




Oregon Federally Certified Rural Health Clinics







Office of Rural Health
February 2005





Oregon Federally Certified Rural Health Clinics

February 2005

Oregon Health & Science University
Office of Rural Health

Prepared by
Troy Soenen, Kate Clemens, & Emerson Ong

THE OREGON OFFICE OF RURAL HEALTH

The mission of the 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 for 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; and
- 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; and
- 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/oregonruralhealth or contact us at 503-494-4450.

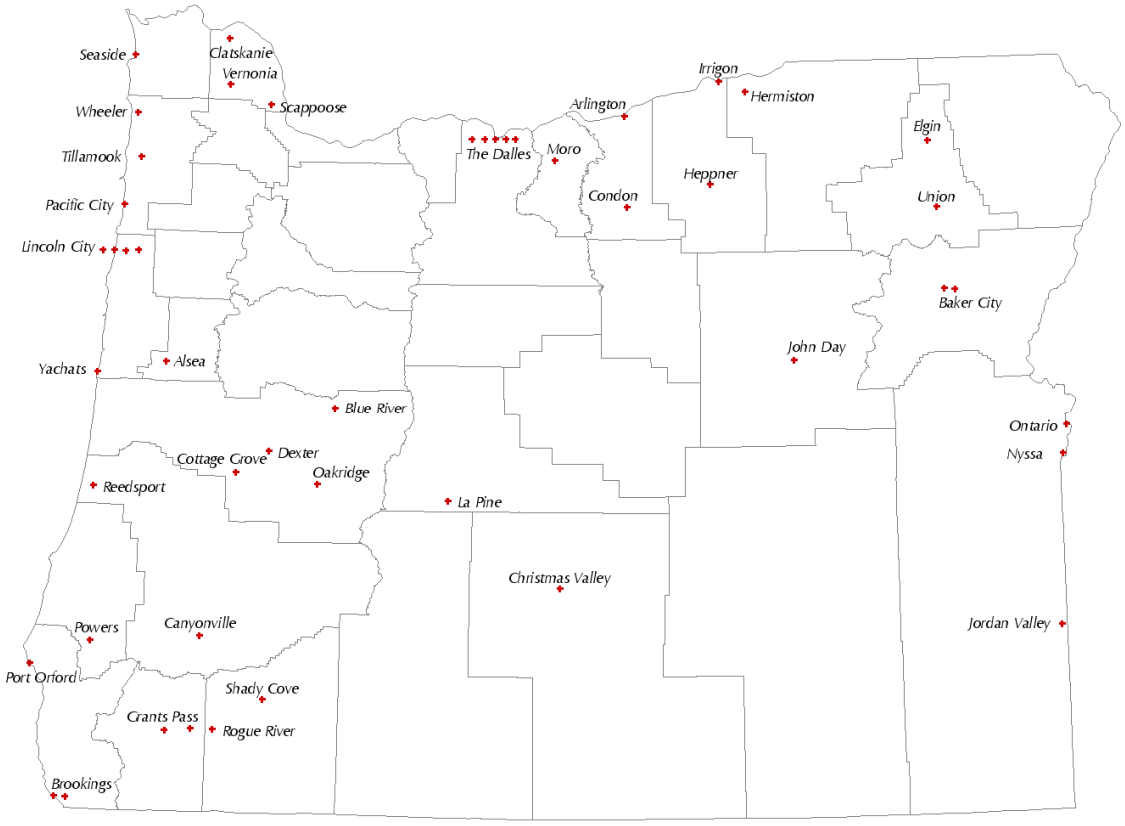
ACKNOWLEDGEMENTS

The Oregon Office of Rural Health thanks all of the Rural Health Clinics who participated in this study. Thank you to those people who shared their time meeting with ORH staff on an individual basis and to those who spent time collecting all of the necessary data. In addition, we would like to thank ORH staff for assistance in editing, data entry, data collection, and analysis. A special thanks goes to Paul McGinnis for content input and analysis.

TABLE OF CONTENTS

TABLE OF CONTENTS, CONTINUED—FIGURES

Figure 1
Map of Oregon RHCs
December 2004



- RHCs exist in 22 of the 36 Oregon counties
- 14 of the 36 Oregon counties have more than one RHC
- 13 of the 36 Oregon counties contain one or more Isolated Rural Health Facility

INTRODUCTION

The Rural Health Clinic program has been a community option to increase the availability of primary health care services to rural Oregonians since 1978. It is one of several options communities have at their disposal. Lately, the Rural Health Clinic program has gained increasing use. In the last two years the number of Federally-certified Rural Health Clinics has more than doubled in Oregon from 22 to 47 in December of 2004.

This paper is written with several purposes in mind. First, the document is intended to serve as an educational tool for communities, healthcare professionals, policy makers, and stakeholders. Most lay rural residents identify any clinic in their community as a "rural health clinic." That is not necessarily so. Rural Health Clinics are certified by the Centers for Medicare and Medicaid Services (CMS) and must meet several criteria. With that in mind, this paper describes some of the basic rules and payment methods in place for certified Rural Health Clinics. It also provides core information about the location, size and scope of current Rural Health Clinics in Oregon. What makes clinics distinctive in towns like Blue River, Alsea, Moro, Jordan Valley, Wheeler, Yachats, Condon, Powers, Union, Elgin, Christmas Valley, and others is that the RHC is the only primary health care facility in town. **In some cases, RHCs are not only the sole health facility in a community but are more than 30 miles from another facility. Without RHCs, several communities across Oregon would not have access to basic health care. Studies have shown that having access to care for basic health care needs not only improves long term health but it also saves the health care system a great deal of money** (Fryer). Maintaining access to basic health care services is critical to improving and maintaining rural Oregon's overall health and wellness.

Second, because there are a relatively small number of Rural Health Clinics compared to the total number of primary care practices in Oregon, Rural Health Clinics often, and rightly so, view themselves as unique. Because they are unique, standard primary care practice management benchmarks and guidance frequently do not apply to their setting. The managers and boards of Rural Health Clinics clamor for data that is specific to them to allow them to compare and contrast their performance against similar clinics. **This paper shares information that should allow comparisons and yet still protects the individual clinics' anonymity. Market share, productivity, hours of operation, numbers and types of employees, access to technology and financial operations of the clinics are presented**. Our hope is that clinics can use this information to improve their business practices and overall financial performance.

Third, this paper will identify and explore issues and problems facing Rural Health Clinics. In 2001, the Oregon Primary Care Association (OPCA) published a study of Oregon RHCs, using 1999 data, which revealed that many of Oregon's RHCs are vulnerable to closing their doors because of financial issues (Redd 13). **In rural areas, it is common to serve a higher portion of patients who are either on Medicare, Medicaid, or do not have any insurance**. Although the RHC program is tailored to assist clinics with enhanced reimbursement for Medicare and Medicaid patients, clinics still struggle with staffing of both providers and administrative staff, clinic management, sufficient patient volume, and a balanced payer mix of private insured versus Medicare, Medicaid and uninsured patients. In the OPCA study, clinics shared financial data, practice management indicators, staffing patterns, primary care services, and qualitative summaries of clinic staff and community members. We have attempted to collect similar information and compare the results from the OPCA study to present. Since the OPCA report was conducted, a significant change in reimbursement for RHCs has occurred. **The Prospective Payment System (PPS) now mandates that states pay 100% of reasonable cost for Medicaid services**. Even though reimbursement for

RHCs has improved, it is not yet known what effect this change has had. Are the Rural Health Clinics any less vulnerable than five years ago when the data was first collected?

Fourth, we hope to use the findings here to improve the services the Office of Rural Health provides through technical assistance. By listening to the qualitative responses of study participants and analyzing the data, we hope to create tools and educational programs that are responsive to community needs. **This report will serve as a tool for ORH staff to target specific clinics and assist them with improving clinic operations**.

Lastly, we forward a list of recommendations that range from potential policy issues to internal management practices. One particular policy issue relates to the debate about whether Rural Health Clinics fall under the category of "safety net clinics." Like beauty, defining a "safety net clinic" is often in the eye of the beholder. Statewide safety net coalitions have advocated for state supported operational subsidies. Most "safety net" definitions describe clinics that see uninsured, offer a schedule of discounts, and are non-profit or publicly held. **Although a large percentage (65%) of Rural Health Clinics are either non-profit or public organizations, and all 37 surveyed RHCs see uninsured patients and 22 offer a schedule of discounts based on ability to pay, there is *NOTHING* in the Rural Health Clinic program rules that requires these clinics to do these functions. "Safety net" clinics are created to provide access to care. The Rural Health Clinic program was created so that there would be providers available in rural communities to serve Medicare and Medicaid patients. There is a distinctive difference between access and availability. This paper proposes the creation of a new type of "safety net" designation called an Isolated Rural Health Facility (IRHF).** Clinics that are the sole provider of primary care for a community and meet certain other conditions would be included in the generally accepted definition of the "safety net." It is our contention that it is in the best interests of the State of Oregon to ensure these clinics remain viable.

As the authors attempted to meet the purposes stated above, it became clear that Rural Health Clinics do not fit into a "one size fits all" category. The diversity of community size, scope of service, business practices and ownership, which produces outlier data, combined with the relatively small number of participant study clinics (37), makes it difficult to draw many definitive conclusions. It has been said, "when you see one rural community, you've seen one rural community." The same may hold true with Rural Health Clinics.

ISOLATED RURAL HEALTH FACILITY

As stated above, one of the purposes of this study is to identify how Isolated Rural Health Facilities are performing and what may be done to help sustain operations of primary care in areas that otherwise would have no availability and therefore no reasonable access to health care. **The proposed definition of Isolated Rural Health Facility (IRHF) is as follows: IRHFs are non-profit or public clinics operating primary care practices in Oregon's rural communities. By definition, these organizations are the *sole source* of available primary care in the community, do not receive any Public Health Service Section 330 monies, and are not school-based health clinics.**

Criteria for designation as an IRHF would be developed and may include:

- Annual board governance training on roles and responsibilities;
- Private non-profit or governmental unit, e.g., health district status;
- Development of an annual strategic plan;

- Provision of quarterly uniform data sets to the ORH for monitoring and evaluation purposes (ORS 442.500 (5)). Reports would monitor the following:
    - Health service utilization
    - Financial status
    - Progress toward plan implementation
    - Implementation of a Community Oriented Primary Care practice methodology;
- Full participation in Medicare and Medicaid programs;
- Operation of a schedule of discounts; and
- Maintenance of existing Rural Health Clinic status or Federally Qualified Health Center look-alike status (if applicable).

If resources are available, the Office of Rural Health would provide technical support to assist communities with meeting IRHF qualifications.

METHODOLOGY OF SURVEY

Each Rural Health Clinic in the state was mailed a packet of information (see Appendix A) requesting financial information, hours of operation, services offered, employee operations, and a set of open-ended questions. Letters in the packets explained the purpose for the study as well as how it would be accomplished. In addition, the 2003 Medicare Cost Reports and Medicaid Encounter Rates were gathered and analyzed.

Thirty-eight clinics were contacted by phone to establish a meeting time in the clinic with a staff member from the Office of Rural Health and a clinic representative who could share details of clinic operations. For their time and efforts in gathering information, each clinic received $100. One clinic elected not to participate in the survey.

The data are organized into an Access database and mathematical analysis has been done with Excel. Figure 2 summarizes the number of data items received for each category. All information collected is confidential and is shared in a manner that maintains the anonymity of each clinic. Data are presented in peer groupings, governance structure, size, etc., so clinics can compare and contrast information from similar clinics. When grouping the clinics by community population we used the RUCA (Rural Urban Commuting Area--www.ohsu.edu/oregonruralhealth/what is rural.html) guidelines for large towns (10,000-49,000), small towns (2,500-10,000), and rural communities (<2,500). When possible, the number of RHCs that provided specific data will be represented by "n."

Figure 2
Data Collected (38 expected)

Data Item	Received	Not complete	Not received
Balance sheet	15	0	23
Profit and loss statement	13	0	25
Audited financial report	12	5	26
Opened–ended survey	37	0	1
Cost report data	33	1	5
Medicaid encounter rates	28	0	10

RHC QUALIFICATION CRITERIA

In 1977, Congress authorized Public-Law 95-210 to assist rural communities with improving the availability of primary healthcare services to Medicare patients. This program, titled the Certified Rural Health Clinic program, is more commonly known today as the "RHC" program. The RHC program is a certification process that rural providers may be eligible for if they meet certain criteria. A clinic must be a predominately primary care (family practice, general internal medicine, pediatrics, obstetrics and gynecology) oriented practice and meet the following criteria to be eligible for certification. This is only a summary of criteria. For more detailed information review "Starting a Rural Health Clinic – A How-To Manual." This manual can be downloaded at www.narhc.org/uploads/pdf/RHCmanual1.pdf.

To start the application process, clinics may contact the Office of Rural Health at 503-494-4450 to verify that necessary RHC qualifications are met. For survey and certification questions, clinics must contact John Pilmer at the Department of Human Services, Oregon Health Services at 503-731-4080.

- 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. www.ohsu.edu/oregonruralhealth/what is rural.html - hpsamuadesign
- 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
- Shortage area designation must have been updated within last three years

WHAT IS A RURAL HEALTH CLINIC?

An RHC is a rural clinic meeting the qualification criteria. In addition, the distinguishing factor from other primary care practices is the manner by which the clinic is reimbursed for Medicare and Medicaid patients. Federally-certified Rural Health Clinics receive *cost-based reimbursement* for Medicaid and Medicare patients. RHCs can either be Independent/Freestanding or Provider-based, and this distinction determines which cost-based reimbursement method is used.

Cost-based reimbursement: A payment system that reimburses a clinic for its actual cost to provide the service

Allowable cost:
Covered Medicare Services such as Physician Services, PA, NP, Nurse Midwife, Clinical Psychologist, Clinical Social Worker; Services and Supplies Incident to above, Provider Services, Visiting Nurse Services

Encounter:
A face-to-face visit between an RHC patient and an RHC provider where a medical decision is made.

Provider-based RHCs owned by hospitals with under 50 beds are reimbursed at 100 percent of *allowable cost* for Medicare patients. Independent/Freestanding RHCs and Provider-based RHCs owned by hospitals with over fifty beds are reimbursed at an "all-inclusive" rate. This rate is based on the clinic's allowable costs for core services under the Medicare RHC program divided by the number of patient *encounters* for a fiscal year. This is calculated every year using a CMS cost-report form. Medicare applies a rate cap that is adjusted annually. In 2004, Medicare paid a maximum of $68.65 per encounter, even though a clinic's actual cost of providing service may be as high as $100. Examples of RHC non-allowable costs include: cosmetic surgery, dental treatment, inpatient hospital services, EKGs, radiology, and contracted lab services. Medicaid encounters are paid in a similar fashion but without a cap. Medicaid reimbursement is discussed in greater detail in the "Should you become an RHC?" section.

PROVIDER-BASED RHCS

A Provider-based RHC must be affiliated with a hospital, skilled nursing facility, or home health agency and must operate under common licensure and governance (additional criteria exist for qualifying as a Provider-based RHC and can be found on the CMS website at http://cms.hhs.gov/manuals/pm_trans/A03030.pdf). Unlike independent RHCs, Provider-based RHCs owned by a hospital with under 50 beds are reimbursed at cost under the hospital reimbursement system and do not have a cap rate. Provider-based RHCs must operate under the hospital infrastructure, which allows them to utilize potential benefits of an organized administration and practice management systems. Data from the Provider-based RHCs in this study were difficult to use because they contained hospital expenditures. Expenses for the clinic are not broken out in a fashion that reveals clinic cost only.

Figure 3
Provider-based RHC Compared To Independent RHC

Clinic Type	Reimbursed under PPS methodology	Medicare All-Inclusive Rate capped at $68.65 for 2004	Cost- Based Reimbursement for Medicaid and Medicare without payment limits	Fiscal Intermediary
Provider-based RHC *under* 50 beds			X	Medicare Northwest
Provider-based RHC *over* 50 beds	X	X		Riverbend/ Medicare Northwest
Independent RHC	X	X		Riverbend

Issues for Provider-based Clinics

CAH (Critical Access Hospital): A rural hospital designation with a twenty five-bed limit that receives cost-based reimbursement for Medicaid and Medicare patients

Provider-based clinics in Oregon represent approximately 29 percent of the total RHCs. Nationally, according to a Maine RHC Study (Gale 1), Provider-based RHCs represent 48 percent of the total RHCs. About half of the Oregon Provider-based RHCs are affiliated with *Critical Access Hospitals (CAH).* CAH status is similar to RHC status except it provides enhanced reimbursement for rural hospitals. Despite the smaller overall number of Provider-based RHCs in Oregon, they represent a significant percentage of the total visits of RHC patients.

Key Findings: *Provider-based Clinic Issues*

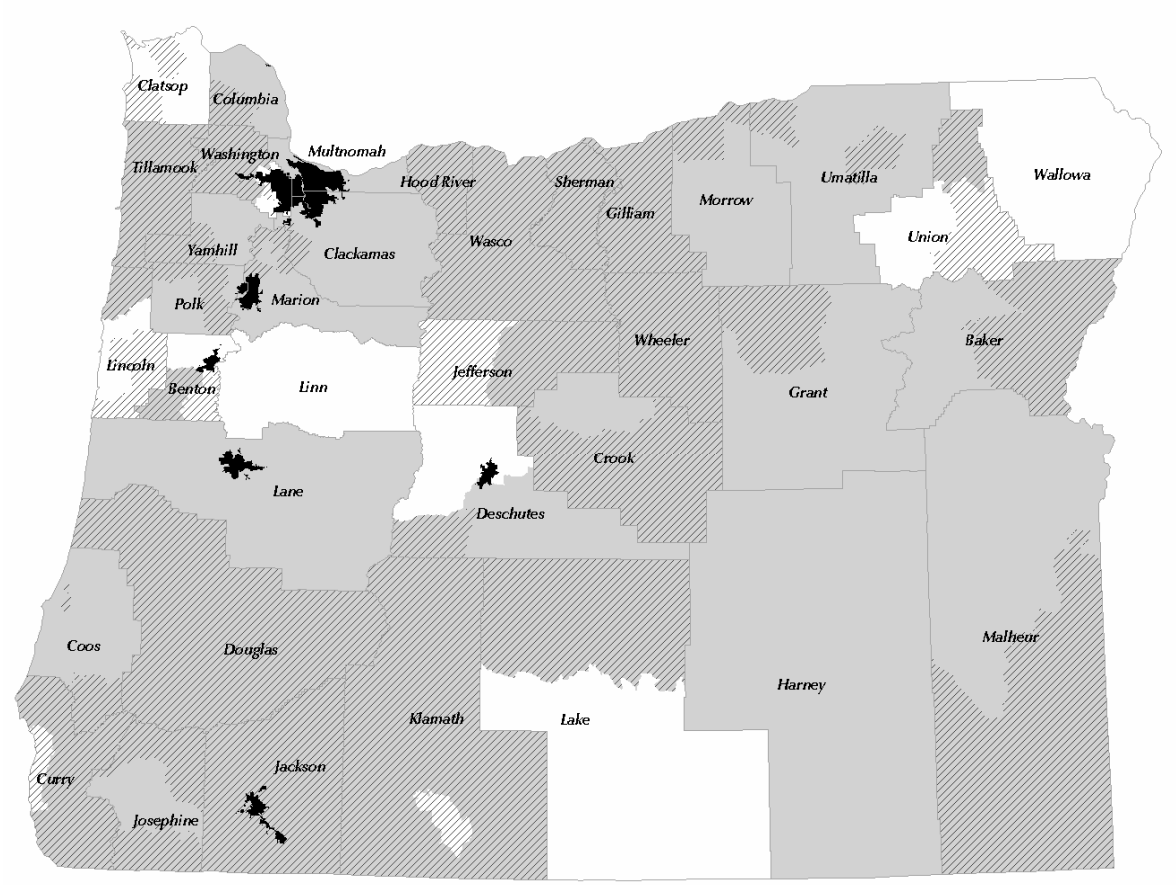
- Almost all Provider-based clinics stated they were confused about several rules pertaining to Provider-based RHCs because no manual specifically addresses this program. This is true for both Medicare and Medicaid.
- Reimbursement issues regarding how to bill for certain procedures and getting paid in a timely manner are a concern.
- Specific Provider-based RHC data for benchmarking would be useful.
- Almost all Provider-based RHCs stated they would like to work more closely with other Provider-based RHCs to share experiences and information.
- Almost all Provider-based RHCs thought it would be beneficial to meet and learn whether there are common issues that they can collectively work on to improve the current program.

Recommendations: Provider-based Clinic Issues

- Provider-based RHCs need billing guides that are specific to the RHC program.
- Provider-based RHCs need group specific meeting agendas and educations sessions.
- Provider-based RHCs should advocate policy issues as a group.

WHO IS ELIGIBLE TO BE AN RHC?

Figure 4
Map of HPSA and MUA Designations



The map above shows which counties have HPSA and MUA designations. The lined area shows Medically Underserved Areas (MUAs), and the shaded areas identify HPSAs. Solid black identifies urbanized areas. A provider located in any of the lined or shaded areas and not in an urbanized area may be eligible to apply for RHC status.

The areas in white do not have designations and are, interestingly, some of the more isolated areas of the state. For example, southern Lake County has only a few providers, but because it's a sparsely populated area, the ratio of providers to population is higher than the qualifying criteria for a HPSA designation. Other criteria do factor into this equation, but essentially a sparsely populated area with few providers could be disqualified even though health resources are scarce.

Detailed information on designations is available on the Health Resource and Service Area (HRSA) website at http://bhpr.hrsa.gov/shortage/. This site also provides the designation date for all HPSAs and MUAs. This is important for the RHC program because a shortage designation must have been updated within the last three years to make a site eligible for RHC status. For in-state information on HPSA designation contact Dr. Nancy Abrams, Department of Human Services, Oregon Health Services, 503-731-4002.

SHOULD YOU BECOME AN RHC?

This is obviously an important question for a rural provider or a community/public board to pose if considering RHC status. What is the benefit? 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. **In practice, Rural Health Clinics differ from other rural primary care settings only by how they are reimbursed for Medicaid and Medicare patients**.

According to the Medicare manual 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 2004 Medicare encounter rate for independent RHCs is $68.65**. However, actual reimbursement from Medicare is 80% of the interim rate (also known as capped rate) and patients are responsible for co-insurance and deductible if applicable (Bell). Medicare patients are required to pay a 20% co-insurance in the RHC program. In addition, Medicare applies an annual productivity standard to physicians (4200 encounters) and mid-levels (2100 encounters). Productivity is discussed later in more detail.

For the Medicaid program an encounter is: *a face-to-face contact between a health care professional and a beneficiary eligible for Medical Assistance Program coverage for the provision of Title XIX and XXI defined services through an FQHC or RHC within a 24-hour period ending at midnight, as documented in the client's medical record*. **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 clinics 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, OMAP pays the encounter rate. OMAP would pay non-RHC clinics $16.08 in 2004 for influenza virus vaccine. At the same time, reimbursement for more complicated procedures will also equal the encounter rate. The average Medicaid reimbursement for Oregon RHCs in 2003 was approximately $81.26 per encounter. Medicaid allowable and reasonable costs are defined in the Oregon Medical Assistance Program (OMAP) billing guide, www.dhs.state.or.us/policy/healthplan/rules/.

Clinics with a payer mix at or above 35 percent combined Medicaid and/or Medicare may benefit from RHC certification. Currently in Oregon, the average RHC payer mix for Medicaid is 23% and 26% for Medicare clients (almost half of all visits are from Medicare and Medicaid patients). The "Starting a Rural Health Clinic – A How-To Manual" is now available through the Health Resources and Services Administration (HRSA). This manual is a good starting point and has a number of questions to consider when determining whether or not to enter the program. The manual can be found on the Office of Rural Health website at www.ohsu.edu/oregonruralhealth/rhcmanual1.pdf 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

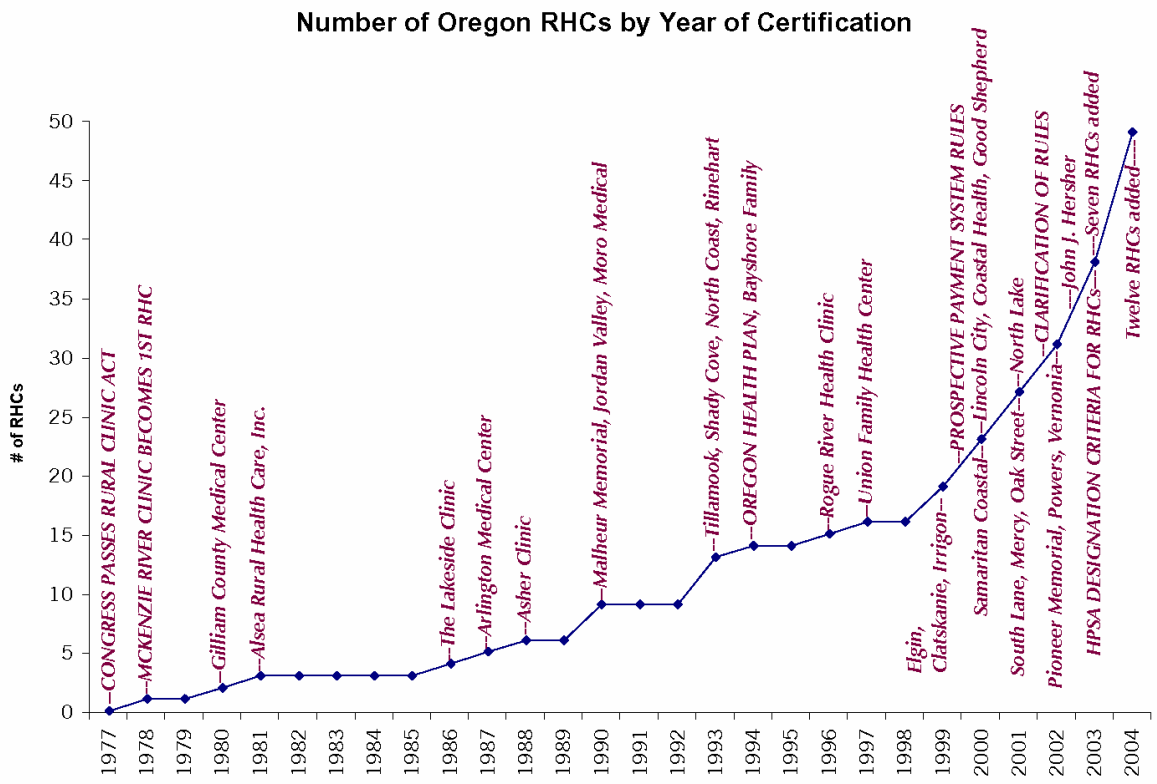


Figure 5 displays the history of the RHC program from its congressional inception with the RHC Act in 1977 to the most recent clinics entering the program. As of December 2004, Oregon has 47 certified RHCs. Compared to some other states, this number is relatively low. For example, neighboring states of Washington and California have more than twice the number of RHCs. According to the University of Southern Maine study, in 1999, RHCs numbered 3,477 nationally (Gale 1). During the first 16 years of program operation, Oregon had a total of 13 certified RHCs. Between 1994 and 1999, the RHC program added six certified RHCs for a grand total of 22. The chart shows significant program growth starting in 2000. In fact, **the program more than doubles between 2000 and 2004 as the number of RHCs grows from 22 to almost 50**.

Three key events stand out as reasons for Oregon's slow RHC growth. First, officials at Oregon's certifying agency were applying the incorrect definition to determine if an area was non-urbanized (a requirement for RHC eligibility). There are currently *five working definitions of rural*, which caused some of the confusion. In Oregon, the Goldsmith Modification of the Office of Management and Budget's definition was used, www.ohsu.edu/oregonruralhealth/goldsmithurban-rural.pdf. **The state should have been using the US Census Bureau definition, which defines non-urbanized much more broadly**, www.ohsu.edu/oregonruralhealth/census urban-rural.pdf. This issue was clarified in 2002 and

Major Definitions of "Rural" used in Oregon:
1) Census Bureau
2) Office of Management and Budget
3) Goldsmith Modification
4) RUCA (Rural-Urban Commuting Areas)
5) Oregon Office of Rural Health
www.ohsu.edu/oregonruralhealth/what is rural.html

enabled a number of clinics, previously thought to be unqualified, to move forward with RHC certification.

Second, in 1994, the State of Oregon received a waiver of Section 1115 of the Social Security Act that allowed the state to create the Oregon Health Plan, a plan that was outside the guidelines established by the Federal Government for Medicaid matching funds. The approved plan featured a provision allowing OMAP to pay FQHCs and RHCs less than 100 percent of reasonable costs. This payment system greatly reduced the financial benefit of becoming an RHC. **In 2000 this changed with the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act, which mandated that all states pay true cost-based reimbursement for Medicaid patients served by FQHCs and RHCs, regardless of waivers**. Under Public Law 106-554, both RHCs and FQHCs must now be reimbursed at 100 percent of their average cost for 1999 and 2000 or if they are new, use an existing clinic rate in the area until their rate can be determined. The rate is based on a per-encounter basis and is adjusted each fiscal year using the Medicare Economic Index (MEI). This form of payment is known as the Prospective Payment System (PPS). Clinics are no longer required to complete an annual cost report for Medicaid encounters because the rate will be adjusted by whatever the MEI is for that fiscal year. This means, for example, clinics getting only $20 from OMAP for an encounter occurring before 2000 are currently reimbursed what it costs them to do business. For most clinics, this reimbursement is much greater than $20 per encounter. For some clinics, PPS doubled, if not tripled, what Medicaid paid.

The third major event that affected Oregon clinics RHC eligibility was clarification from CMS about what type of HPSA designation makes a clinic eligible. There are multiple types of HPSA designations: a primary care designation, which can be geographic or *population- based;* dental shortage; and mental health. **Clarification from CMS made it clear that any type of <u>primary care HPSA</u> is acceptable for the RHC program**. Dental and mental health designations do not qualify clinics for the RHC program. In Oregon, only the geographic primary care designations were allowed until this clarification. There was also a shift in Oregon towards designating whole counties as HPSAs, which made a number of larger rural communities eligible for RHCs.

Population-based:
Low Income
Homeless
Migrant Seasonal Farm Worker

OWNERSHIP/GOVERNANCE TYPE OF OREGON RURAL HEALTH CLINICS

A unique aspect of the RHC program is the participants' diverse governance structure. RHCs can be for-profit/private, not-for-profit, or public entities. Figure 6 displays the distribution of clinic governance structures in Oregon as of December 2004. Thirty-one of the 47 clinics are either not-for-profit or public entities. Of the 24 public clinics, 14 are Provider-based (attached to a hospital, skilled nursing facility, or home health agency), six are health districts that generate tax revenue for operating expenses, and four are owned and operated by public organizations.

Ownership is an important component of any business because governance structure determines whom the business is accountable to and therefore, how the business will operate. Because of the different governance structures within RHCs, it can be a challenge to identify areas of common concern that clinics can work on together.

Figure 6 also compares Oregon's most common corporate structures with the most common corporate structures for the nation in 1999. The chart demonstrates Oregon's reliance on not-for-profit and public entities to provide access to health care in areas where for-profit health care

practices do not exist. Oregon's combined corporate structure for not-for-profit and public entities is 65 percent compared to the national combined corporate structure of 57 percent.

Figure 6
Ownership Type In Oregon

RHC Type	Ownership Description	Accountable to	% Oregon clinics (YR)	% National clinics 1999
Private/ For-profit	Are created / incorporated by obtaining a business license	Ownership and/or stockholders	34%	29%
Independent Not-for-Profit	Are incorporated through state law. They are tax-exempt because provide a substantial community benefit	Board of directors, which, in turn is accountable to the community it serves	38%	41%
Public/ Health Districts	Exist because the state provides the service or the state allows cities, counties, and special districts to provide services	Elected officials governing them	27%	16%

CLINIC OPERATIONS

Market Share

Service Area:
A group of ZIP Codes that the Office of Rural Health has determined most residents stay within to access primary health care.
www.ohsu.edu/oregonruralhealth/what is rural.html

Primary care market share is determined by the number of visits a clinic serves as a percentage of the total estimated demand of primary care visits from the clinic's *service area* population. The Oregon Office of Rural Health calculates demand using age and gender-adjusted population numbers and national averages. Primary care visits are adjusted out by calculating 65 percent of the total visit demand, i.e., according to the National Ambulatory Medical Care Survey, 65 percent of all visits are primary care (Woodwell). Market share is an important indicator for clinics when considering their overall viability. If a clinic has 100 percent market share, it means the clinic is capturing the maximum number of primary care visits for the service area. When a clinic has less than 100 percent market share, it is an indication that people from within the service area are seeking primary care somewhere else, also known as out-migration. This can be particularly true in communities with more than one primary care provider. Occasionally, a clinic will be over 100 percent market share. That means people from outside the service area are receiving primary care at the clinic. Two key points to consider about market share are 1) out-migration takes health care dollars out of the local community; 2) 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 be indicative of sufficient volume to support a clinic. Market share should not be considered the only measure of clinic success.

Key Findings (n=33): Market Share

- As one might expect, as the size of the community gets smaller the market share goes up – in many rural communities the RHC is the only clinic. The average market share for large towns (10,000 – 49,000) is 39% with a range of 7-123%; for small towns (2,500 – 10,000) is 64% with a range of 13-165%; and in the rural communities (<2,500) it is 67% with a range of 34-124%.
- The market share range among all clinics is quite significant from a low of 7% to a high of 165%.
- 20 of 33 clinics are below 50% Market Share.
- 8 clinics are between 50% - 99% Market Share.
- 5 clinics are above 100% Market Share.
- 3 clinics are at or below 10% Market Share.
- Non-profit clinics as a group have the highest market share with an average of 82% with a range of 34% - 165%; health districts come in next with an average market share of 77% and a range of 43% - 124%; followed by Provider-based clinics with an average of 54% and a range of 7% - 123%; the for-profit and public clinics both have average market shares of 33% with ranges of 10% - 97% and 13% - 45% respectively.
- Average market share for Isolated Rural Health Facilities is 75% with a range of 25%-135%.

Figure 7 shows the distribution of market share based on population. Figure 8 shows the distribution of market share based on clinic provider FTE. These figures show that there is no distribution pattern and reinforces the concept that each rural clinic is unique.

Figure 7
Market Share by Population

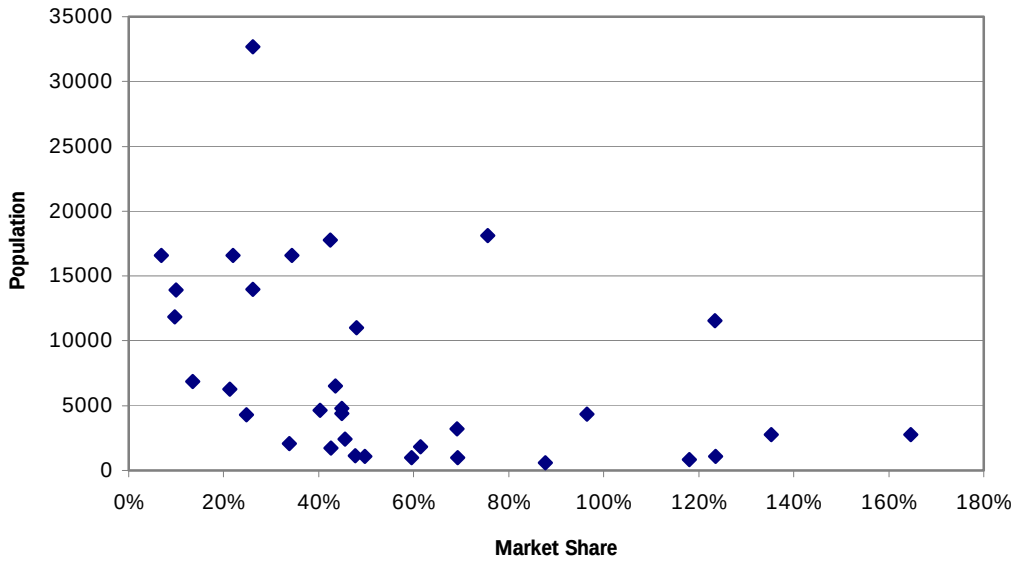
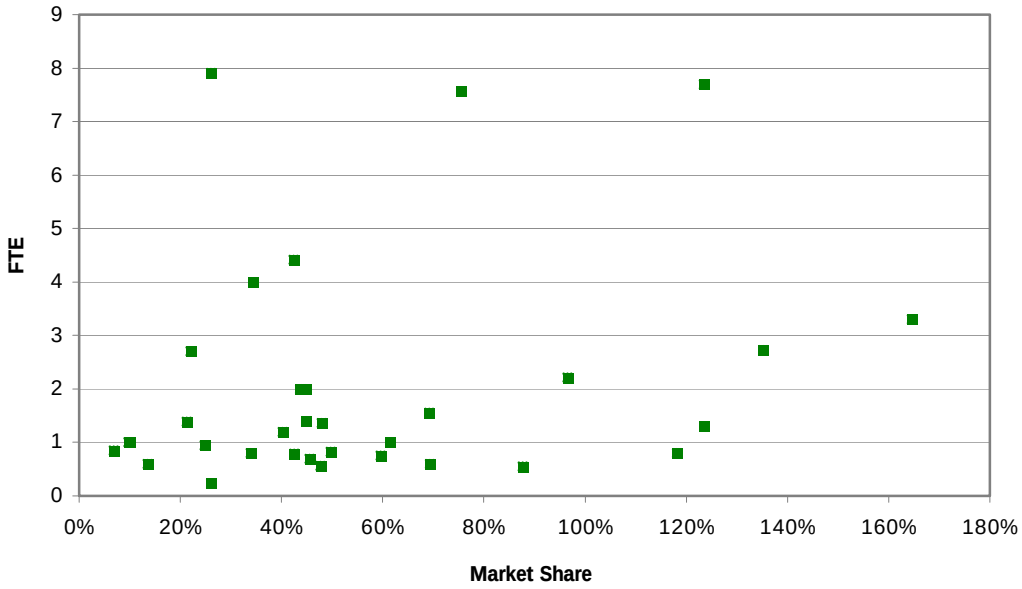


Figure 8
Market Share by FTE



Recommendations: Market Share

- All RHCs should have a web page with clinic services and contact information listed. This can inform people about what services the clinic offers as well as serve as an important advertising medium.
- Clinics should follow basic principles of marketing. Even though it may appear that everyone in a community knows where and what the clinic does, it should never be taken for granted.
- Clinics should be aware of how the clinic appears to the public. Beware of poor maintenance of internal and exterior surfaces, landscaping, signage on walls, and general cleanliness of the building. Healthcare is like any other business in terms of perception from the public. A clean and tidy clinic gives a much better perception of quality and professionalism than one that is dirty and rugged looking.
- All clinic and staff should be signed up on the RHC E-group list serve for Oregon RHCs. This will allow clinics to stay updated on changes to the RHC program – better informed clinics will be better able to market their services.

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 on how these standards were selected. The productivity standard is adjusted by FTE before it is applied to the actual number of encounters. So, a 0.5 FTE Nurse Practitioner 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.

As mentioned before, **Medicare currently caps the payment for RHCs. Because of this cap the incentive to stay at the productivity standard is minimal as long as your cost per encounter does not drop below the cap.** At this point, clinics can exceed the productivity standard while still receiving the highest possible reimbursements for Medicare patients.

If providers go significantly higher, or lower, than the standard there is the likelihood of losing 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, so if you are above or below the productivity standard, your total allowable cost is divided by the higher number, making the average cost per encounter lower – this is what the payment is based on. It is counter-intuitive in a basic business model to work less to make more. However, that is exactly how the RHC program is set up. Every encounter beyond the productivity standard loses money per encounter. Figures 9, 10 and 11 show a sample clinic with a mid-level provider working below the productivity standard, at the productivity standard, and above the productivity standard and how it would affect reimbursement if there were no Medicare cap. In Figure 9, by working below the productivity standard, 250 encounters less than the productivity standard, the clinic is actually losing $14.48 per encounter. In Figure 10, by working at the productivity standard, the clinic is getting 100% of the allowable costs. In Figure 11, by working over the productivity standard, 250 encounters more, the clinic actually loses $12.60 per encounter.

Figure 9

BELOW Productivity Standard

Actual Encounters	1850	
Productivity Standard	2100	
Total Allowable Costs	$225,000/1850	$121.62
Encounter Rate at Productivity Standard	$225,000/2100	$107.14
Dollar Difference		($14.48)

Figure 10
AT Productivity Standard

Actual Encounters	2100	
Productivity Standard	2100	
Total Allowable Costs	$225,000/2100	$107.14
Encounter Rate at Productivity Standard	$225,000/2100	$107.14
Dollar Difference		($0)

Figure 11
ABOVE Productivity Standard

Actual Encounters	2350	
Productivity Standard	2100	
Total Allowable Costs	$225,000/2350	$95.74
Encounter Rate at Productivity Standard	$225,000/2100	$107.14
Dollar Difference		($12.60)

Key Findings (n=32): Productivity Standards

- 20 of 32 clinics are exceeding productivity standards, 12 are below
- Of the 16 Isolated Rural Health Facilities included in the survey, 10 are exceeding productivity standards, 6 are below.
- No clinic is below 75% of the productivity standard based on FTE.
- Of the 11 clinics with over 50% market share, seven of them are over the productivity standard.
- Of the three clinics under 10% market share, two are over the productivity standard.
- Of the clinics at, or above, 100% market share, All are OVER the productivity standard.
- Public clinics have the highest average productivity with 100% or higher; for-profit and non-profit tie at 99% average productivity with ranges of 88-100% and 96-100% respectively; health districts and Provider-based clinics have the lowest average productivity of 92% with ranges of 76-100% and 58-100% respectively.

Recommendations: Productivity Standards

- Clinic staff and hours of clinic operation need to match the demand from the community. For example, clinics that only see between 10 and 15 patients a day should not be open full time.
- Providers should work as close to the productivity standard as possible. If they are not able to meet demand, consider adding additional providers.
- Clinics should contact their elected officials to encourage Congress to eliminate or update the productivity standard.

Hours of Operation

Clinic hours are important from many perspectives. If a clinic is open too much the expenses can significantly outweigh the patient revenue. Alternatively, if a clinic is not open enough then they may not be meeting the needs of their patients, which can affect market share. There is quite a range of hours for clinics; however, the majority of clinics are open five days a week. The following table gives the number of clinics by number of days open per week:

Open 7 days/week:	2
Open 6 days/week:	2
Open 5 days/week:	29
Open 4 days/week:	3
Open 2 days/week:	1

*24 of the 37 clinics close for at least one hour for lunch, the other clinics remain open during lunch.

The holidays that a clinic is open affect total hours throughout the year. Holidays are often good days for clinics to remain open since many patients will not have to work. The following table illustrates the number of clinics open, by holiday:

Martin Luther King Day:	26
President's Day:	28
Day After Thanksgiving:	15
Christmas Eve*:	28
Christmas:	1
All other Holidays:	1

*Many clinics open on Christmas Eve are only open for a half-day in the morning

Employee Hours

There is a wide variety of staffing choices at the RHCs in Oregon. The number of providers needed can be based on current demand estimates and patient flow at the clinics. The number of support staff is generally based on the number of providers, however in some clinics, support staff seems to be more than adequate.

Key Findings (n=37): Employee Hours

- 19 clinics report physician service hours. The average hours per week are 82.4 with an average number of physicians of 2.75 – clinics have an average of about 30 physician work hours per week. The highest number of hours and physicians is ten physicians at 400 hours per week, the lowest is one physician providing two hours per week.
- Of the 19 clinics reporting physician hours, ten are private or Provider-based.
- Fourteen clinics are using mid-levels as primary providers. Four clinics report using Physician Assistant (PA) services, while ten clinics report Nurse Practitioners (NP) as their regular providers.
- Eleven clinics report PA service hours. The average number of PA hours is 36.09 with an average number of providers of 1.25 – this means clinics have an average of 29 PA hours per week. The highest number of hours reported for a PA for one week is 40; the highest number of PAs reported for a clinic is 2.5. The lowest number of hours reported is 16 and the lowest number of PA staff reported is one.
- Twenty-five clinics report NP service hours. Average hours reported are 44.44 with an average NP count of 1.71 – the average clinic has about 26 NP hours per week. The highest number of hours reported is 52 hours per week for 1 NP. The lowest number of hours reported is ten hours for one NP.
- Twenty-seven clinics have at least some hours dedicated for administration. Thirteen clinics have full time administrators (38 hours or more per week). The average hours of administrative time reported is 25.83 with an average of .98 people – an average of 26 hours of administrator time per week. One clinic reports an administrator who works 50 hours a week while two clinics have only two hours reported for administration. Most clinics report one staff person for administration; however, one clinic has two people sharing the administrative tasks.

Figures 12 and 13 that follow, compare the employee type to average total hours as well as average number of employees. The averages for all non-isolated RHCs are shown as well as the averages for the Isolated Rural Health Facilities. It illustrates gaps in employee coverage, particularly in isolated rural facilities.

Figure 12

Avg Employee Hours

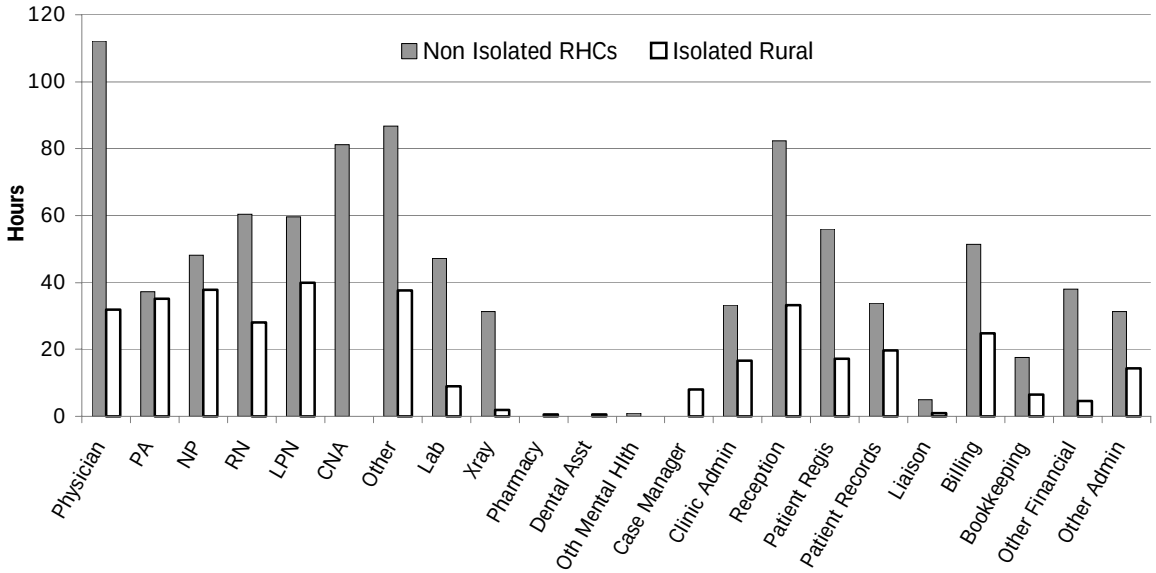
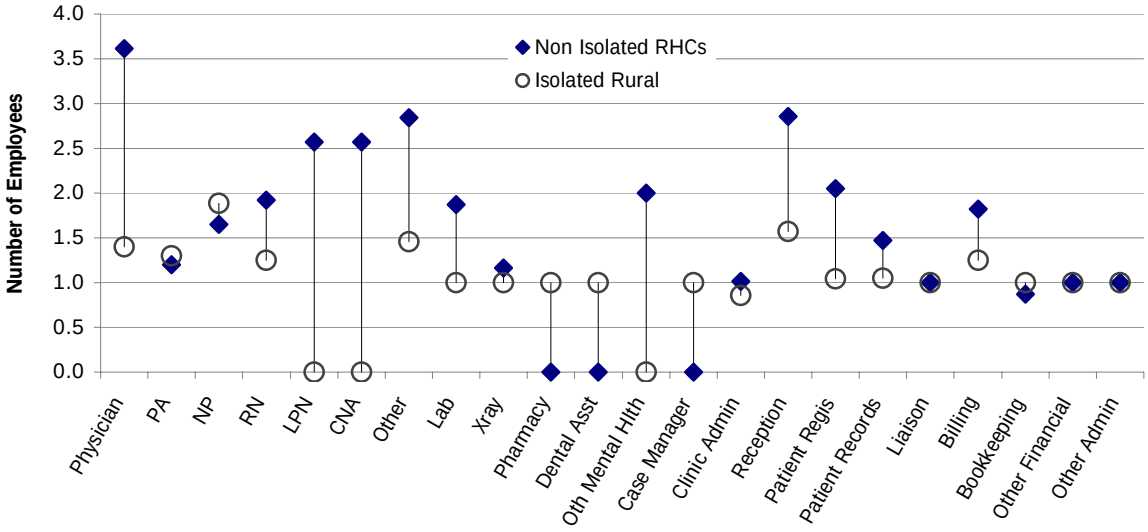


Figure 13

Avg Number of Employees



Recommendations: Employee Hours

- Using annual primary care demand estimates to calculate average demand per day and comparing that with the productivity standard can help determine how many days a clinic should be open.
- In order to adequately serve a community in terms of availability, a clinic may choose to be open slightly more than the demand numbers would suggest.
- Clinics need more FTE time directed to managing clinic operations. Even a clinic with a half time provider can support a full time administrator. In some clinics one person performs multiple tasks. This becomes a real challenge for those clinics that are only open a couple of days a week because no time is left to follow-up on denied claims, rule changes, and other practice management issues.
- Having a full time administrator, or at least a dedicated administrator, means there is someone to deal with all of the rules and regulations of the RHC program, with personnel issues, etc. This can free up a great deal of provider time in clinics where the provider is currently doing this. Reducing provider time spent on administration can reduce provider burn out.
- Clinics need to learn how clinical social workers and clinical psychologists can be integrated into their practices because the RHC program reimburses for these providers.

Fees

Oregon's Rural Health Clinics have a wide range of fees. Fees that are too low can leave a great deal of money on the table if a third party payer is willing to pay more than billed. Some clinics, primarily non-profit and publicly held, express concern that raising fees will cause patients to seek care elsewhere. Instituting a schedule of discounts is an effective way to provide for those who are uninsured and low-income. Fees for a 99213, one of the most common E&M codes, range from a low of $48.00 to a high of $95.00. The average fee for a 99213 for all clinics is $80.92. Figure 14 shows average fees by clinic type.

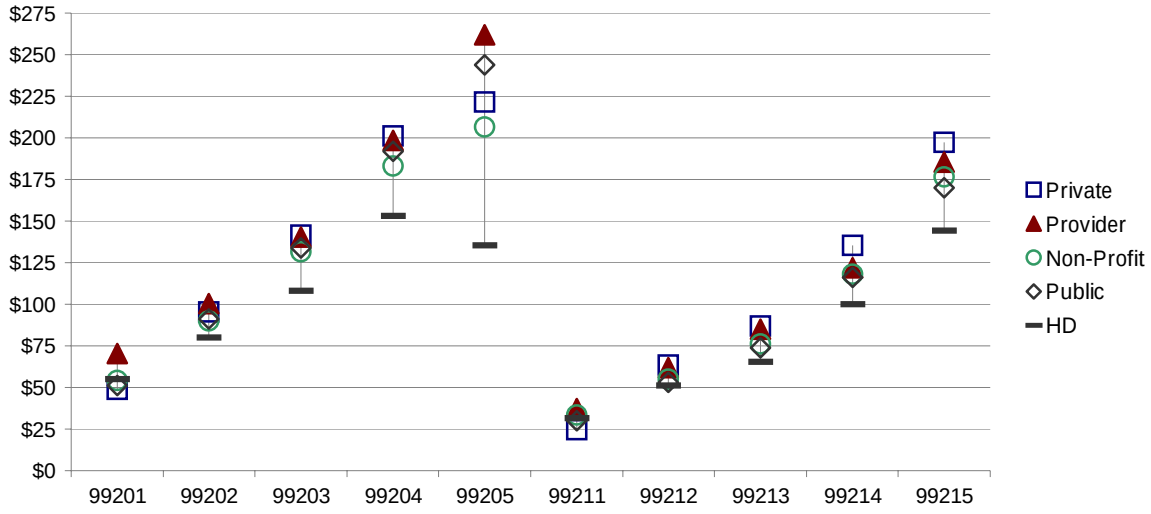
Schedule of discounts: A policy that clinics can implement to discount charges to patients based on patient income

Figure 14
New and Established Patient Fees

RHC Type	99201	99202	99203	99204	99205	99211	99212	99213	99214	99215
Private Avg	$48.99	$95.25	$141.54	$201.34	$221.59	$24.54	$63.35	$87.02	$135.27	$197.42
Provider Avg	$70.50	$100.50	$140.50	$198.50	$262.00	$37.50	$62.00	$85.00	$122.00	$185.50
Non-Profit Avg	$54.33	$90.00	$131.50	$183.00	$206.67	$33.50	$54.83	$76.17	$118.17	$176.50
Public/HD Avg	$54.13	$82.63	$114.50	$162.75	$216.83	$31.25	$51.75	$67.56	$104.00	$150.63
Low	$38.00	$58.00	$74.00	$99.00	$139.00	$24.00	$38.00	$48.00	$76.00	$110.00
Average	**$60.13**	**$98.00**	**$142.00**	**$201.08**	**$264.95**	**$35.02**	**$59.46**	**$80.92**	**$124.89**	**$183.28**
High	$75.00	$116.00	$175.00	$275.00	$320.00	$45.00	$73.00	$95.00	$150.00	$230.00
IRHF Avg	**$54.86**	**$87.00**	**$124.43**	**$173.71**	**$234.91**	**$32.71**	**$53.86**	**$72.25**	**$111.64**	**$163.71**

Figure 15

Comparison of Avg Patient Fees by RHC Type



Key Findings (n=30): Fees

- Private clinics as a group have the highest average fee for a 99213 at $87.02 with a range of $80-90; Provider-based clinics come in next with an average fee of $85 and a range of $80-95; followed by non-profit clinics at $76.17 with a range of $54-95; health district/public clinics have the lowest average fee of $67.56 with a range of $52-75.
- Isolated Rural Health Facilities have an average 99213 fee of $72.25.
- Health district clinics may feel compelled to keep fees low because the public is already paying for the clinic through taxes.
- When grouped by community size there is a great deal of variation. The average fee for a 99213 in large towns (10,000-49,000) is $84.05 with a range of $48-95; small towns (2,500-10,000) average is $80.81 with a range of $52-95; and rural areas (<2,500) have an average fee of $67.50 with a range of $54-75.
- The smallest communities stand out as having significantly lower average fees than the larger communities. This may be due, in part, to the fact that practitioners tend to know the people better and may have a harder time feeling comfortable charging higher fees, particularly if they perceive an inability to pay.

Figure 16 and 17 illustrate the difference in revenue capacity based on the low fees and the number of encounters from a real clinic and the average RHC fees using the same number of encounters. The Number of Office Visits column is adjusted based on the average RHC payer mix. This is an estimate and does not take into account the deductibles and charge-based co-insurance that Medicare patients are responsible for.

Figure 16
Current Fees – Low

Number of Office Encounters > 5857

CPT Code	# of Office Visits	% Times Used	Times Used	Fee Per CPT Code	Charges per CPT Code
99201	2987	0.5%	15	$38	$567
99202	2987	4.4%	131	$70	$9,200
99203	2987	5.0%	149	$92	$13,740
99204	2987	4.0%	119	$132	$15,771
99205	2987	0.6%	18	$164	$2,939
99211	2987	1.3%	39	$30	$1,164
99212	2987	17.7%	529	$42	$22,205
99213	2987	40.8%	1219	$52	$63,373
99214	2987	24.8%	741	$84	$62,226
99215	2987	0.9%	27	$120	$3,226
Medicare	1581			$66	$105,099
Medicaid	1288			$78	$100,287
					$399,802
				Total After Allowances and Deductions at 30%	$279,861

Figure 17
Current Fees - Average

Number of Office Encounters > 5857

CPT Code	# of Office Visits	% Times Used	Times Used	Fee Per CPT Code	Charges per CPT Code
99201	2987	0.5%	15	$60	$898
99202	2987	4.4%	131	$98	$12,880
99203	2987	5.0%	149	$142	$21,208
99204	2987	4.0%	119	$201	$24,026
99205	2987	0.6%	18	$265	$4,749
99211	2987	1.3%	39	$35	$1,360
99212	2987	17.7%	529	$59	$31,437
99213	2987	40.8%	1219	$81	$98,619
99214	2987	24.8%	741	$125	$92,518
99215	2987	0.9%	27	$183	$4,927
Medicare	1581			$66	$105,099
Medicaid	1288			$78	$100,287
					$498,008
				Total After Allowances and Deductions at 30%	$348,606

For Medicare services, the clinic will receive two payments, one from Medicare and one from the patient. Medicare pays the clinic based on the interim (capped rate) for RHCs (roughly $70 in 2005) while the patient pays the clinic based on the actual charges for the service. The following examples illustrate the payment method used by Medicare for RHCs (Bell):

Example 1 - Medicare patient with no deductible

The direct Medicare payment is equal to 80% of the interim rate.

The patient payment (may be due from the secondary insurance) is equal to 20% of charges.

Standard charge	$50
Interim rate	$70
Payment is	$66.00 (80% of $70 plus 20% of $50)

Standard charge	$150
Interim rate	$70
Payment is	$86.00 (80% of $70 plus 20% of $150)

Example 2 – Medicare patient with deductible

If a deductible is due from the patient, the formula changes considerably.

Patient pays a deductible equal to the lesser of 100% of standard charge or the remaining deductible outstanding.

Medicare pays 80% of the interim rate less the deductible due from the patient. Answer may be negative.

Patient pays the greater of no co-insurance or 20% of the standard charge less the patient deductible.

Standard charge	$50
Interim rate	$70
Deductible outstanding	$100
Payment is	$66.00 (patient deductible is $50, Medicare payment is 80% of $70 less $50 or $16, and the patient co-insurance is zero)

Standard charge	$150
Interim rate	$70
Deductible outstanding	$100
Payment is	$86.00 (patient deductible is $100, Medicare payment is 80% of $70 less $100 or a negative $24, and the patient co-insurance is 20% of $150 less $100 or $10)

Recommendations: Fees

- All clinics should evaluate practice management indicators on an annual basis. This should include coding and fee analysis.
- Clinics should never under-code because of a patient's inability to pay (under and over coding are considered violations by Medicare). Fees should be set at market value, not what is believed to be the right price or what one thinks people should pay.
- Fees must be set high enough to capture 100% of what private third party payers are willing to pay, otherwise clinics are leaving money on the table that could be collected.
- In order to ensure proper payment for services clinics must be sure to charge Medicare their regular charges, not the RHC capped rate, and bill the co-insurance to the patient.

Overhead

Clinic overhead is generally defined as non-medical expenses. It is important for clinics to try to allocate as many expenses as possible as allowable expenses because not all overhead can be reimbursed. For non-profit and public clinics, overhead is often an important indicator of efficiency and proper spending for donors and taxpayers.

Key Findings (n=32): Overhead

- The range for overhead as a percentage of total expenses goes from a low of 20% to a high of 65% with an average of 44%.
- There is no difference in the overhead range for clinics when compared by FTE – clinics with more than one FTE had nearly the same range as those with one or fewer. This shows that there may not really be much economy of scale for the larger clinics, at least the way they are currently operating.
- Health Districts as a group have the lowest average overhead at 38% with a range of 20-54%. Private clinics have an average overhead of 44% with a range of 29-64%. Non-profit and Provider-based clinics both have an average overhead of 46% with ranges of 33-55% and 30-65% respectively. Public clinics have the highest average overhead at 52% with a range of 43-60%.
- Isolated Rural Health Facilities have an average overhead of 44% with a range of 20-60%.

FINANCIAL STATUS OF OREGON RHCS

Financial Operations/Practice Management Standards

During the past six years, the reimbursement cap for Medicare has increased from $59.04 to $68.65. The total cost per encounter for 23 clinics in 2003 was $102.07. The OPCA RHC report showed that the total cost per encounter for 17 clinics was $56.34 (Redd 5). From 1999 to 2003, costs increased by $45.73 per encounter while Medicare rates increased by only $8.25 per encounter for the same time period. Healthcare cost increased an additional $33.42 per encounter above the Medicare reimbursement rate for RHCs. Cost report software and information can be obtained from the

Riverbend GBA Intermediary site for independent RHCs at www.riverbendgba.com/audit-reimb/rural-health.shtm. The contact person for independent RHC cost report questions is Tera Reed at (423) 763-3199. Provider-based RHCs should visit the Medicare Northwest website at http://medicare.regence.com/partA for cost report information.

Figure 18
Medicare Rate Caps from 1998 to 2004

Year	***Rate***	
2004	$68.65	
2003	$66.72	(3/1/03--12/31/03)
2003	$66.46	(1/1/03--2/28/03)
2002	$64.78	
2001	$63.14	
2000	$61.85	
1999	$60.40	
1998	$59.04	

*Data from Riverbend GBA Intermediary

Figure 19
Financial Data: OPCA RHC Report Data Compared to 2003

	1999 (n=17)	**2003 (n=23)**	**Difference**
Total Encounters	85,871	122,159	36,288
Total Patient Revenue	$3,250,423	$12,346,225	$9,095,802
Average Revenue Per Encounter	$54.48	$79.90	$25.42
Average Cost Per Encounter	$66.04	$99.01	$32.97
Total Expenses	$4,838,270	$12,469,883	$7,631,613
Total RHC Revenue Per Encounter	$37.85	$101.06	$63.21
Total RHC Cost Per Encounter	$56.34	$102.07	$45.73
Total Patient Revenue Less Total Expenses	-$1,587,847	-$123,658	
Operating Revenue	59% with a negative margin	77% with a negative margin	

The Oregon data above mirrors national trends in terms of the increase in healthcare costs. The 1999 University of Southern Maine study of RHCs shows RHC healthcare costs for Medicare increasing from 44 million in 1991 to 220 million in 1997. Similarly, the cost of serving Medicaid patients increased from 34 million in 1990 to 308 million in 1997 (Gale *x*). One significant factor to consider when discussing Medicaid cost is the Benefits Improvement Protection Act 2000, which mandated

the Medicaid Prospective Payment System (PPS) that requires states to pay 100% of reasonable cost. When comparing financial data from 1999 to 2003, however, it appears that RHCs continue to struggle regardless of PPS. Prior to PPS in 1999, the Maine study shows the national average profit loss for an RHC was approximately $40,000 per year (Gale 14). Although we do not have conclusive quantitative data to compare average profit loss from 1999 to 2003, other data indicators point to RHCs losing money. Revenue from patients still is not adequate enough to support a positive operating margin. **Even with increased revenue as a result of PPS, 77 percent of the clinics reported having a negative operating margin**. Operating margin is revenue generated from patients divided by total expenses. In 1999, according to the OPCA RHC study, 59 percent of clinics had a negative operating margin (Redd 5). Even though PPS has improved total revenue for RHCs, clinics continue to struggle with the rising cost of healthcare. **Fifty-nine percent of Oregon RHCs require additional revenue sources to stay in business. These other revenue sources may include tax dollars generated by health districts, grants, and fund raising activities**.

The financial data clearly indicate three important policy issues for which RHCs must advocate. First, elected officials must be informed how necessary it is that the Medicare cap be eliminated or raised to a level that matches the national increases in health care cost. Second, elected officials must maintain the current PPS system. Even with the PPS requirement that states pay cost, clinics are still not breaking even. Finally, Oregon's elected officials must be informed and helped to recognize the importance of providing support for Isolated Rural Health Facilities, whose potential for generating enough revenue to meet overhead is questionable.

Figure 20
Practice Management Standards by Ownership: 2003

Clinic	Visits	Patient Revenue	Other Revenue	Total Expenses	Operating Margin	Total Margin	Cost per Enc.	Revenue per Enc.
Non-profit Avg	31,681	2,402,791	634,487	2,696,027	-10.87%	12.65%	85.09	75.84
Private Avg	51,900	3,939,646	424,198	4,198,890	-6.20%	3.90%	80.90	75.90
Public Avg	14,251	1,101,407	375,624	1,427,208	-22.82%	3.49%	100.14	77.28
Isolated RHCs	35,309	2,630,801	634,487	3,094,543	-14.98%	5.50%	87.64	74.50

Figure 21
2003 Avg Cost and Revenue per Encounter

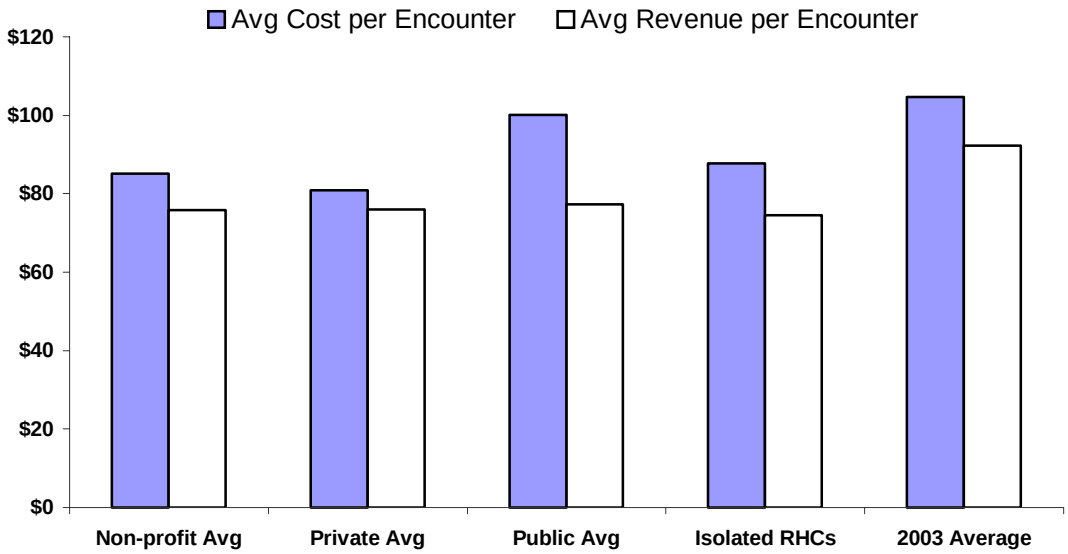


Figure 21 illustrates that for all clinic types the average cost per encounter is lower than the average revenue per encounter. This reinforces how difficult it is for many of Oregon's RHCs to maintain financial stability. Because so many clinics depend on non-operating revenue to maintain a positive operating margin, planning for future operations is especially difficult.

Practice management standards exist for administrative functions as well as for financial data. Clinics were surveyed on administrative functions that can have significant impacts on overall financial wellbeing. Strategic plans and regular review of policy and procedure manuals, for example, can help a clinic overcome unstable financial circumstances and maintain a healthy financial future.

As stated before, although the rules do not require it, all of the clinics surveyed provide care to uninsured patients. In order to evaluate the financial impact on a clinic, and make future decisions regarding treatment of the uninsured, it is necessary to be able to document the number of encounters per year. Unfortunately, a number of clinics do not collect or track this data.

Key Findings (n=37): Practice Management Standards

- 17 clinics have a strategic plan.
- 18 have a quality initiative in place.
- 20 clinics have updated their policy and procedure manual within the last year.
- Only 12 clinics have a strategic plan, quality initiative and have updated their policy and procedure manual within the last year; of these clinics, nine are Provider-based or affiliated with a hospital.
- 27 clinics do outreach activities in the community; the most common activities are providing flu shot clinics, sports physicals, education outreach at schools or through support groups, and many providers make home visits.
- 26 clinics communicate regularly with their communities, primarily through newsletters and articles in local newspapers.
- 22 clinics have a formal published schedule of discounts; five clinics provide cash discounts.
- All 37 clinics responding state that they see uninsured patients; only 17 clinics could report how many uninsured encounters they had during the year – the average for these clinics was 912 encounters per year.
- 13 clinics have signed up for, and participate in, the RHC E-group.

Key Findings for IRHFs (n=14): Practice Management Indicators for Isolated Rural Health Facilities

- All of the clinics that reported patient revenue have a negative operating margin.
- The average revenue per encounter for all clinics is $41 per encounter greater than for IRHFs.

The Rural Health Clinic program has a number of rules and regulations. It is important for clinics to be able to access available resources to answer questions about the program. The resources listed in Figure 22 are the basic resources that all Rural Health Clinics in Oregon should have access to. These resources can answer most questions about rules, regulations, and billing. In order to assess how these resources are being used clinics were asked which resources they have on site, and which ones are used regularly.

Figure 22
RHC Resource Use

Resource	Have on Site	Use Regularly
Medicare Manual	31	5
Medicaid Manual	29	5
Interpretive Guidelines	15	3
RHC Manual	25	6
Link to Office of Rural Health website	23	10

Recommendations: Financial Operations/Practice Management Standards

- Clinics need to collect financial information in a standardized fashion. This will help RHCs make a stronger case that additional resources are necessary. Currently, it is too difficult to gain an accurate analysis of the financial situation because many RHCs cannot produce the information.
- Clinics should work with the Office of Rural Health to develop strategic plans and quality initiatives. RHCs need to operate with a strategic plan that demonstrates a data driven process.
- All clinics should evaluate practice management indicators on an annual basis. This should include coding analysis of evaluation and management codes.
- All RHCs need to invest training money to help office staff and providers code and bill correctly.
- Reviewing Policy and Procedures manuals regularly is an important step to ensuring that the clinic is operating as efficiently and effectively as it can.
- Fees must be evaluated on an annual basis. Clinics should never under-code because of a patient's inability to pay (under and over coding are considered to be a violation by Medicare). Fees must be set at market value not at what is believed to be the right price. Clinics can institute a schedule of discounts to address those who cannot pay the full price. Fees should also be high enough to capture 100% of what private third party payers are willing to pay, otherwise clinics are leaving money on the table that could be collected.
- Clinics should group purchase when possible. Clinics should create their own agendas for training and education.
- Clinics need to be proactive in seeking assistance and information relevant to the RHC program.
- Clinic staff should attend at least one RHC specific seminar on an annual basis. Program rules change often and continuing education is a must.
- Board members should attend an annual RHC education workshop that covers RHC specific material. In addition, board members should have at least one board meeting a year that involves board roles and responsibility training
- Independent RHCs need to start their own association.
- Provider-based RHCs need to create their own association with specific focus on Provider-based issues verses independent clinic issues.
- Clinics need to begin planning how to integrate Electronic Medical Records into their practices.
- Clinics need to contact elected officials to encourage Congress to remove or increase the Medicare Cap.
- Clinics need to contact elected officials to encourage the State to include mid-level providers in the state-based rural malpractice subsidy program.
- RHCs must advocate as a united group. Numbers do matter in politics.
- RHCS need to become more proactive in rule making and hangs for both federal and state programs.

2003 Cost Report Data

Below are tables (Figures 23-26) highlighting some of the information contained in RHC cost reports. The purpose of this information is to provide a benchmarking tool for clinics to compare themselves against other RHCs. Data is shared in low, high, median and average. Cost report data will also be shared by clinic size, location, and ownership type. To see a sample cost report, go to www.riverbendgba.com/audit-reimb/rural-health.shtm.

Cost report data tend to have a large range and may appear to be incorrect. Several factors may exist for an individual clinic that can make it unique in certain categories. For example, rent varies from $66 a year to $79,915 a year. This variation is not a mistake but rather an example of how diverse RHCs can be. Some clinics get physician supervision donated while other clinics pay as much $30,000 annually. To account for this variation, the data has been grouped into peer groups and the average and median for each category is reported. However, provider salaries are reported by FTE and are shown only by the average in Figure 23.

Figure 23
Cost Report Data For All Clinics

	Phys Salary by FTE	Nurse Pract by FTE	Phys Asst by FTE	Utilities	Rent	Medical Supplies	Phys Service Under-Agreemt	Prof Liability Ins	Prop Tax
Low				185	66	230	230	528	100
Average	121,045	78,474	54,413	4,818	24,513	15,117	9,803	9,105	1,291
High				29,308	79,915	78,253	30,248	76,275	6,263
Median				3,102	12,989	8,871	7,374	3,520	597

Figure 24
Cost Report Data For All Clinics

	Telephone	Office Salaries	Depreciation Of Medical Equipment	House Keeping/ Maint	Office Supplies	Admin Cost	Insurance
Low	1,037	7,466	510	60	94	29,633	485
Average	7,799	79,696	7,013	8,299	6,795	178,455	8,269
High	30,324	306,754	60,886	50,879	37,263	546,162	58,028
Median	4,983	44,327	2,658	4,333	7,423	135,140	1,146

Figure 25

Average Cost Report Comparison Data For Isolated Rural Health Facilities

		Utilities	Rent	Medical Supplies	Phys Service Under-Agreemt	Phone
Isolated RHCs	AVG	5,899	10,000	10,567	12,574	4,116
	Median	3,128	10,200	8,524	7,374	3,684
Large Town	AVG	4,729	29,516	19,869	31,202	10,012
	Median	2,671	24,929	8,871	3,125	8,017
Small Town	AVG	7,305	30,703	20,763	11,249	10,577
	Median	4,813	14,078	15,471	8,400	7,091
Rural	AVG	2,660	7,425	6,455	11,422	3,300
	Median	2,698	7,350	5,593	7,369	3,180

Figure 26

Average Cost Report Comparison Data By Ownership

		Utilities	Rent	Medical Supplies	Phys Service Under-Agreemt	Phone
Private	AVG	4,893	30,258	18,530	5,118	10,121
	Median	3,773	18,414	13,010	3,125	7,554
Public	AVG	11,604	1,800	13,621	5,929	4,666
	Median	3,374	1,800	15,109	6,348	5,377
Not-for-Profit	AVG	2,863	28,706	17,194	7,028	9,814
	Median	2,254	17,423	13,865	5,112	4,987
Health Districts	AVG	2,942	11,171	7,205	21,141	3,478
	Median	2,956	14,078	6,552	19,000	3,492

Recommendations: Cost Report Data

- Clinics should evaluate practice management indicators on an annual basis.
- A third party should review cost report expenditures at least once to verify expenses.
- RHC rules and regulations must be understood.
- When billing Medicare list actual charges for each service and do not list the all-inclusive rate amount.
- Clinics need to be diligent about how an encounter is reported. Medicare and Medicaid use different definitions.
- Clinics need to recover as many allowable costs as possible on the Medicare cost report. For example, depreciation, salaries and wages, payroll taxes, health & life insurance, paid vacation and sick leave, and education courses.
- Clinics must claim bad debt of 120 days old.
- An annual budget process can help ensure that all allowable costs are captured on the cost report.

TECHNOLOGY

Technology areas studied include billing software, Internet access type, practice management software, and Electronic Medical Record (EMR) capabilities. The data below again show independence and diversity in how clinics operate and purchase equipment. No one type of software package or program is dominant. Rather, clinics demonstrated a board range of capacity and demand for technology. Of the 37 RHCs surveyed, 24 reported that they do not use or have electronic medical records.

As more and more information is available exclusively on the web, and practice management becomes increasingly computer and web-based, RHCs will need to be able to keep up in order to maintain their ability to conduct business.

The following information is important to consider when encouraging clinics to work together. Clinics using the same software may be able to work together to negotiate for services and products from the vendor; vendors may be willing to create capacities for tracking common data sets if a number of clinics are requesting the same information; and working together, clinics may be able to problem-solve software and data collection issues.

The range of computer use and number of computers is quite broad. The minimum number of computers at a clinic is one. One clinic has 75 computers, while the average number of computers per clinic is ten. The clinics with Electronic Medical Records generally need more computers in order to use the software effectively.

Key Findings: Technology

- Top 3 Billing Software
  - Medisoft
  - Medical Manager
  - PC ACE (Medicare software)

- Top 3 Practice Management Software
  - Medical Manager
  - Practice Partner
  - MARS

  *15 clinics do not use practice management software

- Top 3 Electronic Medical Records (EMR) Software
  - Practice Partner
  - Soapware
  - Encite

  *24 clinics do not use EMR

- Top 2 Other Software Used
  - Quick Books
  - MS Office

  *20 clinics reported plans to upgrade in the near future

Figure 27

Online Capacity

Internet Connection	34	
Dial-up	10	
DSL	13	
T-1	6	
Cable	1	
Other	4	
Would Switch Connection	22	(only if faster)
Connection Used For:		
Electronic Billing	30	
Research	30	
Oregon RHC discussion group	24	
General e-mail	29	
E-mail protected health information	1	

Recommendations: Technology

- Clinics need to begin planning how to integrate Electronic Medical Records into their facilities.
- Clinics should invest in the necessary training for staff to utilize technology in an efficient and effective manner.
- All clinics should at least be connected to the Internet and have a clinic web page.
- Clinics using the same software may be able to work together to negotiate for services and products from the vendor. Vendors may be willing to create capacities for tracking common data sets if a number of clinics are requesting the same information; and working together clinics may be able to problem solve around software and data collection issues.
- Clinics need to look at and consider computer-based practice management systems.
- Clinics need to prepare for a switch by all payers to mandatory electronic billing, some of which will be web-based.

PHYSICAL PLANT

The clinic buildings vary significantly in size, age, and appeal. The physical structure is very important to how people perceive the clinic function – poorly cared for and outdated buildings may give people the impression that the health care provided there is also poor and outdated.

Key Findings: Physical Plant

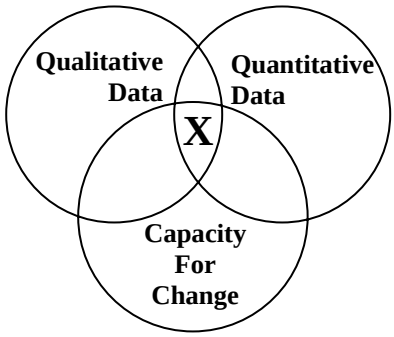
- Average age of the buildings is 22 years. A number of the clinics are in older buildings, many of which have had extensive remodeling in the last few years, while others in older buildings have not had any significant changes since the building opened.
- Nineteen clinics own their own building.
- Eighteen clinics are planning physical plant improvements. These improvements include painting, improving/adding pathways and walkways, landscaping, replacing the floor covering (carpets), and improving/adding external and internal signage.

Recommendations: Physical Plant

- Clinics should be aware of how the clinic appears to the public. Beware of poor maintenance of internal and exterior surfaces, landscaping, signage on walls, and general cleanliness of the building. Healthcare is like any other business in terms of public perception. A clean and tidy clinic gives a much better perception of quality and professionalism than one that is dirty and rugged looking.
- Clinics should maintain a plan that saves money for future capital expenditures.

QUALITATIVE DATA

The data collected in this survey provides a detailed numerical picture of the status of Oregon RHCs. It is clear in examining the data that there are some real needs among Oregon RHCs. However, change is most likely to occur when three elements intersect (X). This happens when the quantitative data is perceived as accurate (qualitative data) and the clinic feels they have the capacity to make change. In order to determine how people feel about the status of their clinics, we asked some open-ended qualitative questions.



Clinics were asked to identify their biggest challenge. Some clinics had more than one response. The responses were varied but some common themes emerged.

- The number one reported challenge is operating revenue. Eleven clinics report struggles with operating revenue and many of those clinics report that keeping the doors open is a constant struggle.
- Concerns about RHC rules and regulations being burdensome and hard to understand/follow were voiced by ten clinics.
- Declining patient volume is reported as the biggest challenge for nine clinics.
- Seven clinics find the government payers difficult to work with, primarily Medicare and Medicaid; this included complaints that OMAP takes too long to pay.
- Recruiting and retaining providers is the biggest challenge for six clinics. Recruiting and retaining qualified staff was stated by four clinics as the biggest challenge.
- For three clinics problems with computer repair and tech support were reported as the biggest challenges.
- Significant administrative burden was mentioned by three clinics as a major challenge.

Clinics were also asked what they would add or change in order to improve their clinics. Some clinics gave more than one response. The responses fit into six distinct categories.

- 11 clinics reported facility changes including the following:
  - New phone system
  - Bigger space for visiting specialists
  - New equipment – medical, office, especially computers
  - New or expanded buildings
  - Improved image
- 11 clinics reported that finance-related changes would make the most difference:
  - Capturing more insured patients
  - Knowing where to get concrete answers for billing questions (Medicare and Medicaid)
  - "Pot of money"
  - Tax levy passing
  - Improved mental health funding
  - Faster payment from government payers
  - Higher reimbursement
  - Increased number of patients
  - Expanded services
- Eight clinics stated solutions relating to administrative functions and staffing:
  - Administrative assistance
  - Hands on training for RHC staff
  - Less administrative burden
  - Adding another provider
  - Coordinating physician services for patient management
  - Subsidy for staffing, to allow higher pay for qualified employees
  - Ability to add staff
  - Adding specialists
- Three clinics stated solutions relating to technology:
  - Interface between hospital and clinic – Electronic Medical Records and Meditech
  - Standardization of electronic billing
  - Getting Electronic Medical Records
- Two clinics felt that rule changes to the RHC program would make the biggest change

- One clinic stated that changing the perception of rural health care would make the biggest difference

Clinics were asked what makes them unique. The answers were varied, but there were some themes in the answers, the overwhelming response related to providers.

- 14 clinics said that their providers make them unique; this ranges from offering a broad range of provider types to having providers who are willing to stay late when necessary.
- Four clinics feel that their staff makes them unique, primarily the good attitudes of staff. Clinics report having a caring staff that works well together and with the patients, one clinic reports a "family" feel with people who really like to work there.
- Two clinics feel that their strong community support makes them unique.
- Some responses did not fit into any category and are as follows:
    - The way the clinic provides flu shots – drive-up service
    - Practice went from private practice to not-for-profit
    - The Gold Card program (this is a type of subscription service available to uninsured patients to ensure access to care at a reasonable cost)
    - Ways people travel to the clinic – tractor, horse, car, etc.

Recommendations: Qualitative Data

- Clinics should document the number of uninsured patients they see.
- Clinics can work together to change or create policy when needed.
- RHCs need to become more proactive in rule making and changes for both federal and state programs.
- Clinics need to contact their elected officials to encourage Congress to remove or increase the Medicare Cap.
- Clinics need to contact State elected officials to encourage the State to include mid-level providers in the state-based rural malpractice subsidy program.
- Provider-based RHCs need to advocate for a billing guide specific to Provider-based RHCs

OVERALL SUMMARY OF RECOMMENDATIONS

Provider-based RHCs

- Provider-based RHCs need billing guides that are specific to Provider-based RHCs.
- Provider-based RHCs need group specific meeting agendas and education sessions.
- Provider-based RHCs should advocate policy issues as a group.

Market Share

- All RHCs should have a web page with clinic services and contact information listed. This can inform people about what services the clinic offers as well as serve as an important advertising medium.
- Clinics should follow basic principles of marketing. Even though it may appear that everyone in a community knows where and what the clinic does, it should never be taken for granted.
- Clinics should be aware of how the clinic appears to the public. Beware of poor maintenance of internal and exterior surfaces, landscaping, signage on walls, and general cleanliness of the building. Healthcare is like any other business in terms of perception from the public. A clean and tidy clinic gives a much better perception of quality and professionalism than one that is dirty and rugged looking.
- All clinic and staff should be signed up on the RHC E-group list serve for Oregon RHCs. This will allow clinics to stay updated on changes to the RHC program – better informed clinics will be better able to market their services.

Productivity Standards

- Clinic staff and hours of clinic operation need to match the demand from the community. For example, clinics that only see between 10 and 15 patients a day should not be open full time.
- Providers should work as close to the productivity standard as possible. If they are not able to meet demand, consider adding additional providers.
- Clinics should contact their elected officials to encourage Congress to eliminate or update the productivity standard.

Employee Hours

- Using annual primary care demand estimates to calculate average demand per day and comparing that with the productivity standard can help determine how many days a clinic should be open.
- In order to adequately serve a community in terms of availability, a clinic may chose to be open slightly more than the demand numbers would suggest.
- Clinics need more FTE time directed to managing clinic operations. Even a clinic with a half time provider can support a full time administrator. In some clinics one person performs multiple tasks. This becomes a real challenge for those clinics that are only open a couple of days a week because no time is left to follow-up on denied claims, rule changes, and other practice management issues.
- Having a full time administrator, or at least a dedicated administrator, means there is someone to deal with all of the rules and regulations of the RHC program, with personnel issues, etc. This can free up a great deal of provider time in clinics where the provider is currently doing this. Reducing provider time spent on administration can reduce provider burn out.

- Clinics need to learn how clinical social workers and clinical psychologists can be integrated into their practices because the RHC program reimburses for these providers.

Fees

- All clinics should evaluate practice management indicators on an annual basis. This should include coding and fee analysis.
- Clinics should never under-code because of a patient's inability to pay (under and over coding are considered violations by Medicare). Fees should be set at market value, not what is believed to be the right price or what one thinks people should pay.
- Fees must be set high enough to capture 100% of what private third party payers are willing to pay, otherwise clinics are leaving money on the table that could be collected.
- In order to ensure proper payment for services clinics must be sure to charge Medicare their regular charges, not the RHC capped rate, and bill the co-insurance to the patient.

Financial Operations/Practice Management Standards

- Clinics need to collect financial information in a standardized fashion. This will help RHCs make a stronger case that additional resources are necessary. Currently, it is too difficult to gain an accurate analysis of the financial situation because many RHCs cannot produce the information.
- Clinics should work with the Office of Rural Health to develop strategic plans and quality initiatives. RHCs need to operate with a strategic plan that demonstrates a data driven process.
- All clinics should evaluate practice management indicators on an annual basis. This should include coding analysis of evaluation and management codes.
- All RHCs need to invest training money to help office staff and providers code and bill correctly.
- Reviewing Policy and Procedures manuals regularly is an important step to ensuring that the clinic is operating as efficiently and effectively as it can.
- Fees must be evaluated on an annual basis. Clinics should never under-code because of a patient's inability to pay (under and over coding are considered to be a violation by Medicare). Fees must be set at market value not at what is believed to be the right price. Clinics can institute a schedule of discounts to address those who cannot pay the full price. Fees should also be high enough to capture 100% of what private third party payers are willing to pay, otherwise clinics are leaving money on the table that could be collected.
- Clinics should group purchase when possible. Clinics should create their own agendas for training and education.
- Clinics need to be proactive in seeking assistance and information relevant to the RHC program.
- Clinic staff should attend at least one RHC specific seminar on an annual basis. Program rules change often and continuing education is a must.
- Board members should attend an annual RHC education workshop that covers RHC specific material. In addition, board members should have at least one board meeting a year that involves board roles and responsibility training
- Independent RHCs need to start their own association.
- Provider-based RHCs need to create their own association with specific focus on Provider-based issues verses independent clinic issues.
- Clinics need to begin planning how to integrate Electronic Medical Records into their practices.

- Clinics need to contact elected officials to encourage Congress to remove or increase the Medicare Cap.
- Clinics need to contact elected officials to encourage the State to include mid-level providers in the state-based rural malpractice subsidy program.
- RHCs must advocate as a united group. Numbers do matter in politics.
- RHCS need to become more proactive in rule making and hangs for both federal and state programs.

Cost Report Data

- Clinics should evaluate practice management indicators on an annual basis.
- A third party should review cost report expenditures at least once to verify expenses.
- RHC rules and regulations must be understood.
- When billing Medicare list actual charges for each service and do not list the all-inclusive rate amount.
- Clinics need to be diligent about how an encounter is reported. Medicare and Medicaid use different definitions.
- Clinics need to recover as many allowable costs as possible on the Medicare cost report. For example, depreciation, salaries and wages, payroll taxes, health and life insurance, paid vacation and sick leave, and education courses.
- Clinics must claim bad debt of 120 days old.
- An annual budget process can help ensure that all allowable costs are captured on the cost report.

Technology

- RHCs need to begin planning how to integrate Electronic Medical Records into their facilities.
- Clinics should invest in the necessary training for staff to utilize technology in an efficient and effective manner.
- All clinics should at least be connected to the Internet and have a clinic web page.
- Clinics using the same software may be able to work together to negotiate for services and products from the vendor. Vendors may be willing to create capacities for tracking common data sets if a number of clinics are requesting the same information, and working together clinics may be able to problem solve around software and data collection issues.
- Clinics need to look at and consider computer based practice management systems.
- Clinics need to prepare for a switch by all payers to mandatory electronic billing, some of which will be web-based.

Physical Plant

- Clinics should be aware of how the clinic appears to the public. Beware of poor maintenance of internal and exterior surfaces, landscaping, signage on walls, and general cleanliness of the building. Healthcare is like any other business in terms of public perception. A clean and tidy clinic gives a much better perception of quality and professionalism than one that is dirty and rugged looking.
- Clinics should maintain a plan that saves money for future capital expenditures.

Qualitative Findings

- Clinics should document the number of uninsured patients they see.
- Clinics can work together to change or create policy when needed.

- RHCs need to become more proactive in rule making and changes for both federal and state programs.
- Clinics need to contact their elected officials to encourage Congress to remove or increase the Medicare Cap.
- Clinics need to contact state elected officials to encourage the State to include mid-level providers in the state-based rural malpractice subsidy program.
- Provider-based RHCs need to advocate for a billing guide specific to Provider-based RHCs.

WORKS CITED

Bell, Michael R. Michael R. Bell and Company. Letter to author. 19 January 2005.

Fryer, GE, Dovey, SM, Green, LA. "The Importance of Primary Care Physicians As the Usual Source of Healthcare in the Achievement of Prevention Goals." American Family Physician. 1 Nov. 2000. www.graham-center.org/x159.xml

Gale, John A., and Andrew F. Coburn. The Characteristics and Roles of Rural Health Clinics in the United States: A Chart book. Portland, ME: Edmund S. Muskie School of Public Service, University of Southern Maine, 2003.

Redd, Diane. Oregon's Rural Health Clinics. Portland, OR: Oregon Primary Care Association, 2001.

Woodwell, DA, and Cherry DK. "National Ambulatory Medical Care Survey: 2002 Summary." Advance data from vital and health statistics; no 346. Hyattsville, Maryland: National Center for Health Statistics, 2004.

Appendix A

Clinic Name: _____

Financial Assessment Tool

This information will be entered into a Financial Risk Assessment tool to evaluate your financial risk relative to other outpatient safety net providers. Please provide the ***most recent, complete*** fiscal year financial data. Please indicate the time period under consideration (eg. June 03- July 04)

Part 1: Liquidity	**Where to Find the Item**	**Data for Time Period Beginning and Ending** _____ to _____
Current Assets	Balance Sheet	
Current Liabilities		
Cash		
Temporary Investments		
Accounts Receivable (Net Patient)		
Total Expenses	Income Statement	
Bad Debt Expense		
Current Year Depreciation Expense		
Part 2 of Tool: Equity/Profitability		
Change in Net Assets	Income Statement	
Net Assets	Balance Sheet	
Current Liabilities		
Long-term Liabilities		
Net Assets		
Change in Net Assets	Income Statement	
Current Assets	Balance Sheet	
Long-term Assets		
Long-term Liabilities		
Net Assets		

Part 3 of Tool: Coverage		
Cash Flow from Operations	Statement of Cash Flow	
Current Liabilities	Balance Sheet	
Long-term Liabilities		
Current Liabilities		
Long-term Liabilities		
Current Assets		
Long-term Assets		
Part 4 of Tool: Activity		
Accounts Payable	Balance Sheet	
Total Expenses	Income Statement	
Interest Expense		
Current Year Depreciation Expense		
Net Patient Accounts Receivable	Balance Sheet	
Net Patient Revenue	Income Statement	
Allowance for Doubtful Accounts	Balance Sheet	
Allowance for Uncollectible Accounts	Auditor Notes	
Net Patient Accounts Receivable	Balance Sheet	
Part 5 of Tool: Other		
Accumulated Depreciation	Balance Sheet or Auditor Notes	
Current Year Depreciation Expense	Income Statement	
Net Patient Revenue		
Total Expenses		
Part 6 of Tool: Other		
Net Patient Revenue	Income Statement	
Bad Debt Expense		
Sliding Fee Adjustment	Auditor Notes	
Total Expenses	Income Statement	

Technology Questions

1. Do you have access to the internet? Yes No
2. If yes, what type of connection:
   DSL Dial-up T-1 Fiberoptic Cable Other

3. How much do you pay for this connection? $_____ per _____

4. Are there other types of connections available in your community?
   Yes No Don't Know
5. If yes, what type (s):
   DSL Dial-up T-1 Fiberoptic Cable Other Don't Know

6. Would you consider another type of connection? Yes No
7. If not, why not?

8. If you have an internet connection what do you use the connection for
   Electronic Billing
   Research
   RHC list serve
   E-mail, general
   E-mail, with patients' protected health information
   Other:

_____

_____

_____

9. How many computers does your office currently use? _____

10. How old are the computers?

_____

_____

_____

11. What type of software do you use and how old is it:
    Billing:

_____

12. Practice Mgmt (scheduling, etc.):

_____

_____

EMR:

_____

Other: _____

13. Are you planning to upgrade? Yes No
14. If yes, when? _____

15. If no, why not? _____

16. Do you bill electronically? Yes No
17. If yes, for which insurance: OHP Private (please specify)
_____

18. If private, do you use a clearinghouse? Yes No
19. If yes, which one? _____

20. If no, why not? _____

21. What type of transcription services do you use?

Administrative/Physical Plant Information

1. How old is your building? _____

2. Do you own your building? Yes No

3. Are you planning any physical plant improvements? Yes No

4. Do you have a strategic plan? Yes No

5. Do you have a Quality Improvement Plan in place? Yes No

6. When did you last update your Policy and Procedure Manual?
(How many months ago?)
_____

7. How do you market clinic services to the community?

8. Do you do any outreach to the community? Yes No
9. If yes, please explain?

10. Do you have any regular, formal or informal, method of communication with the community? Yes No
11. If yes, what type:

_____

_____

_____

Billing and Fee Information

1. Do you offer a formal/published schedule of discounts? Yes No

2. Do you serve uninsured patients? Yes No
3. If yes, how many ENCOUNTERS last year?_____

4. Do you serve underinsured patients? Yes No
5. If yes, how many ENCOUNTERS last year?_____

6. Please indicate your current payer mix:
   Medicare: %
   Medicaid/OHP: %
   Private: %
   Other: % Specify: _____
   Other: % Specify: _____
   Other: % Specify: _____
   Other: % Specify: _____

7. Do you bill all of the services you provide? Yes No
   Example: Do you bill for immunizations?

RHC Resource Questions

1. Do you participate in the RHC e-group? Yes No

2. What RCH resources do you have on site?
   Medicare Manual
   Medicaid Manual
   Interpretive Guidelines
   RHC Manual
   Link to Office of Rural Health Website

3. What RCH resources do you use? List

_____

_____

_____

General Questions

1. What is the biggest challenge for your clinic?

2. What would help the clinic most if you could add, change, or create something?

3. What makes your clinic unique?

Collect the following:
__ List of current board members, including length of time served
__ Copy of your super-bill, or bill slips
__ Copy of current fee schedule
__ Copy of sliding fee scale/schedule of discounts

If possible:
__ Balance Sheet
__ Income Statement
__ Statement of Cash Flow

Please fill out the following items for us to collect:
__ List of Clinic Services Form
__ Office Hours/Holiday Form
__ Employee Hours Form
__ Financial Assessment Tool Form

Check List of Services Offered **Clinic Name:** _____

Medical Services	RHC Staff Provided	Offered in Clinic by Visiting Provider
General Primary Care (other than below)		
Diagnostic Laboratory (technical component)		
Diagnostic X-ray Procedures (technical component)		
Diagnostic Tests/Screenings (professional component)		
Emergency Medical Services		
Urgent Medical care		
24-hour Coverage		
Family Planning		
HIV Testing		
Immunizations		
Following Hospitalized Patients		
Obstetrical and Gynecological Care		
Gynecological Care		
Prenatal Care/Maternity Case Management		
Antepartum Fetal Assessment		
Ultrasound		
Genetic Counseling and Testing		
Amniocentesis		
Labor and Delivery Professional Care		
Postpartum Care		
Specialty Medical Care		
Directly Observed TB Therapy		
Other Specialty Care		
Mental Health/Substance Abuse Services		
Mental Health Treatment/Counseling		
Developmental Screening		
24-hour Crisis Intervention/Counseling		
Substance Abuse Services		
Other Mental Health Services		
Other Professional Services		
Dental Care		
Hearing Screening		
Nutrition Services other than WIC		
Occupational or Vocational Therapy		
Physical Therapy		
Pharmacy		
Vision Screening		
WIC Services		
Other Services		
Case Management		
Child Care		
Eligibility Assistance		
Employment Physicals		
Sports Physicals		
Environmental Health Risk Reduction (via Detection/Alleviation)		
Food Bank/Delivered Meals		
Health Education		
Housing Assistance		
Interpretation/Translation Services		
Nursing Home & Assisted Living Placement		
Hospice		
Outreach		
Transportation		
Home Visiting		
Parenting Education		
Podiatry		
Chiropractic		
Massage		
Other (specify)		

Employee Numbers and Hours **Clinic Name:** _____

PERSONNEL BY MAJOR SERVICE CATEGORIES	HOURS PER AVERAGE WEEK	NUMBER OF EMPLOYEES
Medical Services		
Physician Services		
Physician Assistants		
Nurse Practitioners		
Certified Nurse Midwives		
Registered Nurses		
LPNs		
CNAs		
Other Medical Support Personnel		
Ancillary Services		
Laboratory Services Personnel		
X-ray Services Personnel		
Pharmacy Personnel		
Other Ancillary Services		
Dental Services		
Dentists		
Dental Hygienists		
Dental Assistants, Aides, Technicians, and Support		
Mental Health & Substance Abuse Services		
Mental Health & Substance Abuse Specialists		
Mental Health & Substance Abuse Support Personnel		
Other MH & SA Services		
Other Professional and Other Services		
Other Professionals (Therapists, Podiatrists, & Other)		
Case Managers & Educational Specialists		
Outreach Workers, Transportation Staff and Other Service		
Other Professional and Other Service Support Personnel		
Administrative and Clinic Support Personnel		
Clinic Administrator		
Reception		
Patient Registration		
Patient Records/Filing		
Liaison with Board (minutes, fiscal reports, board packet)		
Billing Services		
Bookkeeping Services		
Other financial Work		
Other Administrative Work		

HOURS PER AVERAGE WEEK: Please indicate the Total number of hours worked for each applicable position, even if there is more than one person doing the job.

NUMBER OF EMPLOYEES: Please indicate how many individuals are represented by the hours worked. If one person works in more than one position please indicate the % of time they spend doing each job.

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

	Time Open	Time Close	Closed for Lunch between
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

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.

	Time Open	Time Close	Closed for Lunch between
New Year's Day			
Presidents Day			
MLK Day			
Memorial Day			
Independence Day			
Labor Day			
Thanksgiving			
Day after Thanksgiving			
Christmas Eve			
Christmas Day			
Other:			
Other:			
Other:			
Other:			
Other:			
Other:			

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

_____ Dates: _____

_____ Dates: _____

Service Offered - Number of RHCs and Other/Visiting Providers:

Services Offered:	By RHC:	By Other:
General Primary Care	34	2
Diagnostic Lab	26	5
Diagnostic X-Ray	12	1
Diagnostic Tests	23	2
Emergency Med Services	13	0
Urgent Medical Care	25	2
24 Hour Coverage	16	1
Family Planning	26	2
HIV Testing	23	1
Immunizations	33	1
Following Hospitalized Patients	14	0
OB/GYN Care	25	1
Gynecological Care	5	1
Prenatal Care - Maternity Case Mgt	5	1
Ultrasound	4	1
Genetic Counseling & Testing	1	0
Amniocentesis	2	0
Labor & Delivery Professional Care	4	0
Postpartum Care	7	1
Directly Observed TB Therapy	4	0
Other Specialty Care	3	0
Mental Health Treatment	9	1
Developmental Screening	11	0
24 Hour Crisis Intervention	3	0
Substance Abuse Services	3	1
Other Mental Health Services	5	1
Dental Care	1	3
Hearing Screening	11	1
Nutrition Services other than WIC	4	2
Occupational-Vocational Therapy	0	1
Physical Therapy	1	1
Pharmacy	3	1
Vision Screening	13	0
WIC Services	1	2
Case Management	13	0
Child Care	4	0
Eligibility Assistance	11	2
Employment Physicals	30	1
Sports Physicals	32	0
Environmental Health Risk Reduction	5	1
Food Bank	0	1
Health Education	20	2
Housing Assistance	1	1
Interpretation - Translation	8	0
Nursing Home Placement	5	0
Hospice	4	2
Outreach	5	0
Transportation	2	0
Home Visiting	17	1
Parenting Education	8	0
Podiatry	2	3
Chiropractic	0	0
Massage	1	0
Other	0	3

OREGON'S RURAL HEALTH CLINICS
February 2005

Alsea Rural Health Care, Inc.
PO Box 229
Alsea, OR 97324-0229
541-487-7116

Arlington Medical Center
PO Box 176
Arlington, OR 97812-0176
541-454-2888

Baker Clinic
3175 Pocahontas Road
Baker City, OR 97814
541-523-4415

Bay Shore Family Medicine
PO Box 655
Pacific City, OR 97135-0655
503-965-6555

Clatskanie Clinic
PO Box 283
Clatskanie, OR 97016-0283
503-728-4905

Coastal Health Practitioners
3015 NE W. Devils Lake Rd
Lincoln City, OR 97367-5131
541-994-5591

Columbia Hills Family Medicine
1620 East 12th Street
The Dalles, OR 97058
541-29-5411

Curry Family Medical
525 Madrona, PO Box 14
Port Orford, OR 97465
541-332-3861

Dunes Family Health Care
620 Ranch Road
Reedsport, OR 97467
541-271-2163

Eastern Oregon Medical Associates
3325 Pocahantas Road
Baker City, OR 97814
541-523-1001

Elgin Family Health Center
PO Box 896
Elgin, OR 97827
541-347-6321

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

Gifford Medical
1050 W Elm Avenue, #110
Hermiston, OR 97838
541-567-2995

Good Shepherd Medical Group
600 NW 11th
Hermiston, OR 97838-8602
541-567-5305

Grant County Health Department
528 East Main, Suite E
John Day, OR 97845
541-575-0429

Internal Medicine Group 1810
1810 East 19th Street
The Dalles, OR 97058
541-296-2353

Internal Medicine Group 1815
1815 E 19th Street
The Dalles, OR 97058
541-296-5256

Internal Medicine Group 1825
1825 East 19th Street
The Dalles, OR 97058
541-296-1151

Irrigon Medical Center
PO Box 789
Irrigon, OR 97844-0789
541-922-5880

John J. Herscher, D.O.
PO Box 1169
Oakridge, OR 97463
541-782-5800

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

LaPine Community Clinic
50792 Huntington
LaPine, OR 97739
541-536-3435

Lincoln City Medical Center
2870 NE W. Devils Lake Rd
Lincoln City, OR 97367
541-994-9191

Malheur Memorial Health Center
PO Box 1726
Nyssa, OR 97913-0226
541-372-3809

Malheur River Clinic
2671 SW 4th Avenue
Ontario, OR 97914
541-889-1988

Mckenzie River Clinic
PO Box 183
Blue River, OR 97413-0183
541-822-3341

Moro Medical Center
PO Box 186
Moro, OR 97039-0186
541-565-3325

North Bend Medical Center-Bandon
110 E 10th Street
Bandon, OR
541-347-5191

North Bend Medical Center-Gold Beach
94189 Second Street
Gold Beach, OR 97444

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

OHSU Family Medicine at Scappoose
33721 E Columbia Avenue
Scappoose, OR 97056
503-418-4222

OREGON'S RURAL HEALTH CLINICS
February 2005

Peace Health Cottage Grove
1515 Village Ave
Cottage Grove, OR 97424
541-942-6555

Pioneer Memorial Clinic
PO Box 9
Heppner, OR 97836-0009
541-676-5504

Powers Health District
PO Box 40
Powers, OR 97466
541-439-7884

Providence Family Medicine Vernonia
510 Bridge St.
Vernonia, OR 97064-1218
503-429-9191

Providence North Coast Clinic
727 So. Wahanna Rd
Seaside, OR 97138-7735
503-717-7000

Rogue River Health Clinic
PO Box 988
Rogue River, OR 97537
541-582-8899

Samaritan Coastal Clinic
PO Box 31
Lincoln City, OR 97367
541-996-7292

Samaritan Health Services dba Woman Care Center
2930 NE W Devils Lake Rd, Ste 3
Lincoln City, OR 97367
541-994-4440

Shady Cove Clinic
PO Box 428
Shady Cove, OR 97539
541-878-2022

Siskiyou Pediatric Clinic, LLP
700 SW Ramsey, Ste 204
Grants Pass, OR 97527
541-955-5683

The Brookings Clinic
PO Box 6819
Brookings, OR 97415
541-469-5377

The Dalles Family Practice
1730 E 12th Street
The Dalles, OR 97058
541-296-5411

The Lakeside Clinic
PO Box 110
Dexter, OR 97431-0110
541-937-2134

The Rinehart Clinic
PO Box 176
Wheeler, OR 97147-0176
503-368-5182

The Village Clinic
218 Chocktoot Street
Chiloquin, OR 97624
541-783-7900

Tillamook Medical Associates, PC
980 3rd St Ste.200
Tillamook, OR 97141-9469
503-842-5546

Union Family Health Center
PO Box 986
Union, OR 97883-0986
541-562-6062

Wellspring Family Practice
1716 Williams Highway
Grants Pass, OR 97527
541-474-6059

Yachats Community Clinic
PO Box 271
Yachats, OR 97498-0271
541-547-3301