklist of Services Offered**

Clinic Name: ________________________________

<table>
<thead>
<tr>
<th>Medical Services</th>
<th>RHC Staff Provided</th>
<th>Offered in Clinic by Visiting Provider</th>
<th>Available Locally (&lt;30 minutes) by Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Primary Care (other than below)</td>
<td></td>
<td></td>
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<tr>
<td>2. Diagnostic Laboratory (technical component)</td>
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<tr>
<td>3. Diagnostic X-ray Procedures (technical component)</td>
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<tr>
<td>4. Diagnostic Tests/Screenings (professional component)</td>
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<tr>
<td>5. Emergency Medical Services</td>
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<tr>
<td>6. Urgent Medical care</td>
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<tr>
<td>7. 24-hour Coverage</td>
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<tr>
<td>8. Family Planning</td>
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<tr>
<td>9. HIV Testing</td>
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<tr>
<td>10. Immunizations</td>
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<td></td>
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<tr>
<td>11. Following Hospitalized Patients</td>
<td></td>
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</tr>
<tr>
<td><strong>Obstetrical and Gynecological Care</strong></td>
<td></td>
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<tr>
<td>12. Gynecological Care</td>
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<tr>
<td>13. Prenatal Care/Maternity Case Management</td>
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<tr>
<td>14. Antepartum Fetal Assessment</td>
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<tr>
<td>15. Ultrasound</td>
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<tr>
<td>16. Genetic Counseling and Testing</td>
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<tr>
<td>17. Amniocentesis</td>
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<tr>
<td>18. Labor and Delivery Professional Care</td>
<td></td>
<td></td>
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<tr>
<td>19. Postpartum Care</td>
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<td></td>
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<tr>
<td><strong>Specialty Medical Care</strong></td>
<td></td>
<td></td>
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<tr>
<td>20. Directly Observed TB Therapy</td>
<td></td>
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<tr>
<td>21. Other Specialty Care</td>
<td></td>
<td></td>
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<tr>
<td><strong>Mental Health/Substance Abuse Services</strong></td>
<td></td>
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<tr>
<td>22. Mental Health Treatment/Counseling</td>
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<tr>
<td>23. Developmental Screening</td>
<td></td>
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<tr>
<td>24. 24-hour Crisis Intervention/Counseling</td>
<td></td>
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<tr>
<td>25. Substance Abuse Services</td>
<td></td>
<td></td>
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<tr>
<td>26. Other Mental Health Services</td>
<td></td>
<td></td>
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<tr>
<td><strong>Other Professional Services</strong></td>
<td></td>
<td></td>
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<tr>
<td>27. Dental Care</td>
<td></td>
<td></td>
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<tr>
<td>28. Hearing Screening</td>
<td></td>
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<tr>
<td>29. Nutrition Services other than WIC</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30. Occupational or Vocational Therapy</td>
<td></td>
<td></td>
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<tr>
<td>31. Physical Therapy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>32. Pharmacy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>33. Vision Screening</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>34. WIC Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Case Management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>36. Child Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Eligibility Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Employment Physicals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Sports Physicals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Services</td>
<td>RHC Staff Provided</td>
<td>Offered in Clinic by Visiting Provider</td>
<td>Available Locally (&lt;30 minutes) by Referral</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>--------------------</td>
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</tr>
<tr>
<td>40. Environmental Health Risk Reduction (via Detection/Alleviation)</td>
<td></td>
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<tr>
<td>41. Food Bank/Delivered Meals</td>
<td></td>
<td></td>
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<tr>
<td>42. Health Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. Housing Assistance</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>44. Interpretation/Translation Services</td>
<td></td>
<td></td>
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<tr>
<td>45. Nursing Home &amp; Assisted Living Placement</td>
<td></td>
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<tr>
<td>46. Hospice</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>47. Outreach</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>47. Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>49. Home Visiting</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>50. Parenting Education</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>51. Podiatry</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>52. Chiropractic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>53. Massage</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>54. Other (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Oregon’s Rural Health Clinics, January 2011

Alsea Rural Health Care
PO Box 229
Alsea, OR 97324-0229
(541) 487-7116

Baker Clinic
3175 Pocahontas Rd
Baker City, OR 97814
(541) 523-4415
http://bakerclinic.net

Bandon Community Health Center
PO Box 423
Bandon, OR 97411
(541) 347-2529
http://bandonchc.org/

Bayshore Family Medicine
PO Box 655
Pacific City, OR 97135-0655
(503) 965-6555
www.bayshorefamilymedicine.com

Bayshore Family Medicine--Lincoln City
1105 SE Jetty Ave Ste C
Lincoln City, OR 97367
(541) 614-0482

C. Scott Graham, DO, PC
620 South J St
Lakeview, OR 97630
(541) 947-2331

Center for Women & the Family
17 SW Frazer, PO Box 1438
Pendleton, OR 97801
(541) 278-3377

Clatskanie Family Medicine Clinic
401 Bel Air Dr
Clatskanie, OR 97016
(503) 728-5111

Coastal Health Practitioners
3015 NE West Devils Lake Rd
Lincoln City, OR 97367-5131
(541) 994-5591

Columbia Hills Family Medicine
1620 E 12th St
The Dalles, OR 97058
(541) 296-9151

Curry Family Medical
94220 4th St
Gold Beach, OR 97444
(541) 332-3861
www.curryhealthnetwork.com/CFM.htm

Deschutes Rim Health Clinic
1605 George Jackson Rd
Maupin, OR 97037
(541) 395-2911
www.deschutesrimhc.com

Dr. Robert J. Alaimo
1726 E 12th St
The Dalles, OR 97058-
(541) 296-1155

Dunes Family Health Care
620 Ranch Rd
Reedsport, OR 97467-
(541) 271-2163
www.dunesfamily.org

Eastern Oregon Medical Associates
3325 Pocahontas Rd
Baker City, OR 97814-
(541) 523-1001
www.eoma.familydoctors.net

Elgin Family Health Center
PO Box 896
Elgin, OR 97827
(541) 437-6321

Gifford Medical
1050 W Elm Ave # 110
Hermiston, OR 97838
(541) 567-2995
www.giffordmedical.com

 Gilliam County Medical Center
PO Box 705
Condon, OR 97823-0705
(541) 384-2061

Good Shepherd Medical Group
600 NW 11th St
Hermiston, OR 97838-8602
(541) 567-5305
www.gshealth.org/clinic

Grant County Health Department
528 E Main Ste E
John Day, OR 97845-
(541) 575-0429

High Desert Health Care
1251 NE Elm St Ste 1A
Prineville, OR 97754-
(541) 447-1680

Internal Medicine Group 1810
1810 E 19th St
The Dalles, OR 97058
(541) 296-7751

Internal Medicine Group 1815
1815 E 19th St
The Dalles, OR 97058
(541) 296-7751

Irrigon Medical Clinic
PO Box 789
Irrigon, OR 97844-0789
(541) 922-5880
www.morrowcountyhealthdistrict.org/icmMC.html

Jordan Valley Health Clinic, Inc.
PO Box 118
Jordan Valley, OR 97910-0110
(541) 586-2422

Legacy Clinic St Helens
500 N Columbia River Hwy Ste 6
St Helens, OR 97051
(503) 397-0471
www.legacyhealth.org/body.cfm?id=130

Lincoln City Medical Center
2870 NE West Devils Lake Rd
Lincoln City, OR 97367
(541) 994-9191
www.lincolncountyhealth.com/HC/LCHIndex.htm

Lisa Callahan, CPNP
1465 NE 7th St Ste B
Grants Pass, OR 97526-
(541) 471-0100

Madras Medical Group
76 NE 12th St
Madras, OR 97741-
(541) 475-3874
mmg.familydoctors.net

Malheur Memorial Health Center
PO Box 1726
Nyssa, OR 97913
(541) 372-2211
ccf.malheurco.org/details?id=201

McKenzie River Clinic
PO Box 183
Blue River, OR 97413-0183
(541) 822-3341
mckenzierriverclinic.org
Milton Freewater Clinic
10 NE 5th St
Milton-Freewater, OR 97862
(541) 938-3314
www.wallowaclinic.com/clinic_tool.cfm?tool=locations&entryid=12

North Bend Medical Center-Gold Beach
94180 2nd St
Gold Beach, OR 97444
(541) 247-7047
www.nbmconline.com/welcome.html

North Bend Medical Center-Bandon
110 East 10th Street
Bandon, OR 97411
(541) 347-5191

North Lake Clinic
PO Box 377
Christmas Valley, OR 97641
(541) 576-2343

Oak Street Health Care Center
PO Box 6579
Brookings, OR 97415
(541) 412-8898

Pine Eagle Clinic
PO Box 647
Halfway, OR 97834-0647
(541) 742-5023
www.pineeagleclinic.com

OHSU Family Medicine at Scappoose
PO Box 979
Scappoose, OR 97056
(503) 418-4226
www.ohsu.edu/xd/health/services/clinics/FamilyMedicineatScappoose.cfm

Pediatric Specialists of Pendleton, LLC
1600 SE Court PI L01
Pendleton, OR 97801
(541) 276-0250

Pioneer Memorial Clinic
PO Box 9
Heppner, OR 97836-0009
(541) 676-5504
www.morrowcountyhealthdistrict.org/PMC.html

Pine Creek Clinic
2500 E 10th St
Roseburg, OR 97470
(541) 672-8585
www.pinecreekmed.org

Providence North Coast Clinic
725 S Wahanna Rd
Seaside, OR 97138-7735
(503) 717-7000
www.providence.org/northcoast/clinics

Piney Valley Family Medicine
120 SW 15th St
Roseburg, OR 97470
(541) 672-2244
www.pinevalleyfamilymedicine.com

Ptarmigan Family Medicine
PO Box 276
Baker, OR 97814
(541) 929-9772
www.ptarmiganfamilymedicine.com

Portland Health
600 N Freeman
Portland, OR 97211
(503) 228-5700
www.oregonhealth.edu

Rogue River Clinic
PO Box 988
Rogue River, OR 97537-0988
(541) 582-8899

Samaritan Coastal Clinic
825 NW Hwy 101
Lincoln City, OR 97367
(541) 996-7480
www.samhealth.org/patientsvisitors/locations/Pages/samaritancoastalclinic2.aspx

Siskiyou Pediatric Clinic, LLP
700 SW Ramsey Ste 204
Grants Pass, OR 97527-5792
(541) 955-5683
www.siskiyoupediatricclinic.com

South Lane Medical Group Dexter Clinic
PO Box 287
Dexter, OR 97431
5419372134
www.peacehealth.org

Strawberry Wilderness Community Clinic
180 Ford Rd
John Day, OR 97845
(541) 575-0404
www.strawberrywildernesscommunityclinic.org

Tillamook Medical Group
1000 Third St
Tillamook, OR 97141
(503) 842-5546
http://tcgh.com/TMGroup-services.php

Tillamook Family Medicine
1000 E 2nd St
Tillamook, OR 97141
(503) 842-5546
http://tcgh.com/TMGroup-services.php

Union Family Health Center
PO Box 605
Union, OR 97883-0986
(541) 562-6180

Urgent Health Care Center
236 E Newport Ave
Hermiston, OR 97838
(541) 567-1137

We Care Clinic
1312 SW 2nd St
Pendleton, OR 97801
(541) 278-8183
www.sahpendleton.org/svc-we-care-clinic.html

Winding Waters Clinic PC
406 NE First St
Enterprise, OR 97828
(541) 426-4502

Woodburn Family Medicine
1390 Meridian Dr
Woodburn, OR 97071
(503) 982-2174
www.silvertonhospital.org/locations/woodburnfamily

Woodburn Internal Medicine
693 Ray J Glatt Circle
Woodburn, OR 97071
(503) 982-0403
www.silvertonhospital.org/locations/woodburninternal

Woodburn Internal Medicine
693 Ray J Glatt Circle
Woodburn, OR 97071
(503) 982-0403
www.silvertonhospital.org/locations/woodburninternal