OREGON OFFICE of RURAL HEALTH

Idaho Bureau of Rural Health & Primary Care

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

OPPORTUNITY Just knock.

Understanding the Rural Emergency Hospital Designation

March 15, 2023

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being

OHSU

OREGON OFFICE
ORH
of RURAL HEALTH

Webinar Logistics

- Audio muted and video off for all attendees.
- Select to populate the ··· to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/rural-emergency-hospital-designation-resources.

OHSU

Our Presenters

Harvey Licht is a Senior Associate with the Varela Consulting Group, where he works on health planning, policy and program development. He worked for more than 20 years at the New Mexico Department of Health where he led the Primary Care/Rural Health Office. Prior to working with the State, Mr. Licht was Project Coordinator for Resources for Community Alternatives, an agency providing management support and technical assistance to community programs throughout the Southwest.

George H Pink PhD is Deputy Director of the North Carolina Rural Health Research Center at the Sheps Center for Health Services Research, and Professor in the Department of Health Policy and Management in the Gillings School of Global Public Health, University of North Carolina at Chapel Hill.

Rural Emergency Hospitals: Basics and Other Considerations

Harvey Licht - Varela Consulting Group

March 15, 2023

Session Topics

- **REH 101 – The basic questions answered.**
- **Additional considerations for REH conversion and operation.**
- **REH: What might the future hold?**

REH 101 – The Basics

What is a Rural Emergency Hospital?

- **A Rural Emergency Hospital (REH) is a new Medicare provider category.**
  - **It was enacted in the Consolidated Appropriations Act for 2021, and authorized to begin on January 1, 2023.**
  - **REHs are created from the conversion of two types of currently authorized Medicare providers.**
  - **REHs are permitted to deliver a specific range of services and be reimbursed under Medicare for those services.**

- **Headline: A Rural Hospital's Excruciating Choice: *$3.2 Million a Year or Inpatient Care*?**
  - **"A new federal program offers hefty payments to small hospitals at risk of closing. But it comes with a bewildering requirement."**
  - **https://www.nytimes.com/2022/12/09/health/rural-hospital-closures.html**

Who can become a REH?

- **There are two Medicare provider categories eligible for conversion:**
  - **General acute care hospitals with no more than 50 beds located in a rural area.**
    - **These hospitals can either be in a rural area or have an active rural reclassification.**
    - **Micropolitan and non-core CBSA counties are considered to be rural.**
  - **Critical Access Hospitals (CAHs) that meet statutory and regulatory criteria**
- **Eligible facilities are those hat were open on December 27, 2020. Facilities that closed after December 27, 2020, are eligible to reopen as an REH if they meet the REH Conditions of Participation.**
- **Existing freestanding emergency rooms, licensed by some states, are not eligible to become REHs.**
- **Other categories of providers cannot modify their service mix to become REHs – e.g., community health centers cannot add-on emergency department and other functions to become REHs.**

What role does a State play in REH conversion?

- **All States have an essential role in REH conversions:**
  - **An REH must be located in a state that provides licensing for such a facility.**
  - **An REH must be approved by the state as meeting the standards for this license, and have an active approved license.**
- **Only a few states have enacted appropriate licensing authority. Some states may be able to establish a REH category under *existing* statutory authority. Neither ID or OR have, at yet, finalized the REH category. Note that states may establish supplemental license requirements not in conflict with Federal requirements.**
- **States may need substantial time to operationalize REH licenses. This includes the time necessary to:**
  - **Enact authorizing legislation;**
  - **Establish rules under that authority;**
  - **Attestation by REH to Conditions of Participation may substitute for an initial on-site survey. The State will need to establish a process for review of attestations and submission of recommendations to CMS.**
  - **For applicants not submitting attestations, the state must:**
    - **Develop survey instruments**
    - **Schedule and conduct licensing/certification surveys.**

Can a REH revert to its previous status?

- **State statutory considerations**
  - **States have enacted REH authorizing statutes which allow converting REHs to *place their prior facility licenses in suspension* for fixed or indefinite periods.**
  - **KS, NE and MI have established these provisions.**

    KS: "A licensed general hospital or critical access hospital that applies for and receives licensure as a rural emergency hospital and elects to operate as a rural emergency hospital *shall retain its original license as a general hospital or critical access hospital*. Such original license shall remain *inactive while the rural emergency hospital license is in effect*."
  - **Without these considerations, reverting facilities would likely need to initiate a new application process.**
- **CMS considerations**
  - **It is likely that CMS would treat reversions by REHs as reapplications. Reverting CAHs cannot resume necessary provider status.**
- **Practical considerations**
  - **It may be difficult for older facilities to meet newer licensing requirements.**
  - **Financial sustainability of the previous license category will not be more likely.**

What services must a REH offer?

- **REH core services:**
  - ***24-hour emergency services*. These may include emergency room/observation beds, but the REH cannot have an annual per patient length of stay average exceeding 24 hours.**
  - ***Laboratory services* identified in the Critical Access Hospital Conditions of Participation and consistent with the needs of the patient population.**
  - ***Diagnostic radiologic services*.**
  - ***Pharmacy* or drug storage area.**
  - ***Discharge planning* by, or under the supervision of, a registered nurse, social worker, or other qualified professional.**
- **Emergency transfer arrangements:**
  - **An REH is required to have a *transfer agreement* with at least one Medicare-certified hospital designated as a level I or level II trauma center to ensure that patients can receive any emergency medical care not available at the REH.**
  - **Multiple agreements are allowed, including referral to lower level centers.**

What additional services can a REH provide?

- **Potential services enumerated in guidance:**
  - **Outpatient department services including:**
    - **behavioral health,**
    - **telehealth, and**
    - **outpatient rehabilitation.**
  - **Emergency Medical Services.**
  - **Post-hospital *outpatient* services.**
  - **Distinct part SNF care (no swing beds).**
  - **Off campus provider-based and *Rural Health Clinic* care.**

- **REHs *cannot* provide any inpatient hospital services other than post-hospital services provided in a distinct part, licensed skilled nursing facility.**

- **REHs are not currently a 340 B Program eligible entity.**

Staffing and additional requirements

- **The REH emergency department must be staffed 24 hours per day and seven days per week by an individual competent in the skills needed to address emergency medical care, and this individual must be able to receive patients and activate the appropriate medical resources to meet the care needed by the patient.**
- **REHs must have a clinician on-call at all times and available on-site within 30 or 60 minutes depending on if the facility is located in a frontier area.**
  - **Clinicians may include a doctor of medicine (MD) or doctor of osteopathy (DO), a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or expertise in emergency care**
- **Since REHs will be providing emergency department services, these facilities must comply with the Emergency Medical Treatment and Labor Act (EMTALA).**
- **REHs must develop, implement, and maintain an effective, ongoing, REH-wide, data-driven Quality Assurance and Performance Improvement (QAPI) program, and it must address outcome indicators related to staffing. Must have an account with the Hospital Quality Reporting (HQR) secure portal.**
- **REHs must have an infection prevention and control and antibiotic stewardship program that adhere to nationally recognized guidelines.**

REH reimbursement and funding - 1

- **Medicare Reimbursement:**
  - **Core REH outpatient department services: payment at the Outpatient Prospective Payment System (OPPS) rate plus 5% for all outpatient department services. Patient co-insurance will not reflect the 5% enhancement.**
  - **Other outpatient services: payment at the OPPS rate without enhancement.**
  - **Laboratory Services: payment under the Clinical Laboratory Fee Schedule, as this is not part of the OPPS. No enhancement.**
  - **Distinct part Skilled Nursing Facility (SNF) services: payment under the SNF Prospective Payment System. No enhancement and no cost-basis permitted for CAH swing beds.**
  - **RHC services: paid at RHC all-inclusive rate. The facility-based rate may vary from the pre-conversion rate as the overall facility cost of the REH may be different.**
  - **Ambulance services: payment under the Medicare Ambulance Fee Schedule. No enhancement or cost-basis permitted for some CAH-based services.**

REH reimbursement and funding - 2

- **<u>Additional Facility Payment</u>:**
  - **Initial amounts:**
    - **$272,866 per month**
    - **$3,274,392 per annum**
  - **Will increase in subsequent years by the hospital market basket percentage increase.**
- **Medicaid and commercial reimbursement to be established separately. There is no guaranteed Medicare payment parity for Medicaid or commercial insurance payments.**
- **Medicare OPPS rate is likely lower than CAH cost-dependent rate.**
- **Medicare reimbursements are on a fee-for-service basis – there is no direct mechanism for value-based payment. Medicare revenue is volume dependent.**

Additional Considerations for REH Conversion and Operation.

Is a REH a Hospital?

- **State statutory definitions typically include reference to acute care in excess of 24 hours. This could be interpreted to exclude REHs. Here's typical statutory language:**
  - **"A hospital in Idaho is a facility providing care to two or more individuals for 24 or more consecutive hours, is staffed to provide professional nursing care on a 24 hour basis, and is primarily engaged in providing, by or under the daily supervision of physicians, one or more of the following:**
    - **Concentrated medical and nursing care on a 24-hour basis to inpatients experiencing acute illness;**
    - **Diagnostic and therapeutic services for medical diagnosis and treatment, psychiatric diagnosis and treatment, and care of injured, disabled, or sick persons;**
    - **Rehabilitation services for injured, disabled, or sick persons;**
    - **Obstetrical care."**
  - **Each state licensing agency will need to determine whether any statutory language amendment is needed before REHs can be licensed.**
- **Federal definitions, for example, those used by the IRS, generally defer to states.**
- **This question has implications for REHs, particularly for 501 (c) 3 charitable hospitals.**

What are other considerations in conversion to a REH - 1

- **Organizational/charter considerations**
  - **Should the *purpose statement* of the hospital's articles of incorporation or charter be amended?**
  - **Does a *public ordinance or other establishing authority* need to be amended?**
  - **For hospitals part of a *special tax district*, will *statutory changes* or other authorization be required?**

- **Hospital closure considerations**
  - **Are there state or other requirements associated with the closing of a hospital facility?**
    - **WARN Act (ID, OR);**
    - **Hospital records disposition (ID);**
    - **Public notice (OR);**
    - **Licensure (ID, OR);**
    - **Certificate of Need or Health Authority review (OR).**

What are other considerations in conversion to a REH - 2

- **Capital funding conditions**
  - **Did capital funding for a hospital facility *limit its use for hospital purposes*?**
  - **This could include public funding through *direct appropriations*, *revenue bonds*, or other mechanisms.**

- **IRS requirements for 501 (c) 3 hospitals**
  - **IRS approval for *revised mission and scope of activities*.**
  - **Changed reporting requirements – *Schedule H*.**
  - **Changed *community needs assessment and health plan requirements*.**
  - **Changed *community benefit requirements*.**
  - ***Protection of organizational assets* dedicated to charitable purposes. This is particularly important if hospitals assets will be disposed.**

What are other considerations for the operation of a REH

- **Operational funding conditions**
  - **Are hospital-dedicated property tax levies, sales tax provisions or other dedicated revenue sources limited to inpatient hospital operations?**
- **Community benefit / charity care obligations**
  - **Are there community benefit or charity care obligations that will carry over from the hospital to the REH?**
- **Hospital reporting**
  - **Are there any State or other hospital reporting requirements that will carry over from the hospital to the REH?**

Community Governance, Guidance and Integration

- **Before conversion**
  - **What *community education, engagement and consultation* should be conducted before a conversion decision?**
  - **Who has *final say* in the conversion decision?**
- **During conversion**
  - **How will the *community be consulted in the planning of services* should be provided under the new REH?**
  - **How will the REH integrate with other *community health care services*?**
  - **How will the REH integrate with *regional health care services*.**
- **After conversion**
  - **How will *community needs be assessed* on an ongoing basis?**
  - **Should the *governing board* have a *changed composition and structure*?**

REH: What might the future hold?

Why was the REH model created?

- **<u>What the REH model does</u>:**
  - **The REH model was developed as a means of *reducing perceived excessive health care costs* in rural areas.**
  - **The aim of the model is to *eliminate costly surplus inpatient capacity* in these areas.**
  - **It was also designed to respond to the closures of rural hospitals by providing funding to support an operational base for rural health services.**

- **<u>What the REH model doesn't do</u>:**
  - **The REH model does not establish a model designed as a *comprehensive system of rural health services* designed to meet core needs of rural communities.**
  - **It is unlikely that the funding and revenue of an REH could support all the comprehensive services needed in a rural community.**
  - **The REH model is *primarily a downsizing of existing facilities*, and cannot be deployed in rural communities without such facilities, even though these communities have significant needs.**

How might the REH model change in subsequent years?

- **Changes in reimbursement rates and mechanisms.**
- **Extension of the average length of stay in emergency/observation beds.**
- **Extension of the model to include short term inpatient beds.**
- **Expansion of the model to include swing beds.**
- **Addition of funding support for capital improvements including telehealth.**
- **Expanding the model with additional support targeted to maternal/infant health and behavioral health.**
- **Permit eligible hospitals closed *prior* to enactment of the authorization to be established as REHs.**

REH References and Resources - 1

- **REH Final Rules and Payment Guidance**
  - https://www.federalregister.gov/documents/2022/11/23/2022-23918/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment#footnote-355-p72256
  - https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1772-fc
  - https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-1
- **REH Conditions of Participation**
  - https://www.federalregister.gov/documents/2023/01/04/2022-28517/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
- **REH Guidance for State Survey Agencies**
  - https://www.cms.gov/files/document/qso-23-07-reh.pdf
- **REH Factsheets**
  - https://www.ruralhealthinfo.org/topics/rural-emergency-hospitals#eligible-facilities
  - **https://www.rhrco.org/_files/ugd/861f85_cf3f30a546884479aed1f5b03f9fd7c2.pdf**

REH References and Resources - 2

- **Idaho State definition of hospital**
  - https://healthandwelfare.idaho.gov/providers/acute-and-continuing-care/hospitals

- **IRS - Definition of hospital and 501 (c) 3 charitable hospital requirements**
  - https://www.irs.gov/charities-non-profits/hospital-definition-under-irc-sections-509a1-and-170b1aiii-versus-irc-section-501r
  - IRS Charitable hospital requirements
  - https://www.irs.gov/charities-non-profits/charitable-hospitals-general-requirements-for-tax-exemption-under-section-501c3
  - CHNA requirements
  - https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

- **IRS Schedule H**
  - Form
    - https://www.irs.gov/pub/irs-pdf/f990sh.pdf
  - Instructions
    - https://www.irs.gov/pub/irs-pdf/i990sh.pdf

REH References and Resources - 3

- **State REH action monitor**
  - https://www.ncsl.org/health/rural-emergency-hospitals
- **NACRHHS REH recommendations**
  - https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2021-rural-emergency-hospital-policy-brief.pdf
- **BPC - Next Steps for the Rural Emergency Hospital Mode**
  - https://bipartisanpolicy.org/blog/next-steps-rural-emergency-hospital-model/
- **PYA – Thoughts on REH model modification**
  - https://www.pyapc.com/insights/rural-emergency-hospital-program-some-thoughts-while-waiting-for-implementing-regulations/
- **REH technical assistance resources**
  - https://www.rhrco.org/reh-tac
  - https://www.rhrco.org/rehresources

NC RHRP

NC Rural Health Research Program

Recent Research into the new Rural Emergency Hospital

George H Pink PhD

Understanding the Rural Emergency Hospital Designation

March 15, 2023

This presentation uses funded by Federal Office of Rural Health Policy, Award #U1GRH03714

Disclosure

Most of the research I will present is supported by the Health Services and Resources Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the presenter and do not necessarily represent the official views, nor endorsement by, HRSA, HHS, or the U.S. Government.

NC RHRP
NC Rural Health Research Program

Agenda

1. The need for an alternative model is growing
2. There are many factors to consider in deciding whether to convert to a REH
3. Hospitals with low volume EDs may be more likely to convert to REH
4. The REH model may appeal to a wide range of rural hospitals
5. The REH model has risk

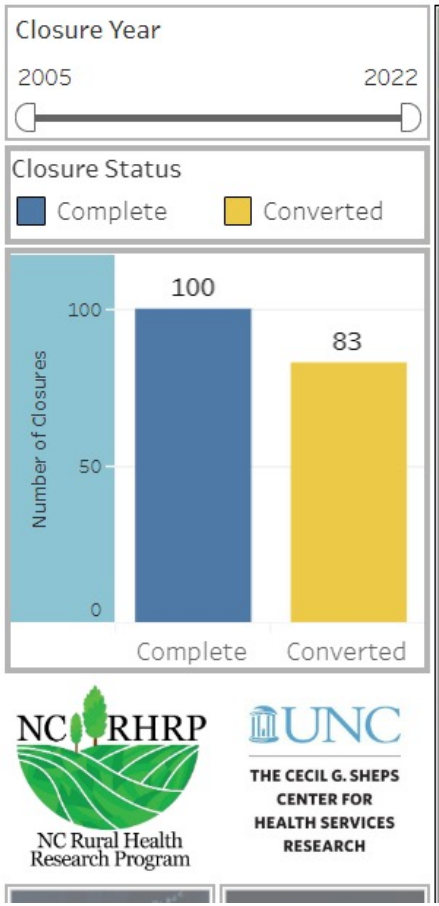
The need for an alternative model is growing

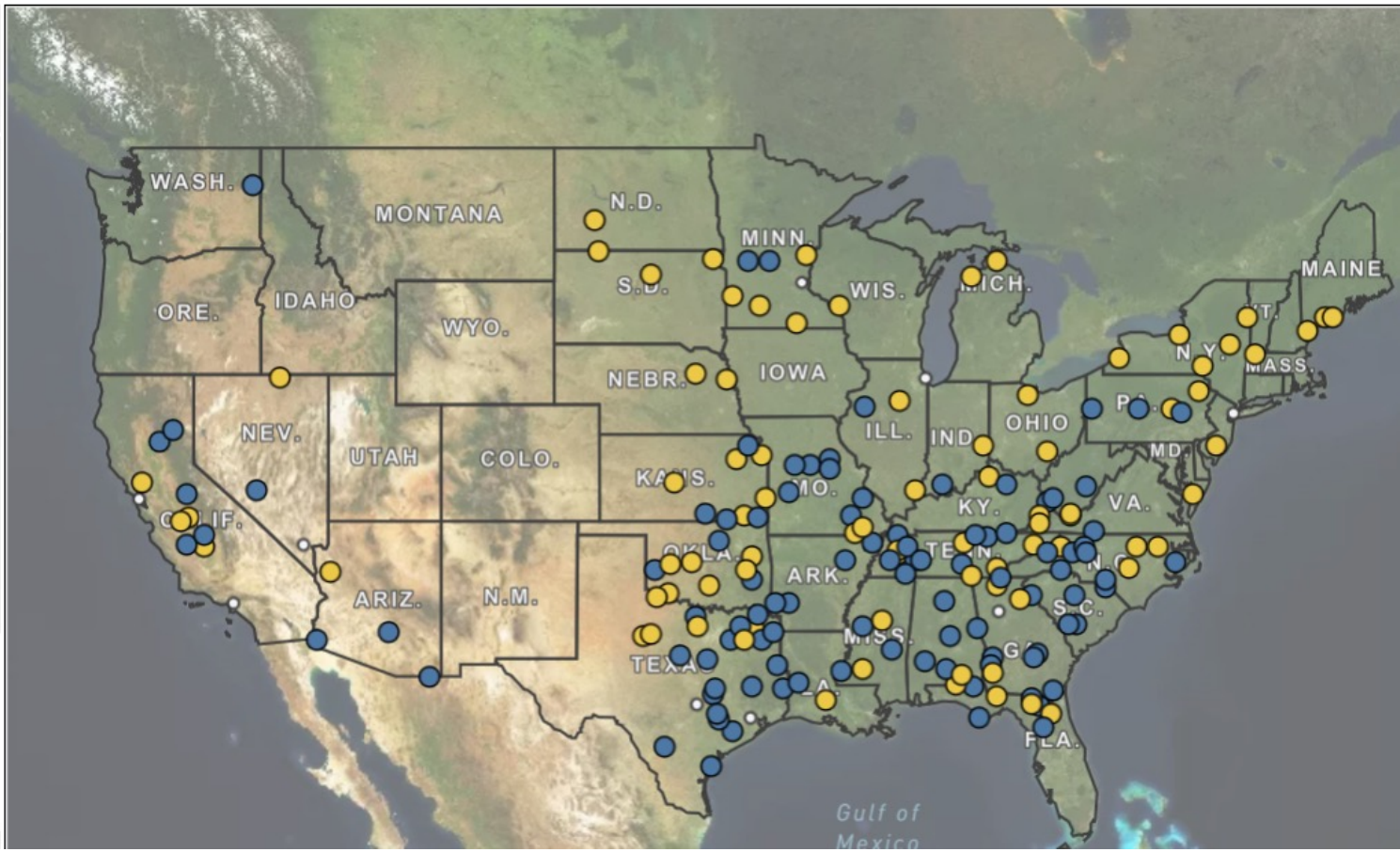
NC RHRP
NC Rural Health Research Program

Rural hospital closures fell during COVID but they are beginning to resume

NC RHRP
NC Rural Health Research Program

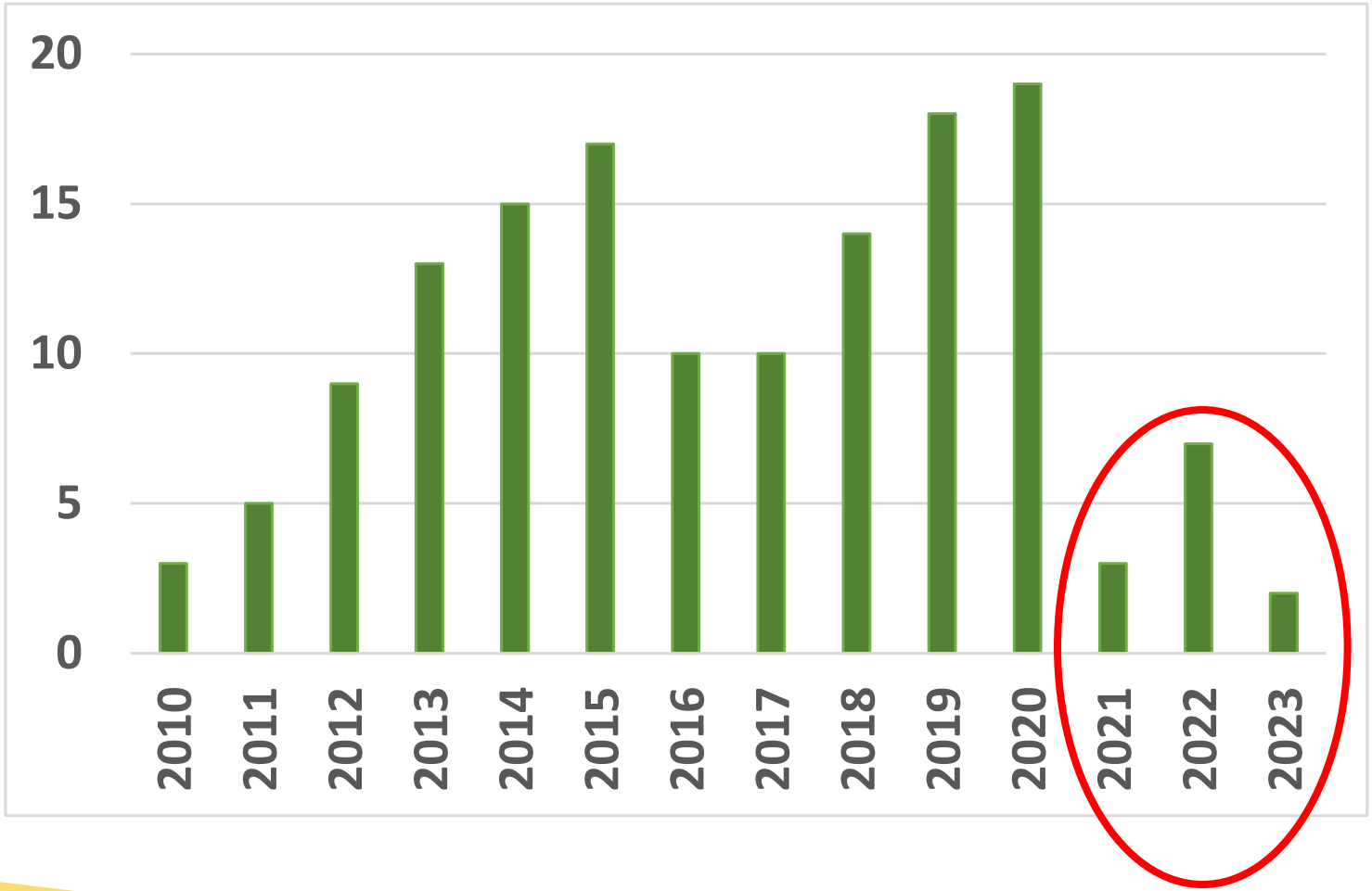
188 Rural Hospital Closures since January 2005





NC RHRP
NC Rural Health Research Program

145 Rural Hospital Closures since January 2010



Our problems are over, right?

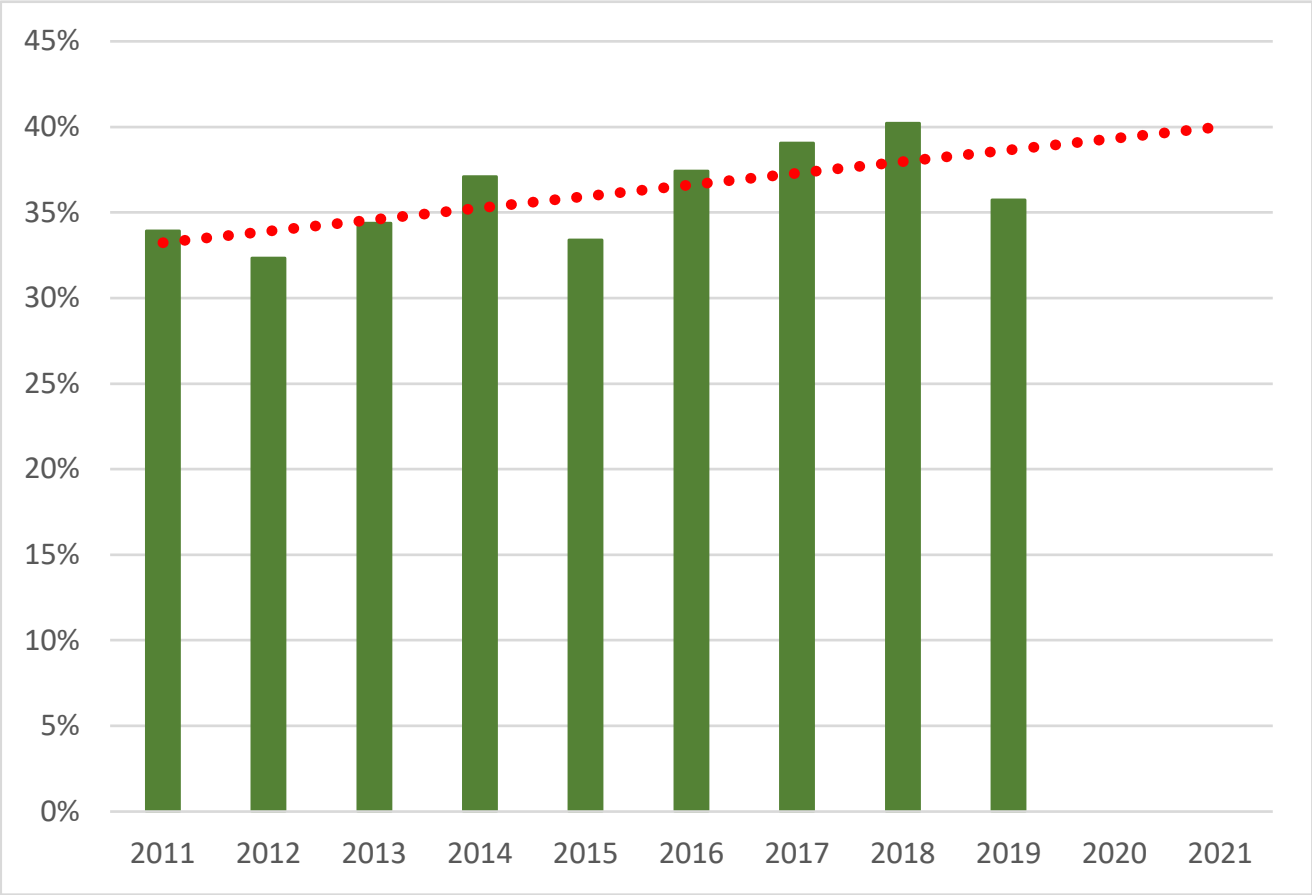
NC RHRP
NC Rural Health Research Program

Long-term unprofitability has not gone away

Rural Hospital Profitability during the Global COVID-19 Pandemic Requires Careful Interpretation

George Pink, PhD; Susie Gurzenda, MS; Mark Holmes, PhD

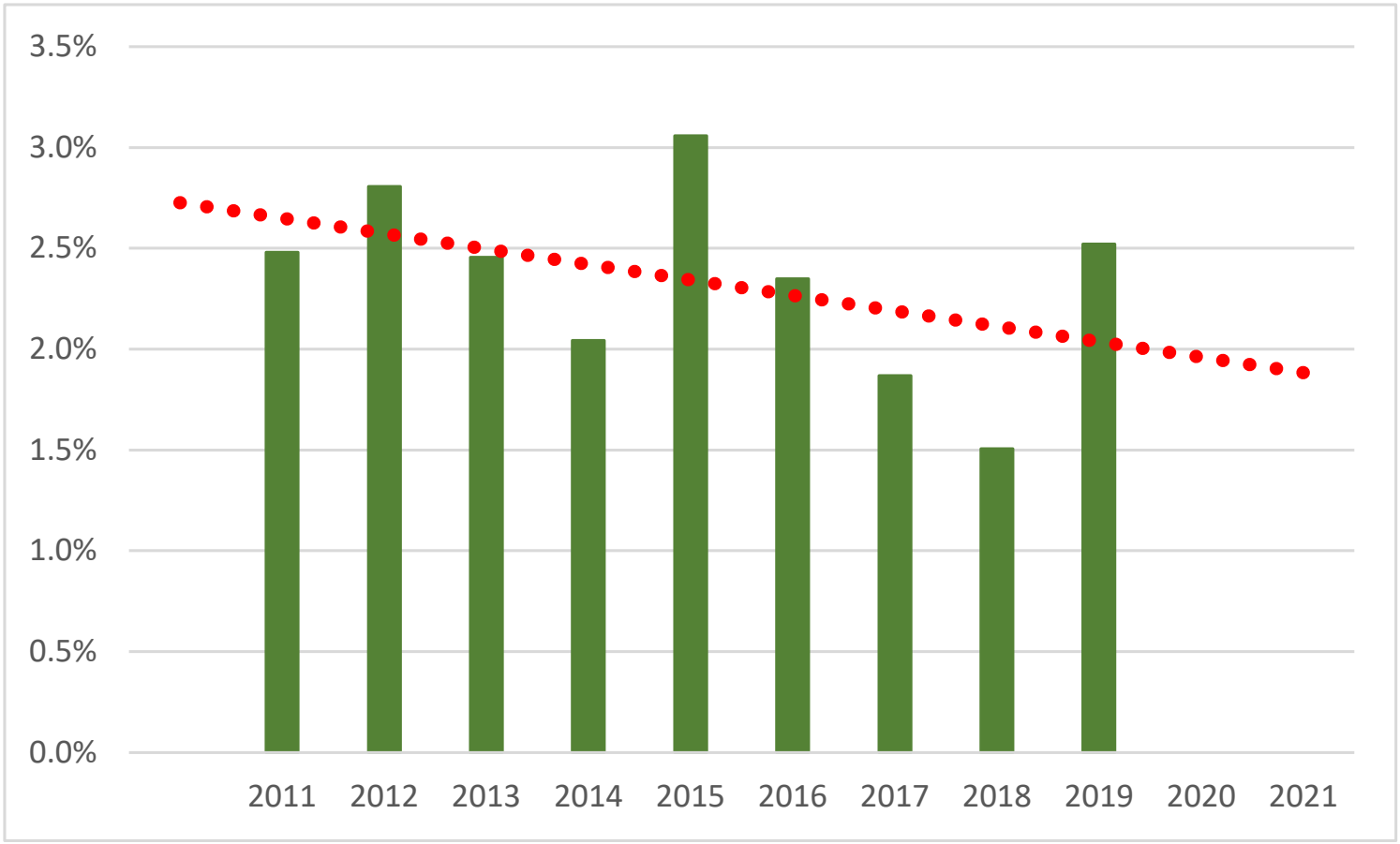
The percentage of rural hospitals with a negative total margin was trending upward before COVID funding



PRF and other COVID funding probably provided a lifeline for many rural hospitals

NC RHRP
NC Rural Health Research Program

The median total margin of rural hospitals was trending downward before COVID funding

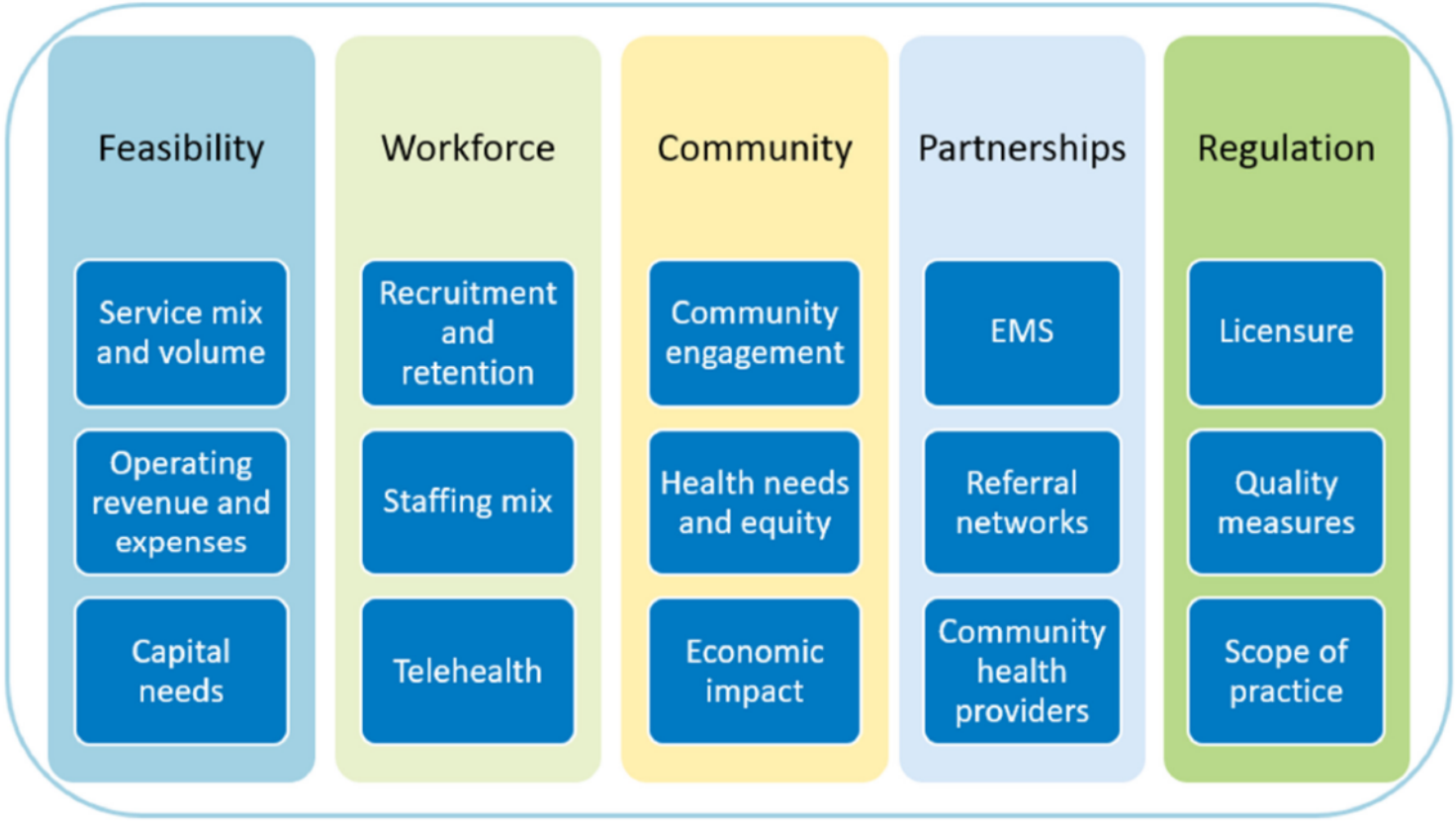


Long-term unprofit-ability has not gone away

NC RHRP
NC Rural Health Research Program

There are many factors to consider in deciding whether to convert to a REH

Figure 1. Conceptual Framework of Key Considerations for Conversion to an REH



Findings Brief
NC Rural Health Research Program
October 2022

Key Considerations for a Rural Hospital Assessing Conversion to Rural Emergency Hospital

Kristin Reiter, PhD; TJ Grant, MHA; Susie Gurzenda, MS; Angelina Budko, MBA; Margaret Greenwood-Ericksen, MD, MSc; George Pink, PhD

Hospitals with low volume EDs may be more likely to convert to REH

- Have lower acute inpatient volume
- Have lower outpatient volume
- Are more likely to own and operate their own ambulance service, more likely to have a Rural Health Clinic or a skilled nursing facility, but less likely to be affiliated with an air ambulance company.
- Have similar access to computed tomography (CT) scanner services but are less likely to provide MRI services.
- Have fewer overall physicians with hospital privileges, but a similar number of Advanced Practice Providers (APPs).

NC RHRP
Findings Brief
NC Rural Health Research Program
October 2022

Small Rural Hospitals with Low-Volume Emergency Departments that May Convert to a Rural Emergency Hospital (REH)

Margaret Greenwood-Ericksen, MD, MSc; TJ Grant, MHA; Susie Gurzenda, MS; Tyler Malone, MS; Angelina Budko, MBA; Kristin Reiter, PhD; George Pink, PhD

The REH model may appeal to a wide range of rural hospitals

- There are large differences among selected financial and operational measures for three rural hospitals that are on the record as having expressed interest in REH conversion.
- REH conversion may attract a wider range of hospitals than we estimated in our 2021 study.
- Factors that might ultimately determine how many rural hospitals convert to REHs include the risk of financial distress and closure, the business case, community support, and consolidation.

The REH model has risk

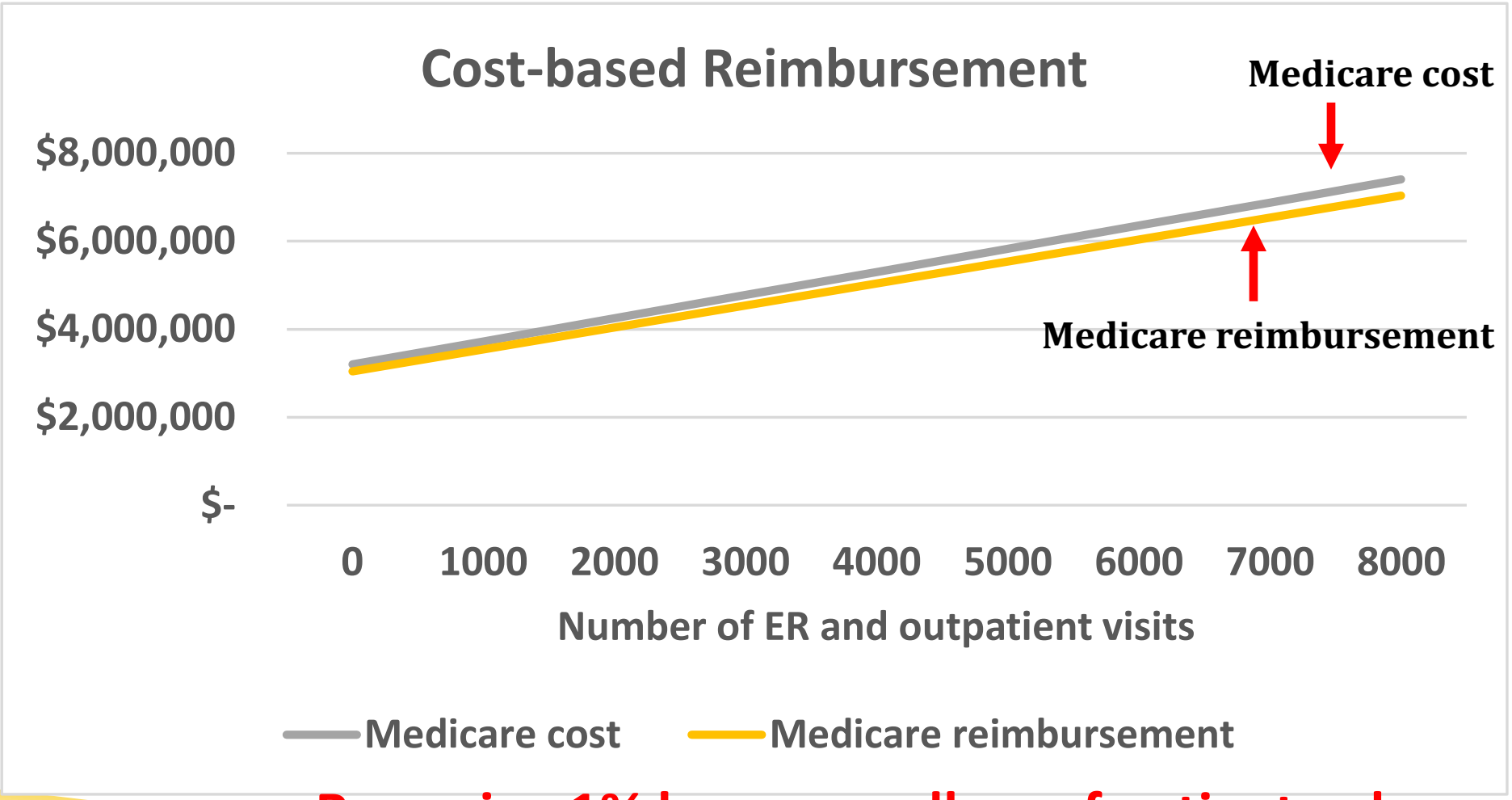
What is risk?

- Business risk – the riskiness of a business' assets, assuming they are all equity-financed:
  - Volume variability
  - Sales price variability
  - Input price variability
- Financial risk – additional risk of debt financing. Debt is fixed by contract and independent of variations in organization's revenues and expenses

What are some sources of business and financial risks of the Rural Emergency Hospital?

NC RHRP
NC Rural Health Research Program

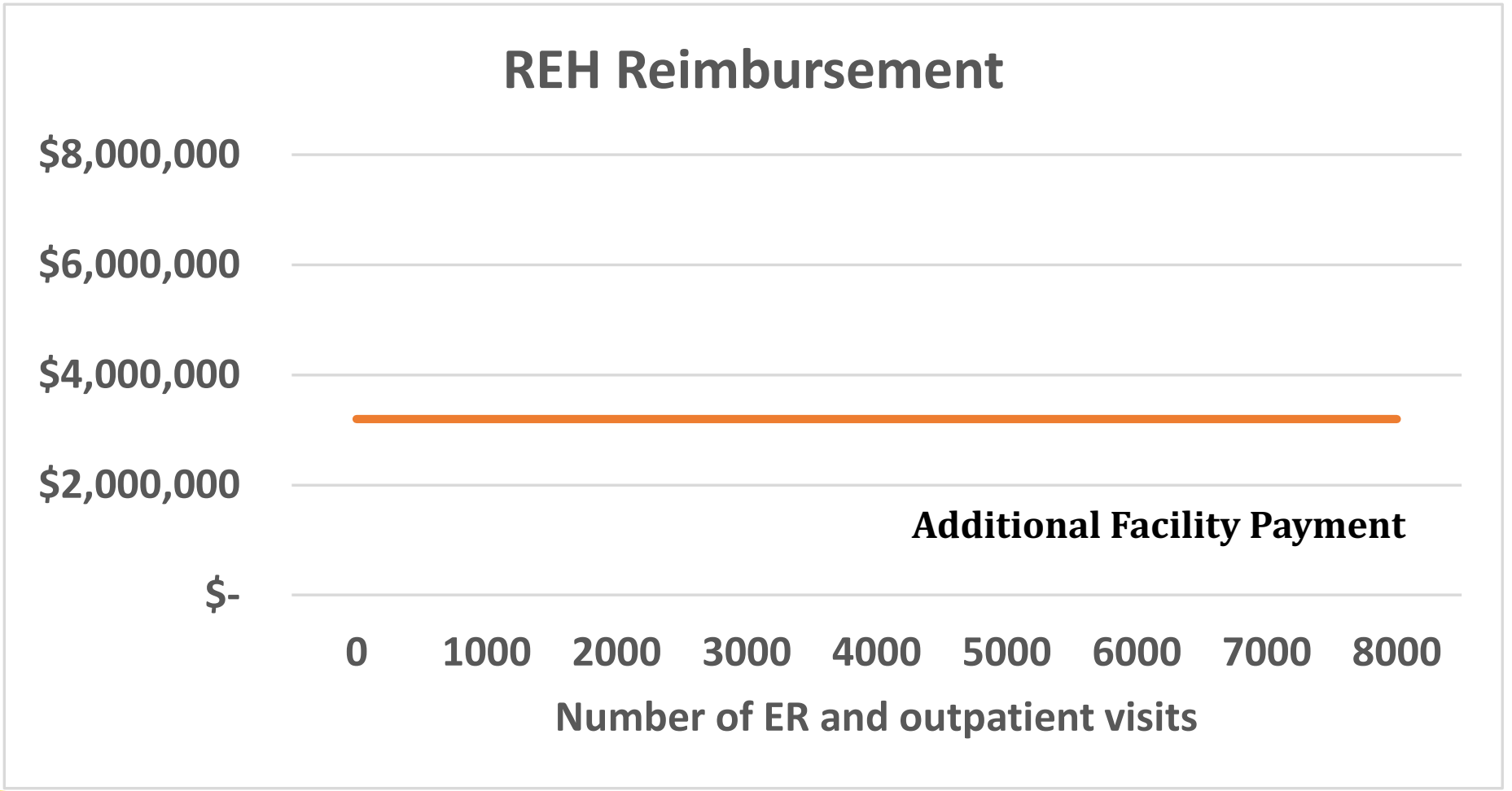
1. Transition from CAH cost-based to REH reimbursement



Recurring 1% loss, regardless of patient volume

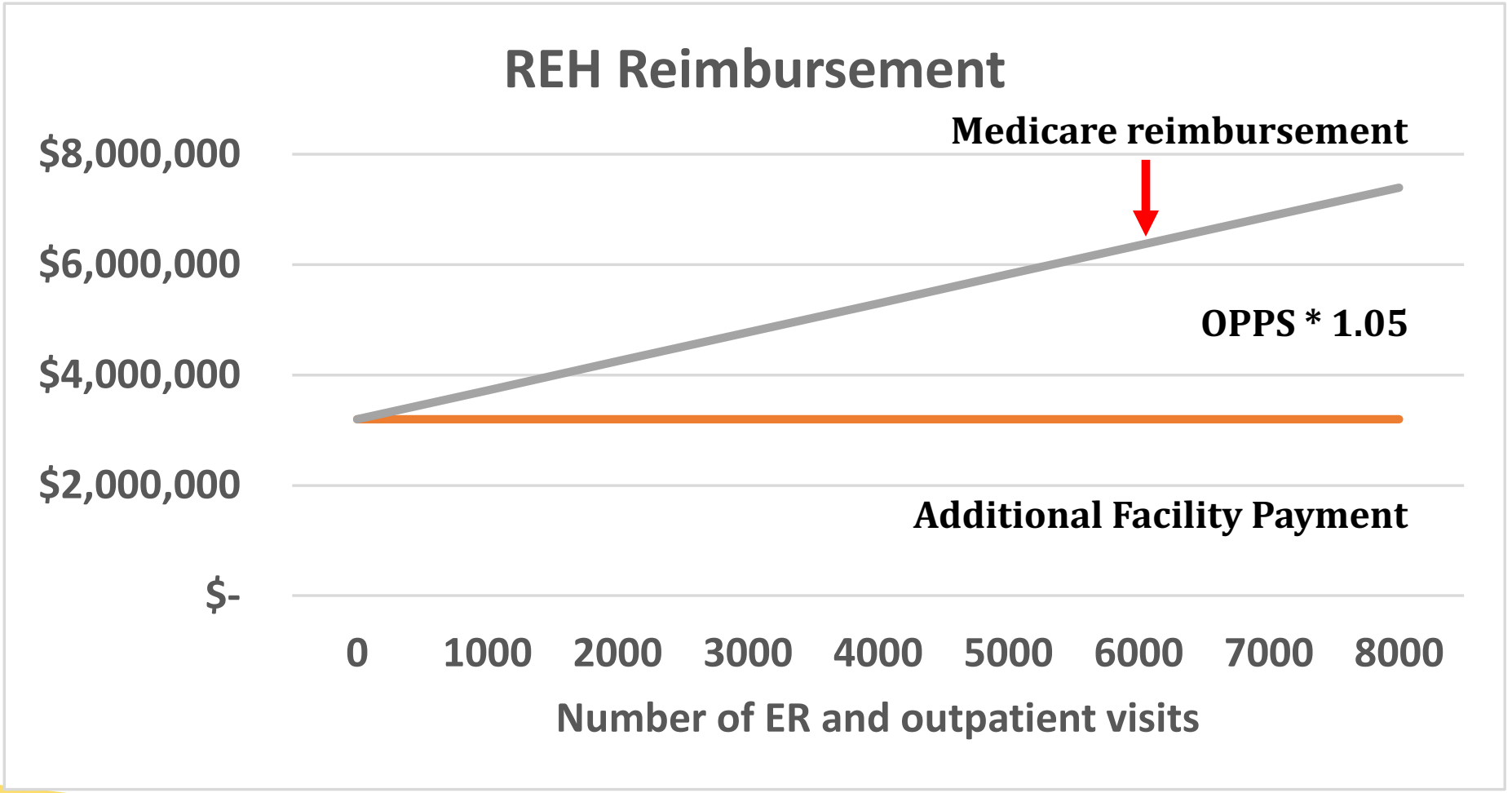
NC RHRP
NC Rural Health Research Program

1. Transition from CAH cost-based to REH reimbursement



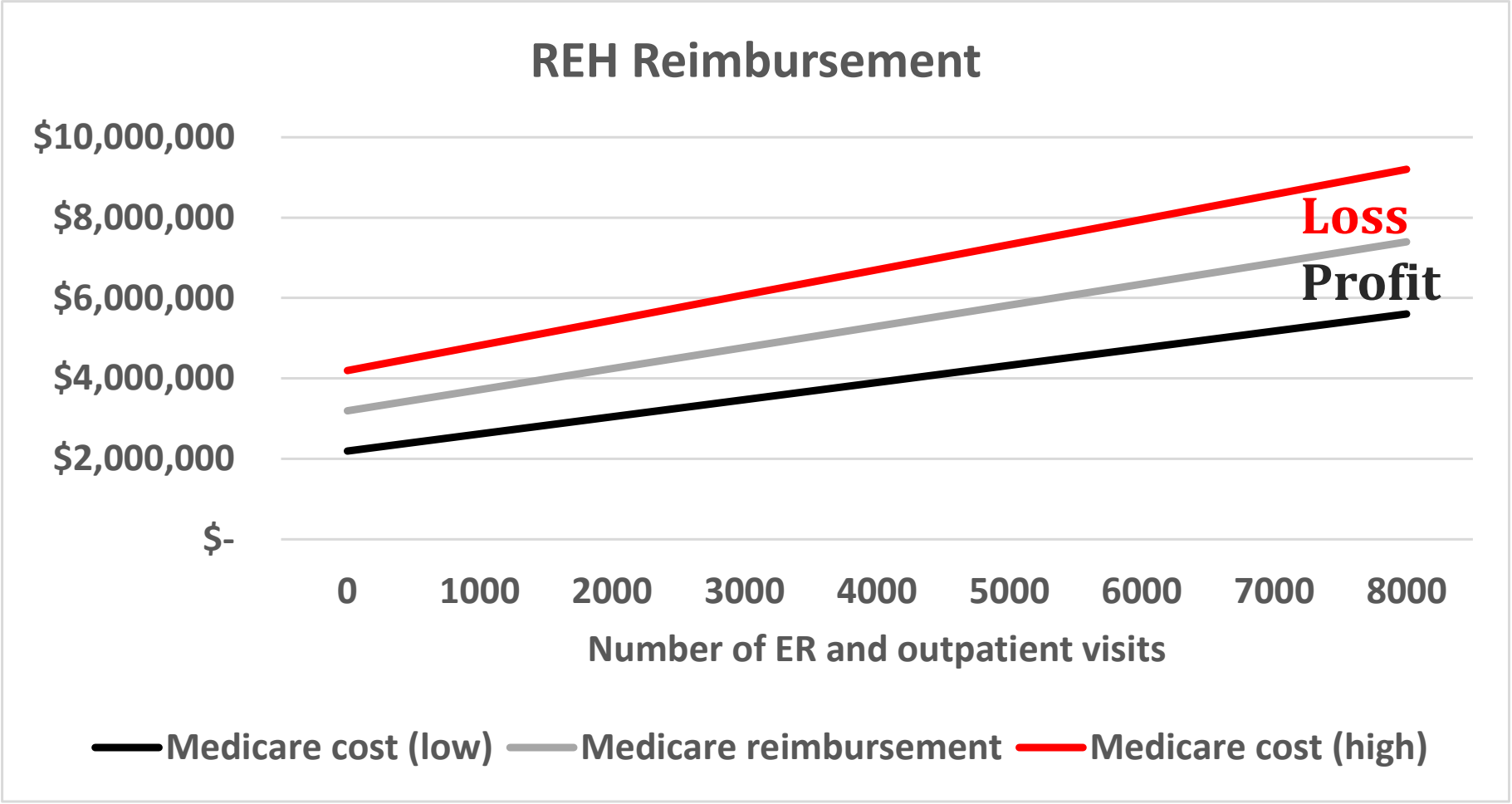
NC RHRP
NC Rural Health Research Program

1. Transition from CAH cost-based to REH reimbursement



NC RHRP
NC Rural Health Research Program

1. Transition from CAH cost-based to REH reimbursement



Profits or losses, depending on volume and cost

NC RHRP
NC Rural Health Research Program

2. Transition from CAH swing beds to SNF DPU

- REHs can elect to have a Skilled Nursing Distinct Part Unit (DPU)
- Our study estimated a typical actual allowed amount per day of $1,676 for CAH swing bed care and a simulated range of standardized allowed amounts of $358 to $609 per day using the CMS SNF standardization method (2016 data).

3. Loss of 340B revenue

- A survey of hospitals participating in 340B found that the median 340B benefit for Critical Access Hospitals was $564,000
- 76 percent of Critical Access Hospitals reported that they rely on 340B savings to keep their doors open.

340BHEALTH

2019 340B Health Annual Survey:
340B Hospitals Use Benefits to Provide Services and Improve Outcomes for Low-income and Rural Patients

https://www.340bhealth.org/files/340B_Health_Survey_Report_2020_FINAL.pdf

4. Increase in ED and outpatient bypass

- Rural Medicare FFS beneficiaries who left their community for inpatient care were more likely to bypass their home hospital for outpatient services
- Rural Medicare beneficiaries whose home hospital was a CAH were more likely to bypass their home hospital for outpatient services
- ED bypass was highest for patients who were transported by ambulance

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF MINORITY HEALTH

Examining Rural Hospital Bypass for Outpatient Services

https://www.cms.gov/files/document/examining-rural-hospital-bypass-outpatient-services.pdf

5. New debt for building and equipment

- Keokuk Area Hospital (KAH) in IA has estimated cost of building an REH in a new location (in lieu of reopening KAH) would be around $30 million, including equipment and space for five to ten observation beds, a lab, and an x-ray machine
- New or renovated building and equipment may require new debt
- Debt payments are a fixed charge

https://www.mississippivalleypublishing.com/daily_gate/who-and-where-the-rural-emergency-hospital-dilemma/article_aa09fb00-c55f-564a-a673-be0b364d27e2.html

6. Other potential REH business risks

- Reimbursement methods and amount used by Medicaid and other payers for REH patients
- Recruitment and retention costs of REH providers and hospital staff
- Patient transfer cost
- Cannot revert to CAH based on necessary provider – must reapply using current eligibility criteria

NC RHRP
NC Rural Health Research Program

Risk and the Rural Emergency Hospital

CAH Cost-based reimbursement for ER and outpatients	→ REH Semi-variable reimbursement for ER and outpatients	
Cost-based reimbursement for post-acute swing patients	→ SNF-PPS reimbursement for post-acute patients	Business risk
Current 340B revenue	→ Loss of 340B revenue	
Current level of ED and outpatient bypass	→ Increase in ED and outpatient bypass	
Existing debt	→ New debt for building and equipment	Financial risk

North Carolina Rural Health Research Program

Location:

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill
Website: http://www.shepscenter.unc.edu/programs-projects/rural-health/
Email: ncrural@unc.edu

Colleagues:

Mark Holmes, PhD
Ann Howard
George Pink, PhD
Kristie Thompson, MA
Kristin Reiter, PhD
Julie Perry
Susie Gurzenda, MPH
Tyler Malone, MSc

NC RHRP
NC Rural Health Research Program

Resources

North Carolina Rural Health Research Program
http://www.shepscenter.unc.edu/programs-projects/rural-health/

Rural Health Research Gateway
www.ruralhealthresearch.org

Rural Health Information Hub (RHIhub)
https://www.ruralhealthinfo.org/

National Rural Health Association
www.ruralhealthweb.org

National Organization of State Offices of Rural Health
www.nosorh.org

NC RHRP
NC Rural Health Research Program

Rural Health Research Gateway

Rural Health Research Gateway

The Rural Health Research Alert email provides periodic updates when new publications become available. Alerts are available by email and posted on our Facebook and Twitter accounts.

Recent Updates

- **May 22, 2020**
  County-Level 14-Day COVID-19 Case Trajectories
  New Research Product
- **May 18, 2020**
  Estimated Reduction in CAH Profitability from Loss of Cost-Based Reimbursement for Swing Beds
  New Research Product
- **May 14, 2020**
  Rural-Urban Residence and Mortality Among Three Cohorts of U.S. Adults
  New Research Product
- **May 13, 2020**
  Most Rural Hospitals Have Little Cash Going into COVID
  New Research Product
- **May 12, 2020**
  Characteristics of Counties with the Highest Proportion of the Oldest Old
  New Research Product

ruralhealthresearch.org/alerts

Connect with us

info@ruralhealthresearch.org

facebook.com/RHRGateway

twitter.com/rhrgateway

For more than 30 years, the Rural Health Research Centers have been conducting policy-relevant research on healthcare in rural areas and *providing a voice for rural communities in the policy process.*

Rural Health Research Gateway

The Rural Health Research Gateway ensures this research lands in the hands of our rural leaders.

ruralhealthresearch.org

Connect with us

info@ruralhealthresearch.org
facebook.com/RHRGateway
twitter.com/rhrgateway

Funded by the Federal Office of Rural Health Policy, Health Resources & Services Administration.

ORH Announcements

- **2023 Forum on Aging in Rural Oregon**: May 15-17 in Seaside, Ore.
  Registration opened February 14

- **Save the date: 2023 Oregon CAH Quality Workshop:** May 16-17, 2023 in Seaside, Ore.
  Registration will open in March
  Questions? Contact Stacie Rothwell at rothwels@ohsu.edu .

- **2022 Oregon Areas of Unmet Health Care Need Report** has been released on the ORH website.

- **PIEC 101: Transitioning to a Performance Improvement Executive Committee**
  March 30, 2023 (register here)
  Most health care organizations maintain a siloed management and monitoring structure that isolates finance, quality, and staff. This presentation explores the concept of a performance improvement executive committee and identifies a specific organizational model to remove silos, promote and express interdependencies, foster accountability and increase alignment between financial and clinical staff.

OREGON OFFICE of RURAL HEALTH

OREGON OFFICE of RURAL HEALTH

Idaho Bureau of Rural Health & Primary Care

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

OPPORTUNITY Just knock.

Thank you!

Sarah Andersen
Director of Field Services
ansarah@ohsu.edu

Stacie Rothwell
Program Manager
rothwels@ohsu.edu

Stephanie Sayegh
Health Program Manager (Idaho Flex and SHIP Coordinator)
stephanie.sayegh@dhw.idaho.gov