ORH/ORPRN
Listening Session Report
2024

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OREGON OFFICE of RURAL HEALTH

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Oregon Rural Practice-based Research Network
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CONTEXT

Building on years of collaboration, the Oregon Office of Rural Health (ORH) and the Oregon Rural Practice-based Research Network (ORPRN) began planning in late 2023 to conduct listening sessions with rural and remote health facilities, public health, coordinated care organizations (CCOs) and community-based organizations (CBOs) to discuss and brainstorm solutions related to what each organization perceived as the most significant challenges to providing and receiving health care in rural Oregon. Session agendas were co-developed with input from facilities, agencies and organizations and tailored to each region's priorities.

This report presents an overview of the common issues heard during the 2024 Listening Sessions. Report findings will be used to develop and inform programming and policy solutions to address rural Oregon health care challenges.

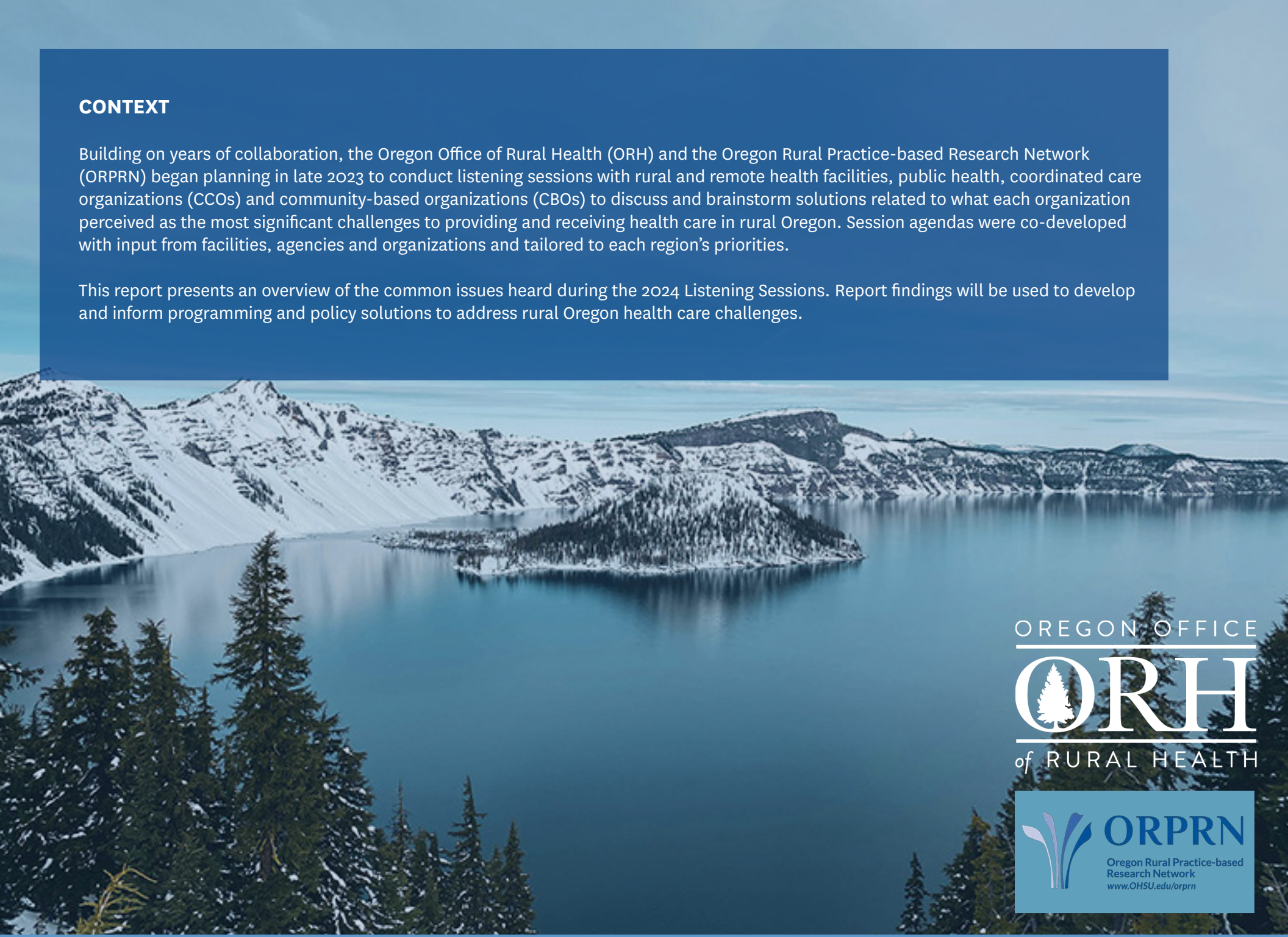
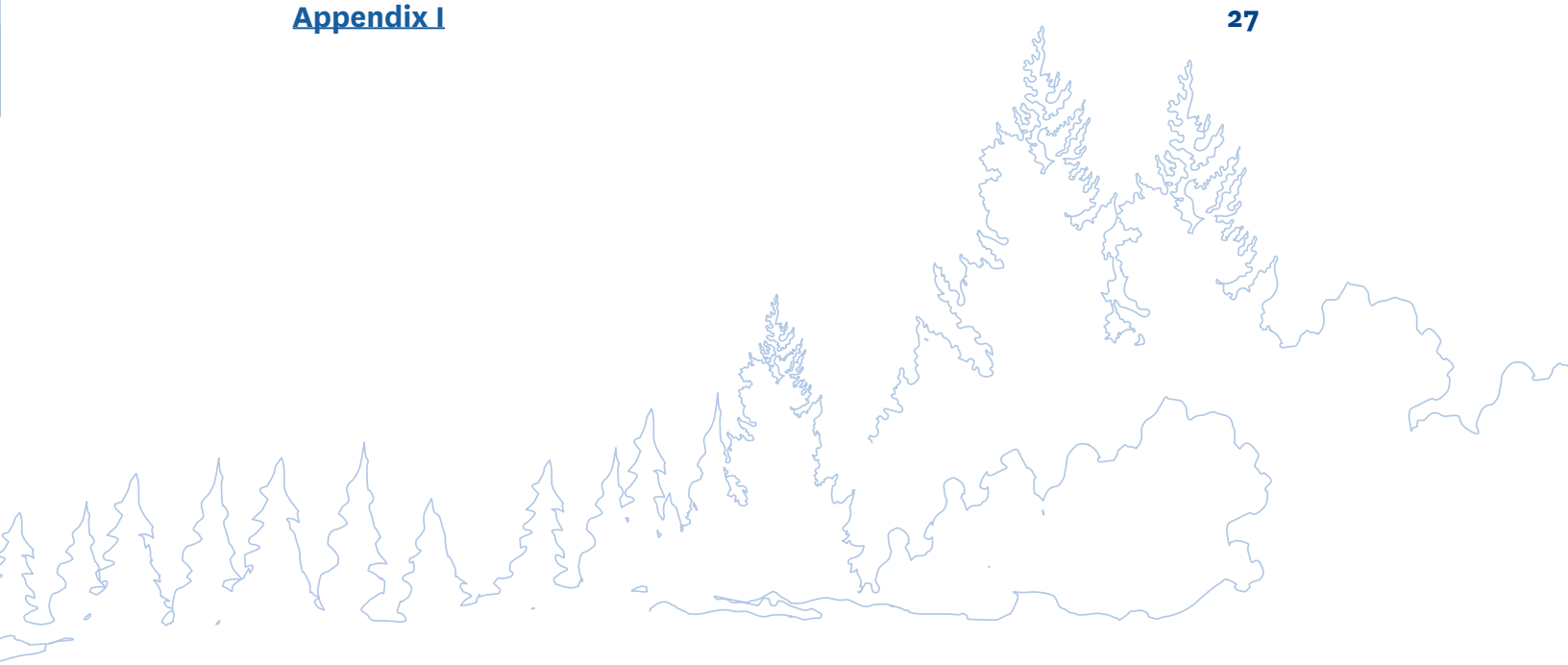


TABLE OF CONTENTS



THANK YOU PARTICIPANTS

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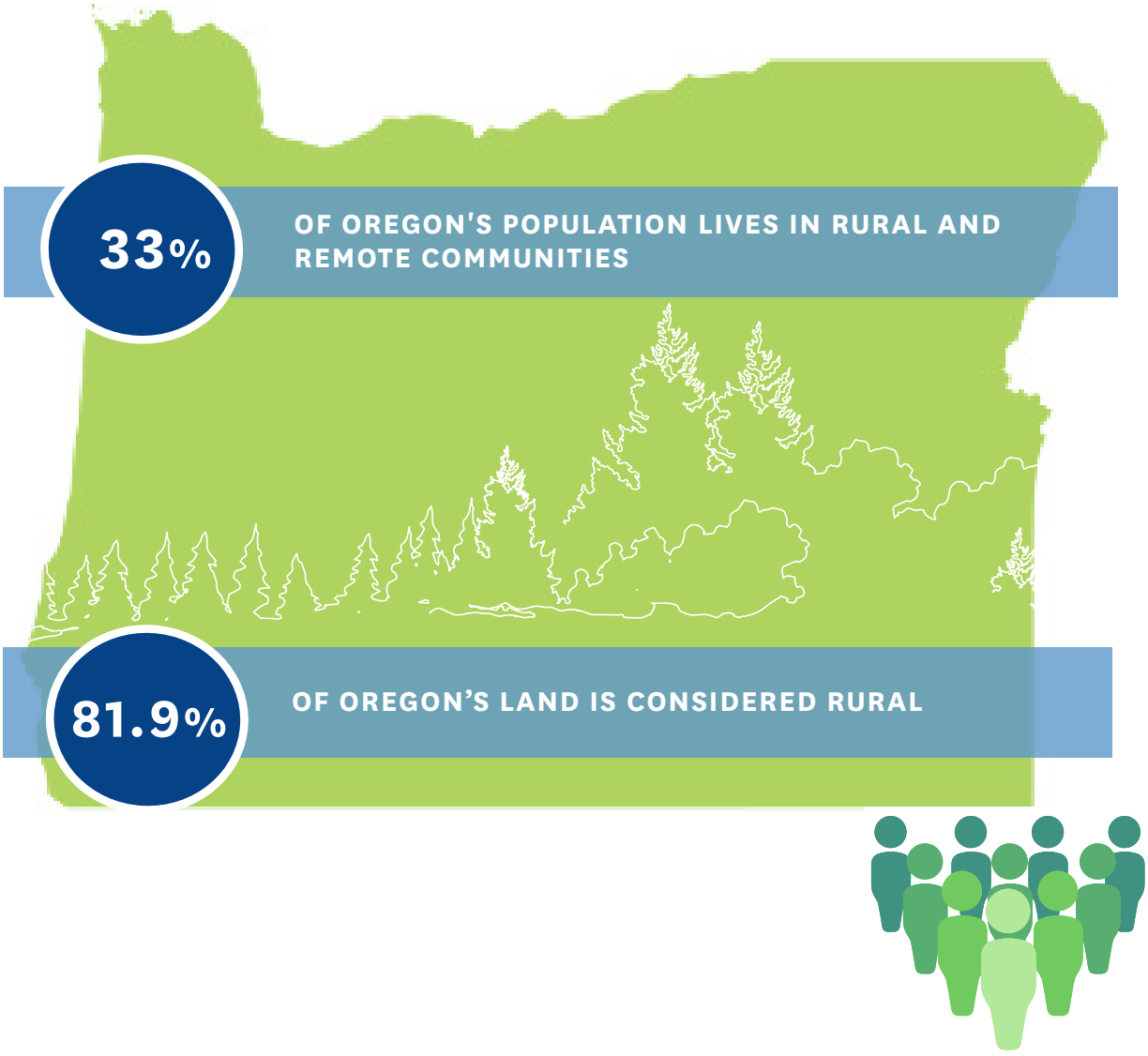
Thank you to our participating facilities, agencies and organizations:

Adventist Health Columbia Gorge
Adventist Health Columbia Gorge Family Medicine
Baker County
Baker County Health Department
Bay Area Hospital
Blue Mountain Hospital
Boost Oregon
Cascades East Area Health Education Center
Clatsop Behavioral Health
Clatsop County Public Health
Coast Community Health Center
Columbia Memorial Hospital
Columbia Pacific Coordinated Care Organization
Consejo Hispano
Coos Health Initiatives
Coquille Valley Hospital
Eastern Oregon Coordinated Care Organization
Greater Oregon Behavioral Health Initiative
Hood River County Health Department
Jefferson County Public Health
Lake Health District
Lower Umpqua Hospital
Morrow County Public Health
Mosaic Medical Center
North Bend Medical Center
North Central Public Health District
Northeast Oregon Area Health Education Center
OCHIN
OHSU Knight Cancer Institute
One Community Health
Oregon AHEC Program Office
Oregon Coalition of Local Health Officials
Oregon Pacific Area Health Education Center
PacificSource Community Solutions
PacificSource Health Plans
Pine Eagle Clinic/Halfway Oxbow Ambulance
Providence Hood River
Providence Seaside Hospital
Saint Alphonsus Medical Group - Baker City
Sherman County Medical Clinic
Southern Coos Hospital
Southwest Oregon Workforce Investment Board
St. Anthony Hospital
St. Charles Family Care Clinic- Madras
St. Charles Health System
St. Charles Madras
St. Charles Prineville
St. Luke's Eastern Oregon Medical Associates
Umatilla County Health
Valley Family Health Care

INTRODUCTION

Thirty-three percent of Oregon's population lives in rural and remote communities, using the Oregon Office of Rural Health (ORH) definition. ORH defines rural as any geographic area in Oregon 10 or more miles from the centroid of a population center of 40,000 people or more. Remote counties are defined as those with six or fewer people per square mile[1]. ORH has identified 10 of Oregon's 36 counties as remote, see Map 1. For more information on definitions of rural and remote, visit ORH's website.

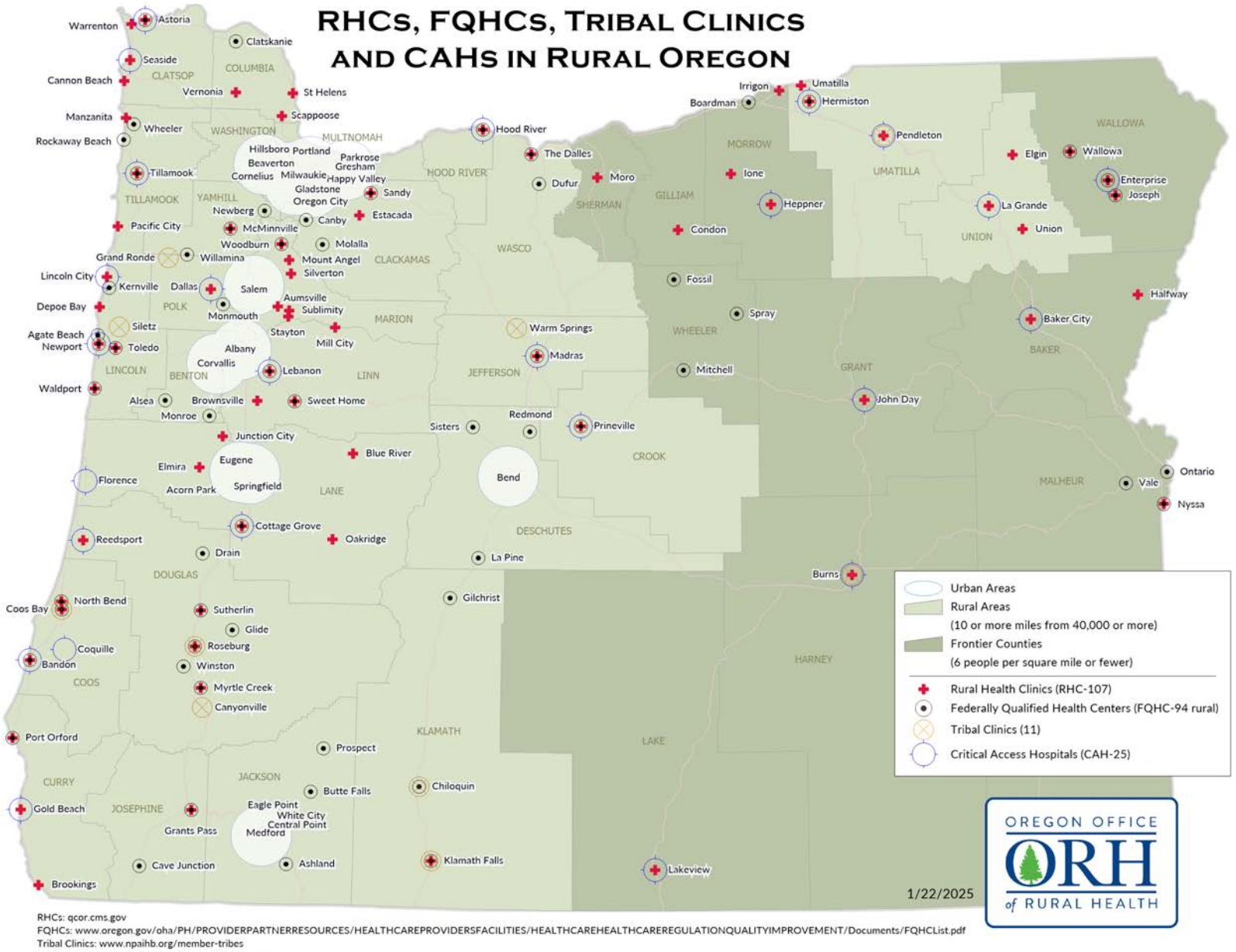
See Appendix I for a list of acronyms used throughout this report.



[1] While the Federal government continues to use the word "frontier" to define areas with low population densities, the Oregon Office of Rural Health is changing its use of the term to "remote." "Remote" will be used instead of "frontier" going forward in this publication.

WHAT IS RURAL AND REMOTE ?

Map 1. Oregon's Safety Net Health Care Facilities



RHCs: qcor.cms.gov
FQHCs: www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/HEALTHCAREHEALTHCAREREGULATIONQUALITYIMPROVEMENT/Documents/FQHCList.pdf
Tribal Clinics: www.npaihb.org/member-tribes
CAHs: www.ohsu.edu/oregon-office-of-rural-health/oregons-cahs

OVERVIEW OF CHALLENGES

The Changing Landscape of Health Care. Rural communities in Oregon and across the U.S. have struggled persistently with ensuring access to readily available care. Health care facilities have, on average, consistently operated just at or below the financial margin over several years. Notably, the COVID-19 pandemic exasperated these issues. The 2024 Rural Listening Sessions began as the nation was emerging from the difficult impacts of the COVID-19 pandemic. At the same time, Oregon began seeing the negative results the pandemic had on health care finances and operations, particularly in workforce recruitment and retention. On the positive side, discussions intensified about how communities, health care and other organizations could collaborate to address the underlying (and increasing) social drivers of health and advance health equity across the state.

The provision of health care continues to change alongside the larger conversation about the future of health care. With small patient volumes and funding often based on population, rural and remote health care influence can seem diminished. The 2024 Rural Listening Sessions reminded us that while many places may be geographically distant from urban centers, rural and remote areas are central to the issues that need attention in all of Oregon's communities and warrant an equity perspective. Unlike their urban counterparts, which tend to have higher numbers of providers and staff, rural and remote providers meet these challenges to care provision by taking on a variety of roles - a primary care physician who is also the emergency medical services (EMS) director and moonlights in a neighboring town's emergency room on weekends; a nurse practitioner who manages a clinic and applies for grants during lunch; a chief executive officer who describes the challenges of recruiting physicians at the rotary club pot-luck. While these challenges continue to be pervasive in our rural communities, we also acknowledge and honor the creativity and innovation that are a part of the fabric of rural communities as they address a plethora of challenges, often with fewer resources than urban communities.

METHODS

After identifying a need to conduct Listening Sessions in Oregon's rural communities to gain contemporary information about challenges facing rural health care and identify potential solutions, ORH and ORPRN invited a group of rural leaders to participate in an advisory committee to provide feedback on the design of Listening Sessions, along with identifying who to invite and where the sessions should be held. See page 4 for a list of advisory committee members. This group met in January 2024 and identified six rural Oregon communities in which to hold sessions (see page 11 for a list and map of session locations). They suggested that the first step should be to ask potential participants (from a 50-mile radius of the identified communities) to participate in a survey to identify the topics to explore in their region and then to conduct the Listening Sessions focused on these topics.

Survey questions were carefully crafted by ORH and evaluated by ORPRN's evaluation team. These questions sought to understand participants' perspectives on the top three challenges to rural health care and their top three ideas for resolutions to those challenges.

The survey, designed in Qualtrics, contained contact information and "yes" and no" questions, along with free-text responses. It was emailed to 280 potential Listening Session participants (identified by ORH and ORPRN staff and the advisory committee), along with their invitation to participate in the appropriate regional session. Participants were also asked to identify others to invite to respond to the survey and participate in the Listening Sessions to ensure that perspectives from community members and leaders were not inadvertently missed. A survey reminder was emailed twice prior to each regional Listening Session. Survey respondents were assured their responses would be confidential and assessed in aggregate to develop each regional agenda. Note that while Listening Sessions were held in specific towns, participants were invited from a 50-mile radius to capture a diverse array of perspectives and to encourage collaboration among participants at each session.

We received 136 responses, or a 48.6% response rate, to the survey. Surveys were analyzed using a mixed-methods approach. Qualitative coding was used to assess the free-text responses from the survey related to the top challenges and solutions to those challenges, and the results were categorized into themes by region to craft Listening Session agendas. Each Listening Session contained four topical agenda items, which were selected based on the top four most pressing challenges identified by region from the survey. Notably, "Health Care Workforce Recruitment and Retention" was identified as the highest-rated topic of interest for all regions except one, though this topic related to "Health Care Access" across all regions. All regions also identified "Health Care Access" and "Social Drivers of Health" as topics to explore. Other topics explored regionally included "Health Care Facility Finances," "Patient Supports" and "Coordinated Efforts Between Health Care Organizations to Efficiently Deliver Care." Subthemes related to each of these topics varied. See Table 1 for more information. Topics identified through the survey and ultimately explored during the Listening Sessions included the following:

Table 1. Listening Session Agenda Items Identified Through Survey[2]

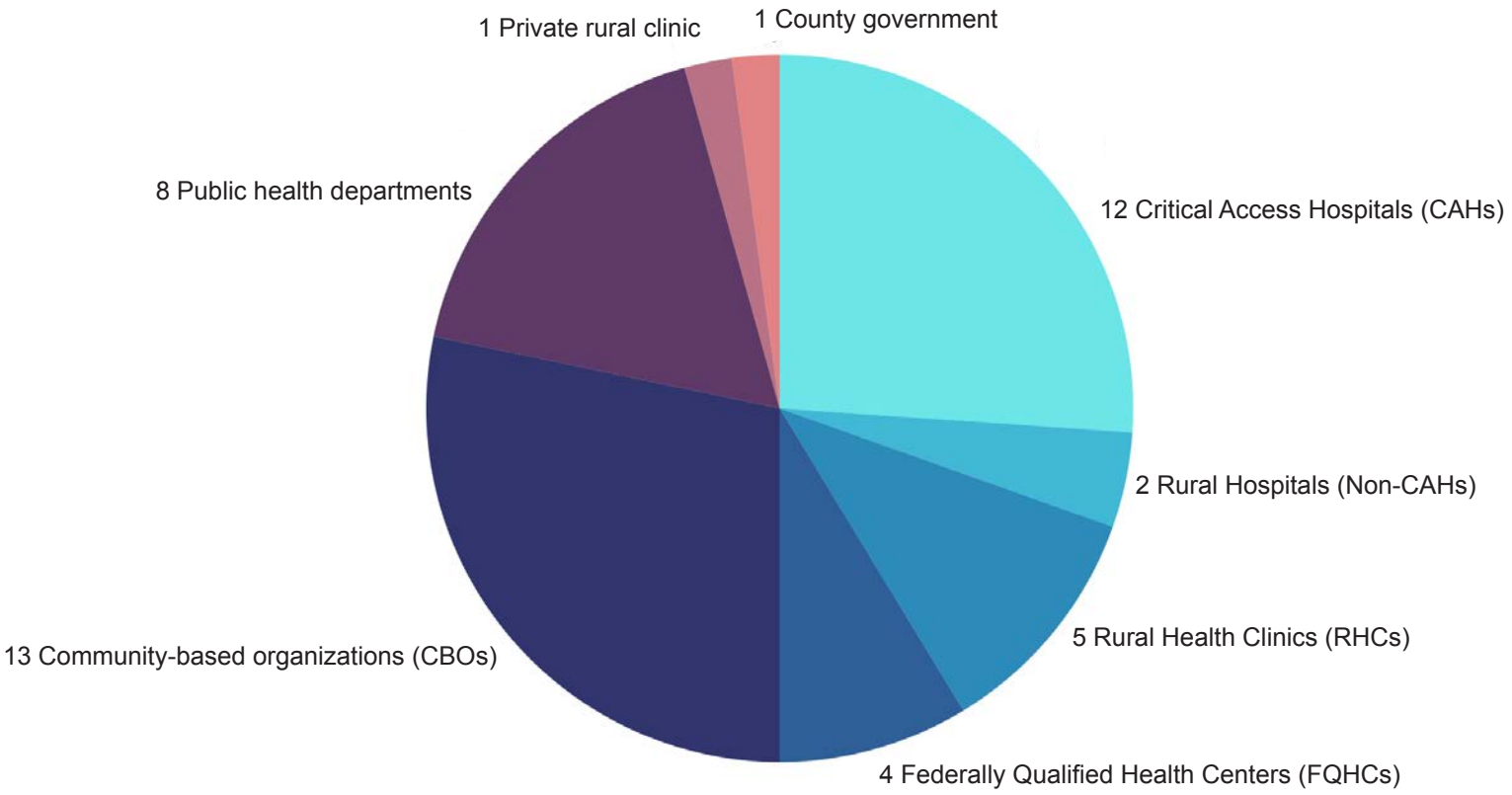
Access to Care (6)	Health Care Workforce Recruitment and Retention (5)	Patient Supports (5)	Health Equity (3)	Community Health/Specific Health Needs[3]	Health Care Facility Finances (2)	Coordinated Efforts Between Health Care Organizations to Efficiently Deliver Care[4]	Regulations and Funding[5]
• SUD treatment (6) • Behavioral health (5) • Primary care (4) • Specialty care (2) • Maternity care (2) • Dental care (2) • Access to timely care (2)	• Primary care providers (4) • Behavioral health providers (4) • Specialists (undefined) (2) • Older adult care providers (2) • Dentists • Social service providers • Physical therapists • Occupational therapists • Support staff	• Social drivers of health (5) ○ Transportation ○ Housing ○ Food insecurity • Aging population needs (3) • Trauma-informed care (3) • Cultural/ linguistic barriers (2) • Affordability of health care (2) • Health literacy/ education • Lack of trust in health care	• No subtopics identified	• Immunizations • Diabetes management • Heart disease • Suicide prevention • Other chronic conditions	• No subtopics identified	• No subtopics identified	• Public Health Funding • CBO Funding for Social Needs • Data and Reporting to Oregon Health Authority (OHA) • Public Health Structure

[2] The numbers in parenthesis after the title of each topic in the table indicate the number of regions that discussed that particular topic. For example the title "Access to Care (6)" means this topic was discussed in six regions.
[3] Discussed in the "Access to Care" agenda item at Listening Sessions.
[4] Discussed throughout the report in the "Solutions" section for each category because it was identified as a solution rather than a challenge.
[5] Discussed in the "Health Care Finances" agenda item at Listening Sessions.

Each Listening Session was guided by a tailored script to explore the topics prioritized in the regional surveys. It was important for each script to be the same for each Listening Session to avoid any data variances resulting from what was said. There was a moderator and two assistants for each session. One assistant took notes, and the other recorded attendee responses on large charts hung at the front of the rooms at each session. Each session was also recorded. Together, the notes and recordings provided the content used for qualitative analysis. A codebook was developed to conduct a qualitative analysis of the sessions, and the transcript and notes from all sessions were hand-coded. Results for each region were aggregated to develop an assessment for the entire state.

Between April 19 and May 16, 2024, 96 participants from 50 rural health care organizations, public health departments, CCOs and CBOs participated in the ORH/ORPRN Rural Listening Sessions. They included:

12 Critical Access Hospitals (CAHs)
2 Rural hospitals (non-CAHs)
5 Rural Health Clinics (RHCs)
4 Federally Qualified Health Centers (FQHCs)
13 Community-based organizations (CBOs)
8 Public health departments
4 Coordinated Care Organizations (CCOs)
1 Private rural clinic
1 County government



LOCATIONS

ORPRN and ORH are thankful for the rich and engaging discussions during the 2024 Listening Sessions, held in six regions throughout rural Oregon. Sessions were held at the following locations (see also Map 2):

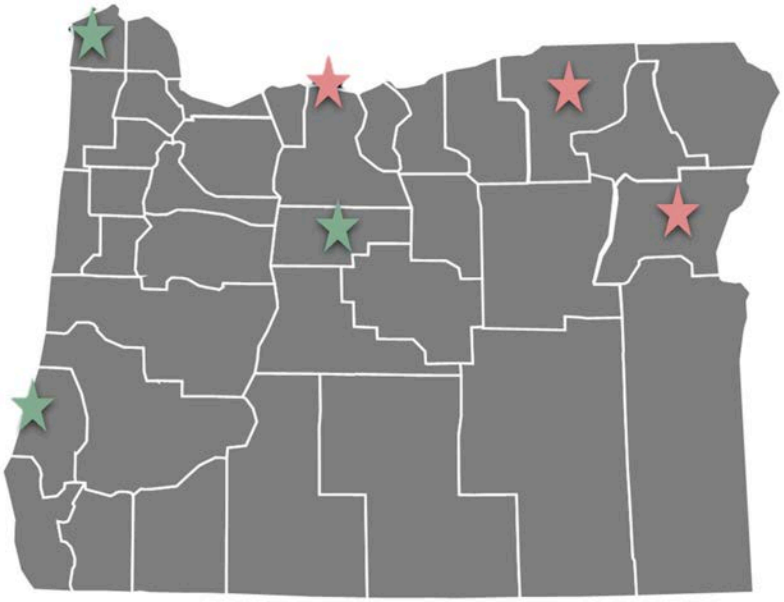
- **Bandon** (Bandon Community Center), April 19, 2024
- **Pendleton** (CHI St. Anthony Hospital), April 29, 2024
- **Baker City** (St. Alphonsus Baker City Medical Center), April 30, 2024
- **The Dalles** (Water's Edge Clinic), May 1, 2024
- **Astoria** (Columbia River Maritime Museum), May 13, 2024
- **Madras** (St. Charles Madras Hospital), May 16, 2024


Astoria


The Dalles

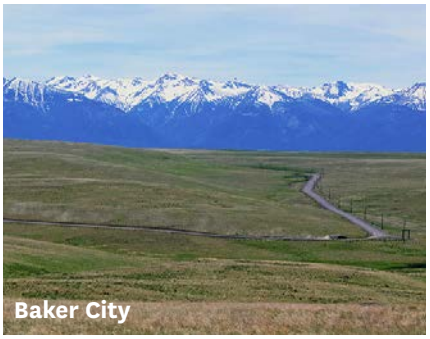

Pendleton

Map 2. Oregon Rural Listening Session Locations




Bandon


Madras


Baker City

2024 ORH/ORPRN LISTENING SESSION RESULTS[6]

In the following section, we explore the primary challenges reported across the regional Listening Sessions, followed by the solutions participants proposed to those challenges. This section is broken into four topic areas, including:

- Health and workforce recruitment and retention.;
- Access to care;
- Patient supports and social drivers of health; and
- Health care facility finances.

HEALTH CARE WORKFORCE RECRUITMENT AND RETENTION

CHALLENGES

While health care workforce recruitment and retention challenges were identified in the pre-session survey as the top agenda item for five regions (83%), the "access to care" topic was intertwined (as it was for all regions) with workforce challenges in the sixth region. Participants identified certain professions as the most challenging to recruit and retain, including behavioral health providers, primary care providers, specialists (undefined), dentists, and older adult care providers. In addition, social workers, physical therapists, occupational therapists, and support staff were cited as needed professionals in one region.

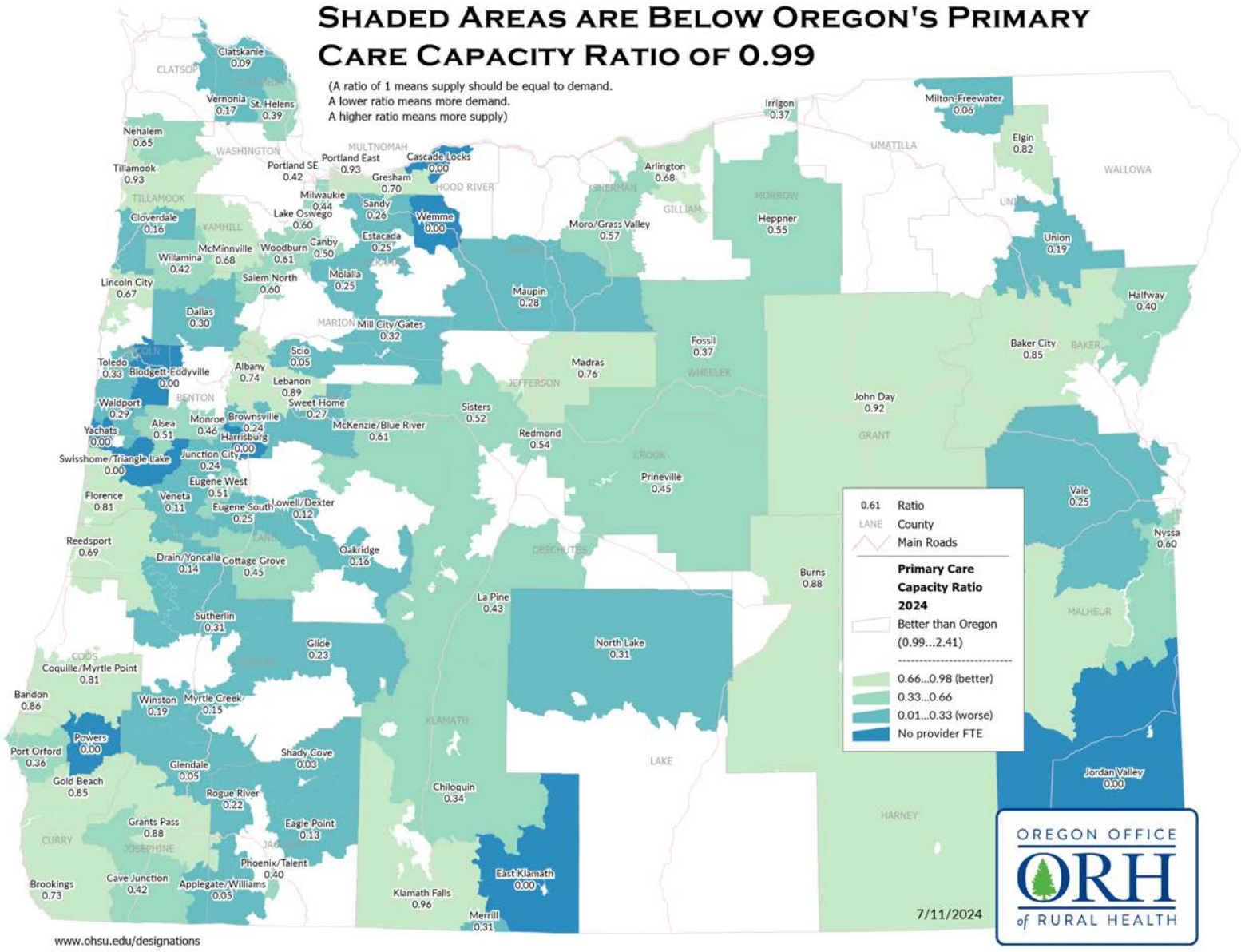
ORH tracks primary care, behavioral health and dental care provider capacity across the state. Its data regarding the lack of capacity for primary care, dental care, and behavioral health care are consistent with the feedback provided by each region. [7,8] See Maps 3 through 5 for ORH's 2024 assessment of the capacity for each of these professions, where darker blue has no providers and white has more providers than the Oregon average (per 1,000 population) as a whole. As the maps show, **rural and remote Oregon areas struggle more with having an adequate number of providers than do their urban counterparts.** See also ORH's interactive map of primary care providers (with some subspecialties) here: https://public.tableau.com/app/profile/oorh/viz/PrimaryCarebyServiceArea/PrimaryCareper1000.

[6] All results presented on the following pages are in aggregate from the six listening session regions. Percentages displayed on these pages use six as the denominator. This does not mean that the challenges and/or solutions do not exist in all regions. Rather, it signifies that the region specifically cited the challenge or the solution. In addition, data are aggregated from the input of 96 individuals who represented their regions. Therefore, the percentages shown for each challenge and solution may be quite different if research was conducted at the individual level.

[7] The Oregon Office of Rural Health does not currently track health care workforce capacity for professions outside of primary care (and some specialties), behavioral health and dentistry.

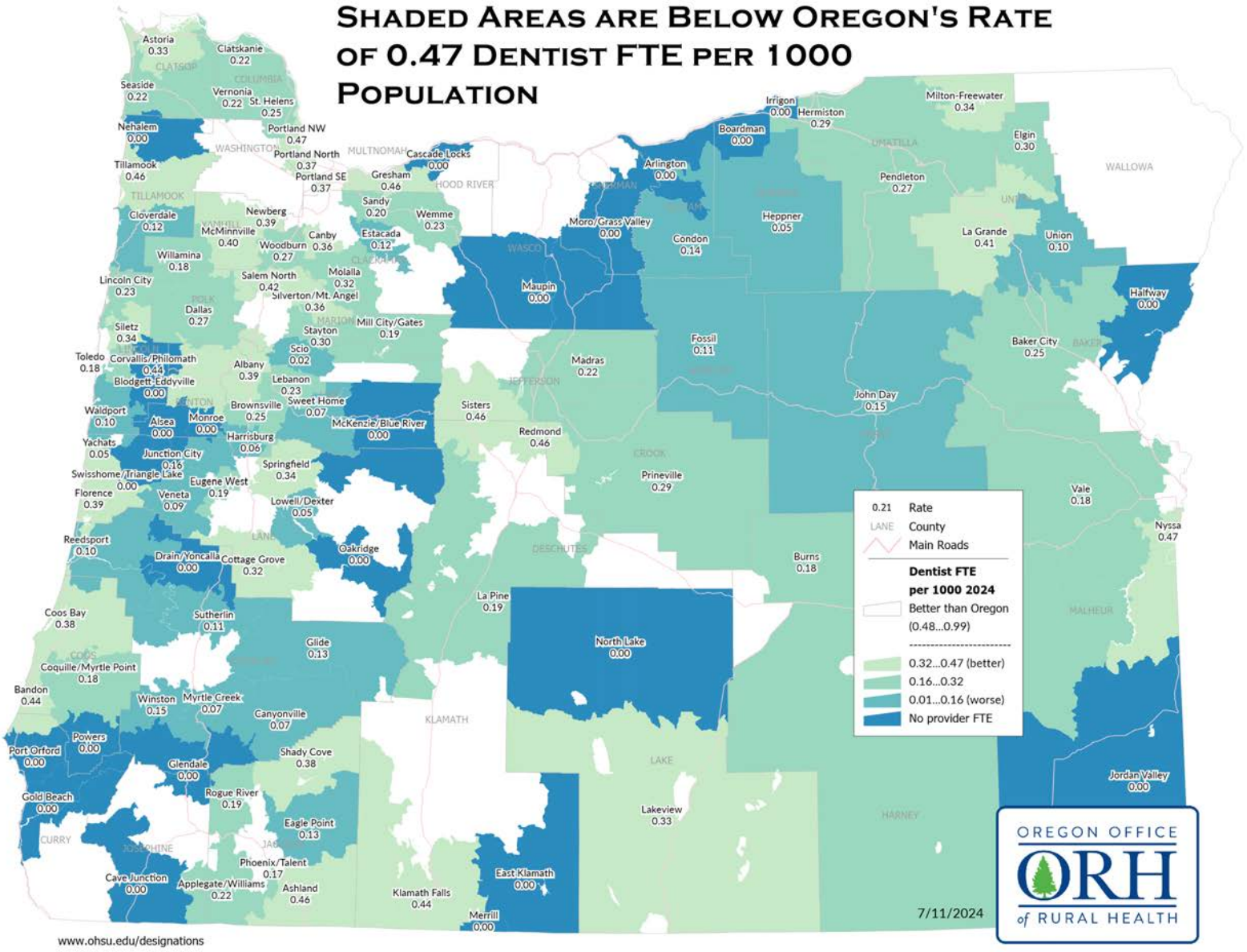
[8] While ORH does not track workforce capacity for public health professionals, interested readers are encouraged to review the Oregon's Local Public Health Workforce Report, 2021 produced by the Oregon Coalition of Local Health Officials.

Map 3. Oregon's Primary Care Providers Per 1,000 Population



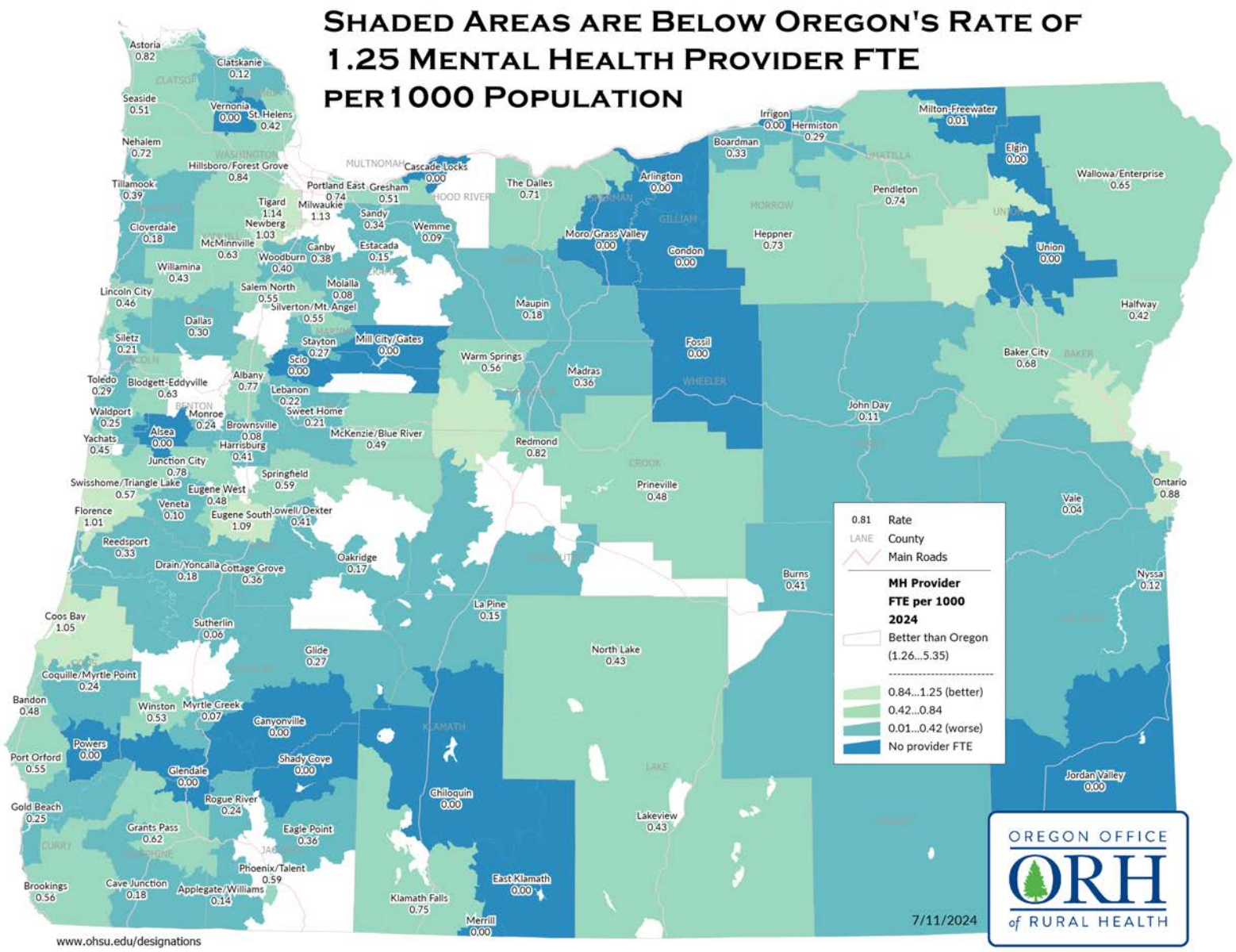
In Oregon, the estimated ratio of primary care visits that can be accommodated is 0.99. This ratio implies that if health care providers were evenly distributed across the state, the primary care capacity should sufficiently match patient requirements. However, rural and remote service areas exhibit a lower ratio of 0.69, which shows a pronounced demand-supply gap, especially compared to 1.16 in urban areas.

Map 4. Oregon's Dentists Per 1,000 Population



Oregon has 0.47 dentist patient care FTE per 1,000 people. Twenty-four primary care service areas (all rural or remote) have no dentist FTE. The urban areas of Portland SW (0.99) and Eugene/University (0.89) have the highest numbers of dentists per 1,000 people.

Map 5. Oregon's Mental Health Providers Per 1,000 Population



There are 1.25 mental health provider FTE per 1,000 people in Oregon. Twenty service areas (all rural or remote) have no mental health providers. The highest FTE per 1,000 are in the urban areas of Portland SW (5.4), Eugene/University (4.6) and Portland NE (3.5).

Listening Session participants also discussed additional challenges to recruiting and retaining other health care staff, including medical assistants, certified nursing assistants, imaging technicians, nurses, dietitians and diabetes educators. In addition, one region is experiencing difficulty retaining community health workers (CHWs) due to "quick burnout due to the nature of their jobs, coupled with low pay." One region reported that CHWs have safety concerns as their work often requires them to visit patient homes alone. Further, three regions (50%) reported that reimbursement from payors for CHWs is insufficient to cover costs to the facilities that employ them.

For all positions, the most cited reason for the difficulty in recruiting was a **lack of adequate and affordable housing**. In other words, if facilities can recruit for a position and the candidate they choose does not currently live in the area, they often decline the position due to a lack of housing. This theme resonated in all six regions (100%). The lack of adequate and affordable housing was attributed to the following:

- Housing inventory is taken up by vacation rentals
- The housing that is for sale is substandard, and candidates are unwilling to renovate to relocate
- There are infrastructure restraints, such as a lack of existing water and electricity lines in areas that could be developed, and it would be costly to install that infrastructure
- City zoning restrictions
- Where land is available for potential development, it is owned by the state or the federal government

Another dominant challenge reported related to recruitment was the **lack of educational opportunities** (83%) available in rural areas to train for needed positions, particularly for nursing, imaging technicians and medical assistants.

Participants also cited a lack of nurse educators at colleges, which contributes to the lack of available education programs for nursing. In addition, where programs are available outside the town where prospective students live, they either move away and do not return or forgo pursuing their degree or certification due to the travel demand placed on them to attend in-person classes. Finally, several regions reported that when they hire new staff who qualify for loan repayment programs, they often only stay to work in their rural facility until their obligation expires, and then they leave.

From the community perspective, participants cited a **lack of daycare and quality schools for providers' children** (33%) as another challenge to recruiting and retaining the health care workforce. Other reasons cited for recruitment and retention challenges included **low pay compared to urban areas** (33%), **providers' interest in alternative work schedules** (i.e., working part-time or only occasionally) (33%), and the **requirements to maintain licenses or certifications for a variety of professions** (16%).

SOLUTIONS AND RECOMMENDATIONS

Listening Session participants offered several solutions to workforce challenges that are either currently working, should expand, or are new ideas. These solutions have been categorized into five areas.

Health care facility solutions. The following lists the solutions participants offered that health care facilities can institute to address workforce recruitment and retention challenges:

- Offer generous hiring bonuses to candidates (33%). One facility reported offering $25,000 bonuses to hire provider candidates who live in their county rather than living in another county or state and commuting to their community for work.
- Sponsor housing initiatives for providers and staff (33%). In one region, the CCO is leading an effort to renovate a hotel they purchased to house providers and staff who do not have other housing options in the area.
- Provide scholarships for workforce training (16%)
- Explore how artificial intelligence can assist the workforce with efficiencies (16%)
- Be open to remote options to recruit behavioral health providers (33%)
- Offer paid internships to high school and college students (16%)
- Identify burnout (especially among nurses) early and address it quickly. It is also important to institute a mentorship program for new graduates to combat professional isolation and prevent burnout (33%).

Partnership solutions. Sixty-seven percent of regions recommended expanding or implementing "grow your own" strategies for workforce recruitment. While a long-term strategy, investing in programs that expose younger students (at least middle and high school students) to health careers can effectively expand the rural health care workforce.[9] This includes partnerships between education systems, public and private sector employers and CBOs, such as Area Health Education Centers (AHECs), to promote an interest in pursuing health careers in rural areas.[10] Another potential solution offered in one region is for health care facilities and systems to host a job fair together to bring potential candidates to one place where they can find the right rural community fit for them.

Policy solutions. Listening Session participants provided the following state and federal policy-focused solutions to address workforce recruitment challenges:

- CMS increase in funding for residency slots (CMS provides the bulk of the funding for residency slots (16%))
- Improve and expand health care workforce loan repayment programs, as keeping providers after their service obligation time ends is difficult. Further, facilities would like to see such programs expand to include other non-physician providers (50%)
- Create a state advocacy group to expand the scope of practice for non-physician providers (16%)

Education solutions. Listening Session participants (33%) discussed current programs, such as Pacific University's program to educate CHWs to become diabetes educators and the free CHW training and cross-training provided through the Healthy Rural Oregon program (funded through HRSA's Rural Public Health Workforce Network Training grant, which ends in July 2025) as models that helped them increase their community health workforce. They would like to see these programs continue and expand across the state. Further, two regions discussed working with their community college to build health care workforce programs for needed professions. However, there are often not enough instructors or funding available to support building new programs, such as a dental hygiene program.

Philanthropic solutions. To address the need for childcare among providers and other staff, one region suggested seeking grant funding to provide childcare for providers and other staff. They noted that childcare needs to be available 24 hours per day, seven days per week, to accommodate hospital schedules.

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[9] Thill, N., Fortune, M., & Radcliffe, A. (n.d.). Addressing the national rural health care worker shortage with a focus on kindergarten through 12th grade educational strategies. National Rural Health Association Policy Brief. https://www.ruralhealth.us/getmedia/47a40e1e-e08a-46b8-a0a3-00037dd998f9/2024-NRHA-Rural-Workforce-Pathway-Programs-policy-brief.pdf.

[10] Ibid.

ACCESS TO CARE

CHALLENGES

General access challenges. Participants reported that patients find it **difficult to access care for substance use disorder (SUD) treatment** (100%), **behavioral health** (83%), **primary care** (67%), **dental care** (50%), **specialty care** (33%), **maternity care** (33%), and **home health and hospice** (33%). Access is exacerbated in three regions that reported that some private practice physicians and dentists in their areas do not accept Medicaid or Medicare insurance, which are more common insurance types in rural than in urban areas.[11]

Unsurprisingly, all regions reported that **access to care is often attributed to a lack of providers** for each of these needs, a challenge that is intermingled with workforce recruitment and retention.[12] One region reported that patients frequently go to the emergency room for care due to a lack of primary care providers in the area. This is well-known to increase the cost of care, lead to less effective preventative care, and take resources away from patients with emergent care needs.[13] Thirty-three percent of regions reported that patients wait three months or longer to see a specialist if one is available. These same regions reported that specialists often request that patients undergo additional tests before their first encounter. This delays care and places more burden on primary care providers who must order the required tests. Further, one region reported that its primary care providers are experiencing increased complexity in its patient population. What used to be a 15-minute visit is now a 40-minute visit. They attributed increased appointment lengths to a growing older population with more complex health needs.

In a region adjacent to the Washington border, most health care is provided on the Oregon side. The unique issue for that region is that **Medicaid patients from Washington** (just a few miles away) **cannot access Medicaid services** in Oregon. Instead, they must travel an hour from their homes to receive care from a Washington Medicaid provider. This issue is also experienced in communities that border other states adjacent to Oregon, such as Idaho and California.

SUD and behavioral health. Listening session participants reported significant barriers to accessing SUD treatment and behavioral health. While 100% of regions cited a challenge with SUD treatment access, **83% reported difficulty finding inpatient beds for patients at a treatment facility. Sixty-seven percent reported difficulty in finding inpatient beds for behavioral health patients**. All participants reported that patients with either higher-level behavioral health or SUD treatment needs must board in small rural hospitals (where hospitals are often not reimbursed for the cost of boarding these patients) while staff try to find them a bed. One hospital shared that they have adult and adolescent patients who have suicidal ideation in their emergency room daily. These patients cannot be released from the hospital until appropriate treatment is found, often some distance from their homes. Another region said they are seeing additional expectations put on primary care providers to be responsible for SUD treatment.

Telehealth. Patients' and providers' acceptance of telehealth increased dramatically during the pandemic in both rural and urban areas. However, this period also revealed **disparities in access to telehealth caused by insufficient and expensive broadband**.[14, 15] Fifty percent of Listening Session participants reported limited broadband in their area, which impacts patients' and providers' ability to conduct telehealth appointments. Further, when telehealth is available, it can be inaccessible to patients due to cost and a lack of digital literacy.

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[11] Foutz, J., S. Artiga, and R. Garfield. 2017. The role of Medicaid in rural America. Washington, DC: Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/.
[12] Refer to Maps 3 through 5 as well as ORH's interactive map of primary care providers (that lists some subspecialties) here: https://public.tableau.com/app/profile/oorh/viz/PrimaryCarebyServiceArea/PrimaryCareper1000.
[13] Rust G, Ye J, Baltrus P, Daniels E, Adesunloye B, Fryer GE. Practical barriers to timely primary care access. Archives of Internal Medicine, 168(15), 1705. https://doi.org/10.1001/archinte.168.15.1705.
[14] Graves, J. M., Abshire, D. A., Amiri, S., & Mackelprang, J. L. (2021). Disparities in technology and broadband internet access across rurality. Family & Community Health, 44(4), 257–265. https://doi.org/10.1097/fch.0000000000000306.
[15] Kolluri, S., Stead, T. S., Mangal, R. K., Coffee, R. L., Littell, J., & Ganti, L. (2022). Telehealth in response to the rural health disparity. Health Psychology Research, 10(3). https://doi.org/10.52965/001c.37445.

"The more you experience a system that is not working for you, the more your comfort in access care is impacted."

– Listening Session Participant

Transportation.[16] **Patients' ability to secure transportation to get all types of care was expressed as a significant concern in 67% of regions**. This concern was raised due to a lack of public transportation in some areas, coupled with patients who cannot afford a vehicle or older adults who no longer drive. A lack of robust public transportation systems or programs to help rural populations get to their appointments is a systemic issue that must be addressed to ensure equity of care. It is often assumed that telehealth will help address patients' transportation barriers. While it sometimes does, as described in the previous section, broadband access is frequently unavailable or unaffordable in rural communities. Further, some people grapple with digital literacy issues.

Health equity. All regions addressed health equity in some way and discussed topics such as limited English proficiency among patients, certification barriers for health care interpreters, the need for cultural humility skills and training, and the provision of trauma-informed care. Each of these health equity sub-areas is explored in detail below.

Access to health care due to language barriers was identified as an issue in 50% of the regions. Several facilities do not employ health care interpreters and feel that language lines (virtual translating during appointments) do not provide the care patients deserve as they are less personal. Instead, they would prefer to have in-person interpreters. One participant said, "Using the language line makes it difficult for patients to feel comfortable and connected. For 12 years, I've talked about the importance of having a live interpreter and the need for a bilingual and bicultural person so patients feel safe and cared for." Another participant said, "Language is an equity issue. We have a Spanish-speaking workforce that is capable of interpreting, but the state doesn't allow them to have certain care conversations with patients unless they are certified [as interpreters]. We rely on language lines, but they are not the same as providing interpretation in person." In addition, one region reported they have patients who speak non-Spanish South American dialects, and it is difficult to find interpreters to translate for patients who speak these dialects. For that reason, care can be delayed until an interpreter can be identified. In addition, these dialects are only spoken (not written). Therefore, written materials do not work for patients who speak these languages. Another region reported that their staff speak a more formal Spanish dialect, which is sometimes confusing for the migrant farmworker population they serve.

As mentioned earlier, all facilities indicated they would prefer to employ health care interpreters. However, **67% of regions reported that the certification exam for interpreters (even for native speakers who have worked in health care) is extremely difficult to pass**. This difficulty creates a substantial barrier to providing in-person language services to patients.

The need for **trauma-informed care and cultural humility skills among health care staff was discussed in 67% of regions**. One participant described how providers' body language is often an indicator of unconscious bias. Several regions discussed the importance of implementing patient and family advisory councils into the hospital structure and focusing on weaving cultural humility and trauma-informed care into the fabric of their health care systems as solutions to address unconscious bias. One participant summarized their thoughts by stating, "It is especially difficult to get an appointment at a time that works for many Latinx patients. There needs to be better language access, culturally appropriate care, Indigenous care, and more accessible times available to make appointments."

Trust in the health care system was discussed in two regions (33%). In one region, a participant shared that "There is a large Indigenous population in our service area who lack trust in the [health care] system here. For that reason, it is difficult to reach out to them." Another participant shared that it is difficult to understand the health needs of Indigenous populations because "Data are not reflective of the community being served because many people have a lack of trust in providing their data to health care providers and researchers."

[16] While patient transportation challenges were discussed in the "Patient Supports" portion of the agenda in some regions, it was discussed in the "Access to Care" portion in others.

Finally, related to health care access overall, a participant in one region shared the following perspective, "[Many] of the Latinx and middle-class populations don't qualify for Medicaid because they [make just enough money] and buying insurance is still too expensive. Also, the types of jobs the Latinx population typically has often do not provide insurance, and they can't ask for time off for a patient visit for themselves or their children. Additionally, the Latinx population is retiring, and they have never had health insurance and don't know that they might qualify for Medicare- that is, until they have an emergency. There is a lack of information for our Latinx population on how to access health care."

SOLUTIONS

Listening Session participants offered several solutions to health care access challenges that are currently working, should expand, or are new ideas. These solutions have been categorized into three areas.

Health Care Facility Solutions. Listening Session participants offered the following solutions health care facilities could use internally (and collaboratively) to address health care access challenges for patients:

- Employ more CHWs and peer support specialists to address patients' social and behavioral health needs (50%)
- Implement an end-of-life doula program to assist with hospice care gaps (16%)
- Share specialists among hospitals and clinics (16%)
- Implement mobile health units or street medicine to meet patients where they are. However, the challenge is taking what limited staff you already have out of the office to see a limited number of patients (50%)
- Investigate starting school-based health programs to meet patients (i.e., families and children) where they live (16%)
- Implement patient and family advisory councils, which are effective in getting patient voices involved in health care delivery (33%)
- Focus on creating a trauma-informed care environment within facilities through training and incorporating it into the fabric of the health care system (16%)

Partnership Solutions. Listening Session participants offered a myriad of ideas to work with partners to address access issues for patients, including the following:

- Develop specialty care connections (i.e., telehealth and/or e-consult partnerships) with other clinics and hospitals and utilize local technicians and personnel to support this service (33%)
- Explore whether a CCO has a program to pay for the health care interpreter exam (16%)
- Bring together regional advisory councils to request reviews for research and to engage community voices in the research (16%)
- Consider collaborations to reach out and serve populations that lack access, and continue collaboration discussions in community quarterly meetings (16%)
- Develop more collaboration and outreach services within the community. Community members will often work with health care facilities to support community projects in hopes of keeping these efforts going (16%)
- Find ways to integrate public health into the health care structure to prioritize prevention (16%)
- Some CCOs visit people in their homes to explain Medicaid to them. Investigate whether CCOs regularly do this (16%)
- Collaborate to conduct a needs assessment focused on access issues (16%)
- Collaborate to find grant funding for mobile health vans or community transportation programs to get patients to appointments (16%)

Policy Solutions. Listening Session participants offered a few policy-based solutions to improve access for patients, including the following:

- Allow behavioral health services across state lines via telehealth through a state compact (33%)
- Involve local people in thinking about health care. When local people provide input, that impacts local-level policy (16%)
- The state should incentivize direct care in a patient's preferred language rather than focusing on interpretation requirements (16%)
- Improve the certification/proficiency testing for health care interpreters to remove unrealistic barriers (33%)

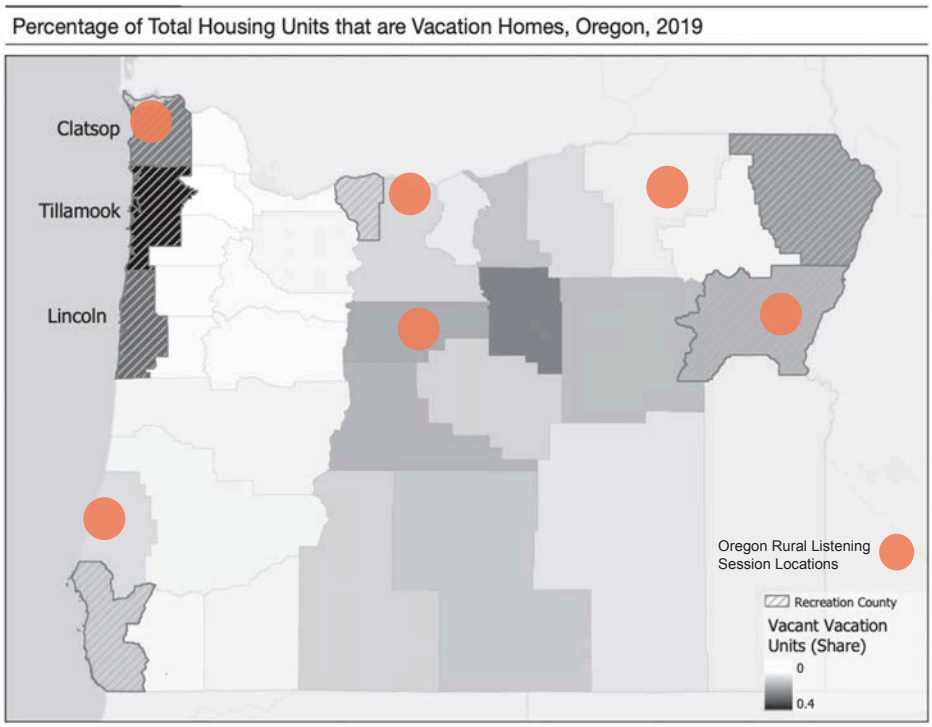
PATIENT SUPPORTS AND SOCIAL DRIVERS OF HEALTH

CHALLENGES

While some regions (83%) identified "Patient Supports" as an agenda item, the discussion was focused primarily on the social drivers of health in all regions. In many cases, these topics were intertwined with care access challenges for patients. Note that transportation issues were discussed in the previous section (see page 19). Therefore, this section focuses on social needs such as food insecurity, access to nutritious and culturally appropriate foods and inadequate housing. It also focuses on requirements health care facilities now have through both Medicare and Medicaid to collect patient's social needs data.

Housing. Housing for community members was discussed as a significant issue in 100% of regions, though only 67% of regions focused their discussion about housing on their patient populations (100% discussed the problem for their workforce). As covered in the workforce section (see page 17), housing is challenging in rural communities for a myriad of reasons, including the vacation rental market taking up housing stock, affordability, substandard housing and a lack of the ability to develop land. To illustrate two of these points, see Map 6 and Figure 1. Vacation housing density is higher for all Listening Tour regions than it is for more urban communities in Oregon (Map 6). **Eighty-seven percent of the regions that participated in the Listening Sessions have a housing cost burden where the percent of renter households pay a gross rent of 30% or more of the household income** (Figure 1). One region stated that housing, especially affordable housing, is a significant concern for them. They said they have housing vouchers available, but there is an 18 to 24-month wait for patients to be placed in a home.

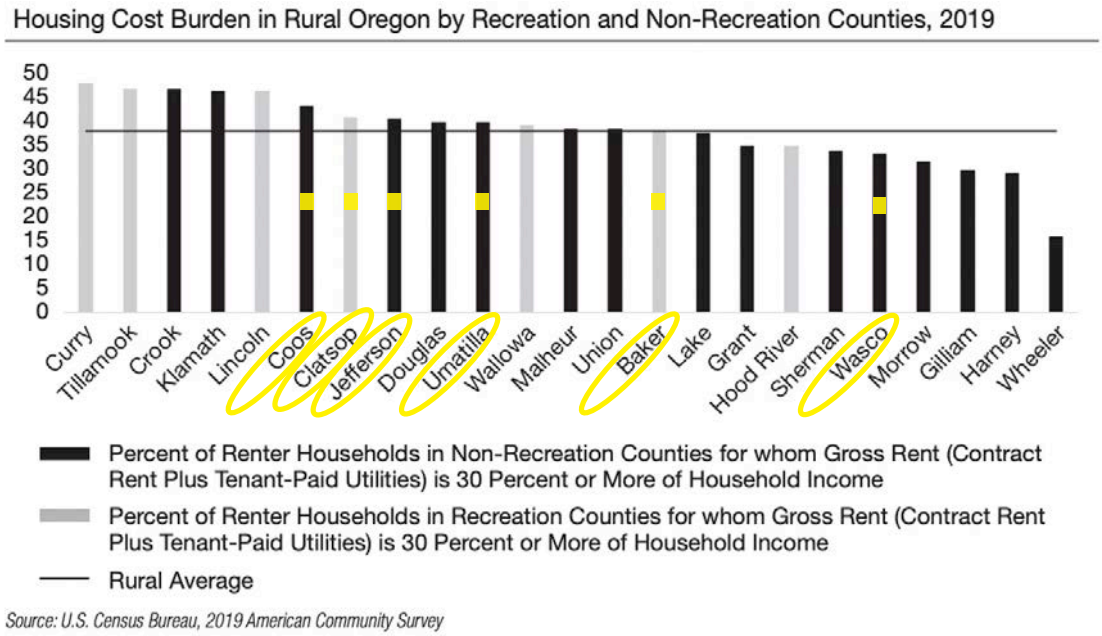
Map 6: Percentage of Total Housing Units In Oregon That Are Vacation Units[17]



Source: U.S. Census Bureau, 2019 American Community Survey

[17] Ray, K. & U.S. Department of Housing and Urban Development. (2021). Recreation counties and available housing in rural Oregon. In Cityscape (No. 3; Vol. 23). https://www.huduser.gov/portal/periodicals/cityscpe/vol23num3/ch13.pdf.

Figure 1. Housing Cost Burden in Rural Oregon[18]



Source: U.S. Census Bureau, 2019 American Community Survey

Food access. Fifty percent of regions expressed concerns about food insecurity and access to nutritious and culturally appropriate food for patients, especially the Medicaid population. Food insecurity is a significant concern across Oregon in rural counties, as the top five most food-insecure counties in Oregon are rural (see Figure 2).[19]

One participant said, "If we have food resources, but [the patient has] no transportation, how do they get it? My point is that even when resources are available, they are not always accessible." Another participant shared their concern that when health care facilities or CBOs are able to provide food boxes, they are typically not culturally appropriate. Instead, food boxes should contain nutritious food that meets an individual's cultural needs. Another participant added that some food prescription programs (developed in partnership between health care facilities and CBOs) create culturally appropriate food boxes that contain culturally specific recipes in the patient's language.

Figure 2. Oregon's Most Food-Insecure Counties[19]

Top Counties by Food Insecurity Rate (%)	Overall Food Insecurity Rate (2020 Projection)
Lincoln County*	20.90%
Coos County*	20.40%
Klamath County*	20.20%
Grant County*	19.60%
Curry County*	19.40%
Lane County	17.42%
Multnomah County	16.58%
Marion County	15.15%

** indicates rural county*

[18] Ray, K. & U.S. Department of Housing and Urban Development. (2021). Recreation counties and available housing in rural Oregon. In Cityscape (No. 3; Vol. 23). https://www.huduser.gov/portal/periodicals/cityscpe/vol23num3/ch13.pdf.

[19] New Projections Reveal Worsening Food Insecurity in Pandemic's Wake. (2020, November 12). Oregon Food Bank. https://www.oregonfoodbank.org/new-projections-reveal-worsening-food-insecurity-in-pandemics-wake?gclid=CjwKCAiArNOeBhAHEiwAze_nKCRbuFETD-6c3k7ZDlwahv2FdCx4XvLvgbgS8YONJLblxc1lgrE2t6hoCZNAQAvD_BwE.

Reporting requirements and Medicaid funding for social needs. The majority of the conversation about social needs and patient supports in all regions focused on the reporting requirements for health care facilities along with the availability of funding through Oregon's 1115 Medicaid waiver to address social needs. One participant shared that even though health care is starting to collect social needs data, "The system is set up to continue to reimburse for treating disease, not preventing health issues." Another participant said, "It's good we are asking questions about social drivers of health, but we do not have the bandwidth to address the needs. **There is moral distress when staff cannot help patients with their social needs**."

Health care systems and providers reported **barriers to utilizing Medicaid funding to address social needs**. One participant shared, "It's difficult for providers and patients to navigate CCO funding to address social drivers of health. The request form is written at a level of high literacy. It is lengthy with unrelatable pictures. Further, it is difficult to find on OHA's website. The 30-day delay is unhelpful for patients experiencing an emergency. Most patients do not understand what portion of Medicaid they have and what it covers for them." Where participants did not seek Medicaid assistance to address social needs, due to the reason stated above, or they do not have access to Medicaid dollars (as was reported is the case for many CBOs), they seek grant funding from private foundations to assist patients with their social needs. **However, 33% of participants reported that grants to address social needs are often given to organizations that do not serve all rural communities in a region and instead focus on the larger towns within that region**. Another shared that "**grant funding for social drivers, services and resources is unsustainable. Grants come and go**." This participant added that it makes it difficult for a population to trust that organizations can help them with their needs.

SOLUTIONS

Listening Session participants offered several solutions to social needs challenges that are currently working, should expand, or are new ideas. These solutions have been categorized into four areas.

Health Care Facility Solutions. Participants (33%) offered one solution to addressing social needs internally: Provide patients with a primary contact, such as a patient navigator or a CHW, as they don't always know what services are available and what to ask for.

Partnership Solutions. Participants offered a few solutions to addressing social needs through partnerships, including the following (16% for each solution):

- Form partnerships between hospitals and FQHCs to address social needs
- Leverage the library to create a centralized resource list for patient support, including social needs
- Partner with local community action agencies and/or community-based organizations and investigate whether they will accept referrals for patients with social needs

Policy Solutions. Participants offered the following solutions from a policy perspective that could help them address social needs (16% for each solution):

- Increase payor payments for CHWs so facilities can hire more
- The state should provide billing and coding training specific to social needs
- The state should consider creating a standardized billing hub for social needs to help small and mid-sized organizations navigate the system
- The state should require more flexibility for social needs spending
- The state should consider funding human service organizations at a higher level so health care facilities can refer patients to them to address social needs

Philanthropic Solution. While participants recognized grants as an unsustainable way to address social needs, they recommended seeking out funding to provide nutrition classes and food boxes for patients.

HEALTH CARE FACILITY FINANCES

CHALLENGES

Health care facility finance was on the agenda and briefly discussed in two regions, while two others briefly discussed the financial challenges for local public health departments.

Health Care Facility Finances. The following outlines the challenges discussed by clinics, hospitals and public health (16% for each challenge):

- It is challenging to stay updated on metrics for value-based care, which negatively impacts finances
- Value-based purchasing, increased labor and supply costs, and cost growth targets make hospital finances very challenging
- There is a wasted administrative burden to navigate insurance coverage for patient care. There should be one set of standardized forms that all payors accept
- A long-term financial stabilization solution for health care facilities is needed
- Medicaid funding is stagnant, and delayed payments create financial challenges for health care facilities
- The low volume of patients in rural communities negatively impacts payments
- Public health funding is not adequate

SOLUTIONS

Listening Session participants offered several solutions to health care and public health finances that are currently working, should expand, or are new ideas. These solutions have been categorized into two areas.

Health Care Facility Solutions. Participants (16%) offered one solution to health care finances internally: Partner with other health care organizations to share overhead expenses.

Policy Solutions. Most health care and public health financial solutions provided by participants focused on the policy realm and included the following (16% for each solution):

- The State of Oregon should standardize CCO operations to reduce the burden on health care facilities
- Advance a single electronic medical record (EMR) system statewide to reduce administrative costs and support access to patient information across systems
- Focus on increased reimbursement from Medicare, Medicaid and private payors
- Increase funding for public health

CONCLUSION

The 2024 Rural Listening Sessions provided valuable insights into the challenges facing rural and remote health care facilities, local public health agencies, CCOs and CBOs across Oregon. While the needs vary to some degree by region, several overarching themes emerged. Workforce recruitment and retention difficulties, particularly for behavioral health providers, primary care providers and others, are severely impacting rural residents' access to care. The lack of affordable housing was consistently cited as a significant barrier to recruiting new staff.

Access issues also stemmed from persistent shortages of specialty care, difficulties addressing social drivers of health such as food insecurity and inadequate housing, barriers for non-English speakers to receive linguistically and culturally appropriate care and transportation limitations. Participants saw opportunities to better integrate community health workers, collaborate with CBOs to address social needs and strengthen partnerships to help connect patients to needed services.

Financial strains on facilities further threaten their ability to serve rural communities. Participants urged policy solutions such as increased reimbursement rates from Medicare and Medicaid, streamlining administrative processes, investment in a single, shared EMR, and boosted public health funding to stabilize this critical infrastructure.

The challenges illuminated during these Listening Sessions demand innovative, collaborative solutions from health care providers, policymakers, payors, educators, community organizations and other partners. Rural and remote communities deserve equitable access to high-quality, culturally appropriate care. By prioritizing the voices and experiences shared here, Oregon can make strides toward achieving that goal for all its residents, regardless of geography. ORPRN and ORH are committed to turning these findings into actionable next steps.

APPENDIX I

Appendix I: List of Acronyms Used

Acronym	Refers To
CBO	Community-based organization
CCO	Coordinated care organization
CHW	Community health worker
EHR	Electronic health record
FQHC	Federally Qualified Health Center
OHA	Oregon Health Authority
OHSU	Oregon Health & Science University
ORH	Oregon Office of Rural Health
ORPRN	Oregon Rural Practice-based Research Network
SUD	Substance Use Disorder

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