

A light blue outline map of Oregon serves as the background for the top half of the page. The map shows county boundaries and major water bodies like the Willamette and Columbia rivers.

OREGON OFFICE



2016

Oregon Rural And Frontier Health Facility

**LISTENING  
TOUR**



The Oregon Office of Rural Health (ORH) coordinates an annual Listening Tour of rural and frontier health facilities to discuss and share current challenges, and to encourage partner collaboration to address solutions. This report is an overview of the common issues heard during the 2016 Listening Tour.

More detail, including current partner activities to address these challenges, is available on the ORH website at: [www.ohsu.edu/orh](http://www.ohsu.edu/orh).



The 2016 Rural and Frontier Listening Tour report was made possible with funding from the Oregon Rural Health Association and support by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Medicare Rural Hospital Flexibility and State Offices of Rural Health Grant Programs.

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## CONTENTS

<b>ACKNOWLEDGEMENTS</b>	<b>4</b>
Facility Participants .....	4
Partner Participants .....	5
<b>INTRODUCTION</b>	<b>6</b>
What Is Rural and Frontier?.....	8
<b>WORKFORCE</b>	<b>10</b>
Overview of Challenges .....	11
Availability and Affordability of Housing .....	12
The Nursing Challenge .....	13
Credentialed Medical Assistants.....	14
Health Information Technology .....	15
<b>ACCESS</b>	<b>16</b>
Overview of Challenges .....	17
Primary Care Providers .....	18
Specialists .....	22
Long-Term Care .....	31

# Acknowledgements

## Thank You Facility Participants

**BETWEEN AUGUST 22 AND  
NOVEMBER 7, 2016, 45 FACILITIES  
PARTICIPATED IN THE LISTENING TOUR.  
THEY INCLUDED:**

**14 Critical Access Hospitals (CAHs)**

**2 Type C (50+beds) Rural Hospitals**

**23 Rural Health Clinics (RHCs)**

**1 Rural Clinic**

**4 Federally Qualified  
Health Centers (FQHCs)**

**1 Tribal Clinic**

Adventist Health Tillamook Medical Group,  
Bay Ocean, Manzanita and Tillamook

Applegate Valley Family Medicine, Grants Pass

Blue Mountain Hospital, John Day

Clackamas County Community Health Centers,  
Oregon City

Coast Community Health Center, Bandon

Columbia River Community Health Services, Boardman

Coquille Valley Hospital, Coquille

Curry Family Medical, Port Orford

Curry General Hospital, Gold Beach

Dunes Family Health Care, Reedsport

Gifford Medical Center, Hermiston

Good Shepherd Medical Center, Hermiston

Good Shepherd Medical Group, Hermiston

Harney District Hospital, Burns

Harney District Hospital Family Care, Burns

Ione Community Clinic, Ione

Irrigon Medical Center, Irrigon

Lake District Hospital, Lakeview

Lake Health Clinic, Lakeview

Lower Umpqua Hospital, Reedsport

Malheur Memorial Health Clinic, Nyssa

Mercy Medical Center, Roseburg

North Bend Medical Centers, Coos Bay,  
Bandon, Gold Beach

OHSU Family Medicine, Scappoose

Orchid Health Clinic, Oakridge

PeaceHealth Cottage Grove Community Medical Center,  
Cottage Grove

PeaceHealth Peace Harbor Medical Center, Florence

Pioneer Memorial Hospital and Nursing Facility, Heppner

Pioneer Memorial Clinic, Heppner

Reedsport Medical Clinic, Reedsport

Saint Alphonsus Medical Center, Baker City

Salem Health West Valley, Dallas

Samaritan Coastal Clinic, Lincoln City

Samaritan Medical Clinic, Lincoln City

Samaritan North Lincoln Hospital, Lincoln City

South Gilliam Health Center, Condon

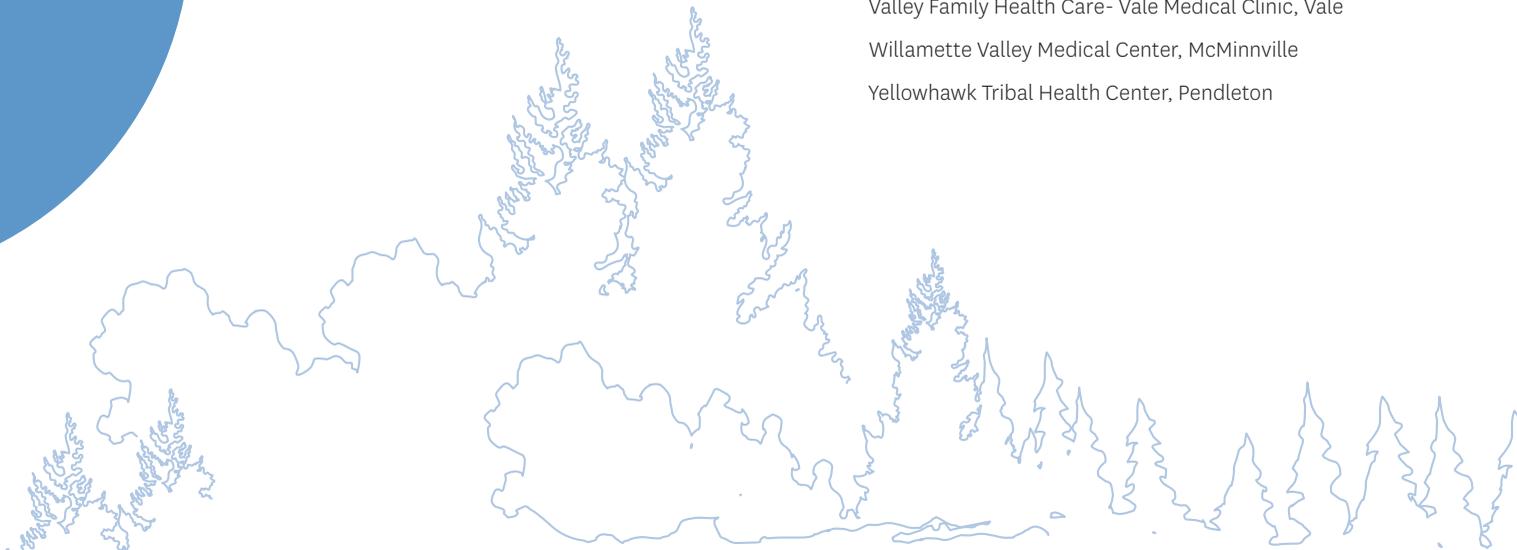
Strawberry Wilderness Community Clinic, John Day

Tillamook Regional Medical Center, Tillamook

Valley Family Health Care- Vale Medical Clinic, Vale

Willamette Valley Medical Center, McMinnville

Yellowhawk Tribal Health Center, Pendleton



# Thank You Participating Partners

*Facility participants were asked to choose which partners and representatives they would like the Oregon Office of Rural Health to bring to their visit. Thank you to the 36 partners who participated in this year's Listening Tour.*

## CareOregon

Mindy Stadtlander  
*Director of Network and  
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## Columbia Pacific Coordinated Care Organization

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*Executive Director*

## Eastern Oregon Coordinated Care Organization/Greater Oregon Behavioral Health, Inc. (EOCCO/GOBHI)

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*Executive Director*

## Oregon Association of Hospitals and Health Systems (OAHHS)

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*Associate Vice President  
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Barb Van Slyke  
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## Oregon Health Authority (OHA)

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*Executive Director*

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*Operations and Policy Analyst*

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*Licensing Manager*

## Oregon Representatives

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Dallas Heard  
*District 2*

## Oregon Rural Practice-Based Network (ORPRN)

Angela Combe  
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*Comprehensive Primary Care Initiative  
Practice Enhancement Research  
Coordinator*

Beth Sommers  
*Practice Enhancement Research  
Coordinator*

## Oregon Senators and Staff

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*District 16*

Senator Arnie Roblan  
*District 5*

Rosie Shatkin  
*Policy Advisor for Senator Arnie Roblan*

Adam Walsh  
*Senator Arnie Roblan's Office*

## Trillium Coordinated Care Organization

Jim Connolly  
*Vice President of  
Network Development*

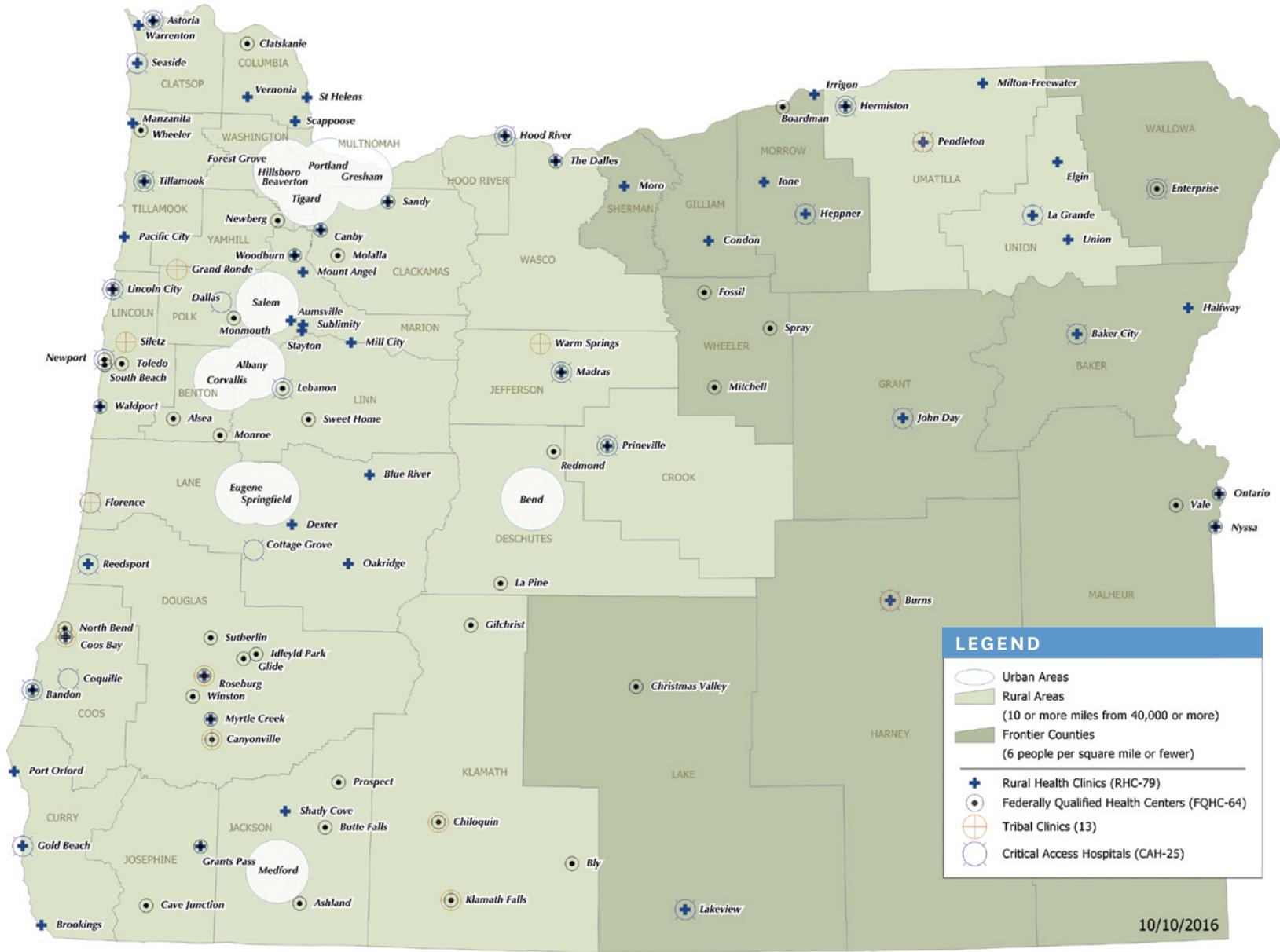


# INTRODUCTION

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36% of Oregon's population lives  
in rural and frontier communities.

# SAFETY NET FACILITIES IN RURAL AND FRONTIER OREGON



**LEGEND**

- Urban Areas
- Rural Areas  
(10 or more miles from 40,000 or more)
- Frontier Counties  
(6 people per square mile or fewer)
- Rural Health Clinics (RHC-79)
- Federally Qualified Health Centers (FQHC-64)
- Tribal Clinics (13)
- Critical Access Hospitals (CAH-25)

RHCs: [http://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Documents/RHC\\_List.pdf](http://public.health.oregon.gov/ProviderPartnerResources/HealthcareProvidersFacilities/HealthcareHealthCareRegulationQualityImprovement/Documents/RHC_List.pdf)  
 FQHCs: <http://datawarehouse.hrsa.gov/tools/DataPortal.aspx>  
 Tribal Clinics: [http://www.npalhb.org/member Tribes/oregon\\_member Tribes](http://www.npalhb.org/member Tribes/oregon_member Tribes)  
 CAHs: <http://www.ohsu.edu/xd/outreach/oregon-rural-health/hospitals/cah.cfm>

## What Is Rural and Frontier?

The Oregon Office of Rural Health (ORH) defines rural as any geographic areas in Oregon ten or more miles from the centroid of a population center of 40,000 people or more.

Frontier counties are defined as those with six or fewer people per square mile. ORH has identified 10 of Oregon's 36 counties as frontier.

The Oregon Office of Rural Health analyzes data at the zip code level in order to identify the unique characteristics of communities. To do this, ORH breaks Oregon into 130 Primary Care Service Areas, 86 of which are rural and 18 are frontier. These areas are updated annually according to changes in population and health utilization.

For more information on definitions of rural and frontier, and a map of the primary care service areas, visit our website at: [www.ohsu.edu/orh](http://www.ohsu.edu/orh).

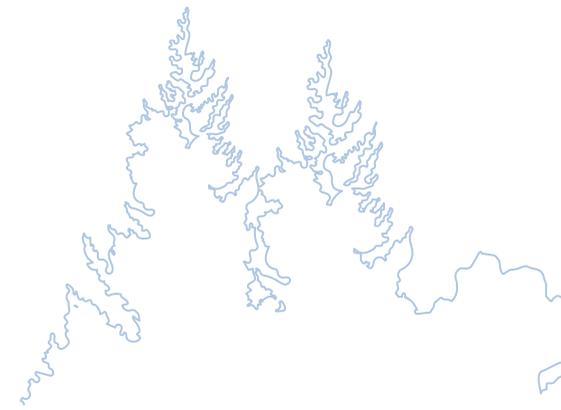
## Frontier Is Not the Same as Rural

Being a frontier facility requires thinking differently about service and staffing models. Distances to specialty care and higher level trauma hospitals are greater. For example, a patient at South Gilliam Health Center in Condon is carried by ambulance 70 miles one-way to the nearest hospital. When discharged, the patient must coordinate and finance transportation for the 70-mile trip home. With distances like these, frontier facilities must work more independently than their urban or rural colleagues. For a frontier facility, this necessitates recruiting providers who are skilled and comfortable working without a nearby referral safety net.

Most frontier facilities do not have a large enough population to pay for expanded services (through health tax district funds or patient volume). Instead they must rely on impermanent grant or state funds, resulting in an increased need for staff to focus on care coordination and grant administration. As one hospital CEO stated, "Here a grant, there a grant... everywhere a grant, grant."

## Borders Are a Challenge

For facilities near state borders or Coordinated Care Organization (CCO) coverage area boundaries, referrals and coordinating care can be a challenge. Patient preferences often do not align with these borders. For example, a patient may prefer to seek specialist care in the closest city rather than travel further in order to stay within the CCO coverage area or within Oregon. Many facilities are struggling with the lack of specialist referrals available in their area, the length of time for the out-of-network referral to be approved and length of time following approval before specialists can see a patient. Adding to this care coordination challenge is the impact of having little or no health information exchange within Oregon and between states.



*“Hospital leadership is not unique—we need to share resources.”*

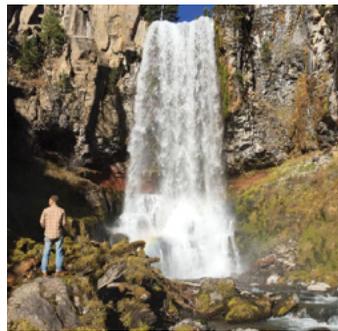
— CEO OF A CRITICAL ACCESS HOSPITAL

## Regional Scale and Solutions Are Needed

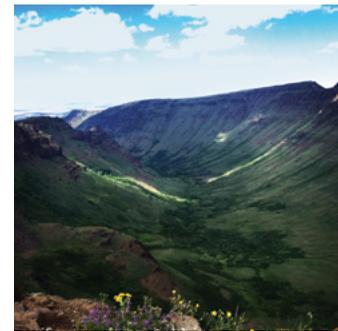
To offset the expenses and challenges that result from being in remote areas, regional partnerships have become increasingly important. Partnership initiatives highlighted during the Listening Tour included:

- Collaboration by Veterans Affairs and southern Oregon hospitals to develop an accredited allied and mental health college in Roseburg;
- Partnership between Curry General Hospital in Gold Beach and Coast Community Health Center in Bandon to improve services in Port Orford; and
- A successful collaborative grant application for regional Lean training by Grant, Harney, Lake and Morrow Health Districts.

Suggestions for where regional partners could work together to create scale included: leadership and new staff training, administrative support services, data collection, home and social support services, and regulatory compliance.



Tumalo Falls



Kiger Gorge

Wasco

# WORKFORCE

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Recruiting and retaining a qualified workforce continues to be a priority challenge for rural and frontier health facilities.



## Provider Recruitment and Retention

The most commonly discussed provider shortages focused on primary care providers, dentists, behavioral health specialists and ancillary staff.

Facilities differed on preferences for new graduates versus experienced providers. While some prefer experienced providers, others prefer to hire new graduates who are knowledgeable about technology and ready to build a practice.

The most commonly discussed concerns about provider recruitment and retention included:

- Funding recruitment incentives
- Loan repayment and forgiveness program restrictions
- Regional competition
- Residencies and rotations to get students into the communities
- Finding the right fit for the community- not just the job
- Housing availability and affordability
- Process delays for licensing
- Process delays for provider and payor credentialing

## Administration and Leadership

While enthusiastic about health reform, facilities are concerned about regulatory change and requirements. Rapidly changing regulations often necessitate additional staff work with no additional reimbursement, creating either untenable workloads for current staff or the need to hire staff not budgeted for. As one hospital CEO noted, “Rural hospitals are held to the same standards, but with fewer resources.”

As a result of high senior leadership turnover during the past year, especially for CEOs at Critical Access Hospitals, facilities requested that a leadership workforce pool and career development opportunities be developed.

For detail on ORH and partner programs to address these challenges, including the Oregon Health Authority’s Common Credentialing and Provider Incentive programs, please visit the ORH website at [www.ohsu.edu/orh](http://www.ohsu.edu/orh).



John Day

*“I need a nurse, not a report.”*

— CLINIC ADMINISTRATOR

**WORKFORCE:**

# Availability and Affordability of Housing

A lack of affordable housing impacts a facility’s ability to recruit and retain providers and ancillary staff as well as its ability to coordinate care for patients whose housing difficulties can impact their access to healthcare or adherence to care plans.

### Support from Coordinated Care Organizations

- 9 provide short-term rental assistance*
- 8 provide services to keep individuals in permanent housing*
- 5 provide rental advocacy with property owners, including lease negotiations*

— OHA REPORT ON OREGON CCO HOUSING SUPPORTS: SEPTEMBER, 2016

Facilities located in high tourism communities, primarily along the Oregon coast, were concerned that lucrative vacation rentals through companies like VRBO and Airbnb are driving up rental prices and decreasing the amount of long-term rentals as well as homes for sale.

Facilities in communities such as John Day and Burns experience population increases due to seasonal workers (e.g., firefighters and farm workers), which impacts the availability of rentals in the spring and summer.

To illustrate these challenges for four service areas, the table shows census housing unit data\* as well as snapshot views of homes for sale on Zillow and available rentals on VRBO and Airbnb.

*“I personally have been acting as a realtor.”*

— A CHIEF NURSING OFFICER ON RECRUITING PROVIDERS

Population <i>Nielsen Claritas 2016 Population Facts by ZIP Code.</i>	Bandon 7,574	Burns 7,152	John Day 7,149	Tillamook 17,271
<b>HOUSING OCCUPANCY</b>				
<b>Total housing units</b>	<b>4,734</b>	<b>3,822</b>	<b>4,101</b>	<b>10,832</b>
Occupied housing units/percentage	3,869 / 82%	3,090 / 81%	3,120 / 76%	6,902 / 64%
Vacant housing units/percentage	865 / 18%	732 / 19%	981 / 24%	3,930 / 36%
Owner-occupied units/percentage	2,793 / 72%	2,094 / 68%	2,295 / 74%	4,607 / 67%
Rental-occupied units/percentage	1,076 / 28%	996 / 32%	825 / 26%	2,295 / 33%
<b>GROSS RENT</b>				
<b>Occupied units paying rent</b>	<b>941</b>	<b>818</b>	<b>659</b>	<b>2,113</b>
Median (dollars)	\$646	\$566	\$597	\$737
<b>AIRBNB (www.airbnb.com) RENTALS AS OF JANUARY 17, 2017</b>				
<b>Active rentals</b>	<b>39</b>	<b>3</b>	<b>16</b>	<b>25</b>
Rentals that are an entire home	28	1	12	23
<b>VRBO (www.vrbo.com) RENTALS AS OF JANUARY 17, 2017</b>				
<b>Active rentals (all full homes)</b>	<b>110</b>	<b>0</b>	<b>6</b>	<b>645</b>
<b>HOMES FOR SALE ON ZILLOW (www.zillow.com) AS OF JANUARY 16, 2017</b> <i>Information is from a search of Zillow for 2 to 4 bedrooms/ 1+ bathroom houses for sale. Any properties with 5+ bedrooms or 10+ acres of land were removed from the results.</i>				
<b>Number for sale</b>	<b>78</b>	<b>41</b>	<b>17</b>	<b>56</b>
Lowest price	\$89,000	\$35,000	\$56,500	\$62,400
Highest price	\$2,750,000	\$260,000	\$499,000	\$2,000,000
Median	\$399,000	\$99,000	\$105,000	\$395,000

\* Census data was obtained from the 2010-2014 American Community Survey for each ZIP Code that makes up the service areas. A housing unit is defined as: **a house, an apartment, a group of rooms, or a single room occupied or intended for occupancy as separate living quarters. Separate living quarters are those in which the occupants do not live and eat with other persons in the structure and which have direct access from the outside of the building or through a common hall.**

## WORKFORCE:

# The Nursing Challenge

Oregon is projected to have a shortage of nurses statewide by 2025. Rural and frontier areas are already experiencing shortages and are facing challenges with recruiting and retaining nurses at all levels.

## Developing a “Home-Grown” Nursing Workforce:

- Insufficient nursing faculty and education programs in rural and frontier Oregon limit the number of nurses available in these areas.
- Insufficient rural and frontier clinical training sites, especially for acute shortage specialties like obstetrics or ambulatory care, make finding nurses difficult.

## Recruiting a Nursing Workforce:

- Sites reported that a licensure compact in Oregon would allow rural and frontier sites to better compete for out-of-state nurses. Facilities described the time it takes to obtain an Oregon nurse license as unpredictable, ranging from two weeks to three months.
- Working as a nurse in a rural or frontier area requires an ability to work independently and to the full scope of their license.

For more information on the nursing workforce in Oregon, including information on Oregon’s nurse faculty challenges, visit the Oregon Center for Nursing’s website at: [www.oregoncenterfornursing.org](http://www.oregoncenterfornursing.org) and the Oregon State Board of Nursing at: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN).

### CERTIFIED NURSING ASSISTANTS (CNAs)

Practicing in Oregon (2014): **16,233**

Licensed in Oregon (2014): **18,414**

Level 2 approved training programs in Oregon (2015): **19**

Graduates: **NA**

Median hourly wage (2016): **\$14.42**

Median annual salary (2016): **\$29,987**

### LICENSED PRACTICAL NURSES (LPNs)

Practicing in Oregon (2014): **3,737**

Licensed in Oregon (2014): **4,660**

Approved training programs in Oregon (2015): **15**

Graduates (2015): **411**

Median hourly wage (2016): **\$23.32**

Median annual salary (2016): **\$48,515**

### REGISTERED NURSES (RNs)

Practicing in Oregon (2014): **38,832**

Licensed in Oregon (2014): **47,456**

Median hourly wage (2016): **\$39.51**

Median annual salary (2016): **\$82,181**

**ASSOCIATE DEGREE**  
Available seats at approved schools (2014-2015): **778**

Total number of applicants (2014-2015): **2,738**

Total number of new graduates (2014-2015): **613**

**BACCALAUREATE DEGREE**  
Available seats at approved schools (2014-2015): **832**

Total number of applicants (2014-2015): **4,293**

Total number of new graduates (2014-2015): **747**

### NURSE PRACTITIONERS (NPs)

Practicing in Oregon (2014): **2,404**

Licensed in Oregon (2014): **2,794**

Approved training programs in Oregon (2015): **2**

Graduates: **NA**

Median hourly wage (2016): **\$53.17**

Median annual salary (2016): **\$110,603**

#### SOURCES:

Supply Statistics: Oregon Health Authority “Oregon Health Professions: Occupational and County Profiles” found at [www.oregoncenterfornursing.org/reports](http://www.oregoncenterfornursing.org/reports).

Training/Graduate rates: Oregon State Board of Nursing: [www.oregon.gov/OSBN/Pages/educational\\_programs.aspx](http://www.oregon.gov/OSBN/Pages/educational_programs.aspx) and [www.oregon.gov/OSBN/pdfs/passrates.pdf](http://www.oregon.gov/OSBN/pdfs/passrates.pdf).

Average salaries: State of Oregon Employment Department: <https://www.qualityinfo.org>

Many facilities noted a need for ancillary medical staff; specifically, for Credentialed Medical Assistants (CMAs) - a critical component of facility staffing and team-based care models. The shortage of CMAs is illustrative of the need for access to education and financial support for all levels of healthcare staff in rural and frontier areas.

## What Is Meaningful Use?

Meaningful Use (MU) is a federal program that provides financial incentive to Eligible Providers (EPs) and facilities for the transition to, and use of electronic health records (EHRs). Meaningful Use payments can be an important source of financial support. During the first year, facilities that implemented a certified EHR received \$21,250 for each of their Medicaid EHR Incentive EPs. Years two through five, facilities receive \$8,500 per EP that achieves MU.

## The Role of Credentialed Medical Assistants

One MU requirement is computerized physician order entry (CPOE), entering clinician instructions electronically in order to reduce errors. In practice settings, Medical Assistants (MA) may complete these tasks under the supervision of an EP, allowing the EP to spend more time providing direct patient care. The use of non-credentialed MAs to complete CPOE can put EPs and facilities at risk of not receiving significant MU dollars.

## Credentialing Medical Assistants

Facilities noted that there is interest from community members to become CMAs. However, tuition costs and the distance to attend education programs often contribute to the limitations of a “home-grown” solution.

Employment opportunity for MAs in Oregon is expected to grow by 24.6%, with 441 total job openings yearly, from 2014 to 2024.\*

- In 2014, 26 Oregon MA programs graduated 1,206 students.
- 15 of those programs were in urban/metro areas.
- Only 2 programs were west of The Dalles, in Ontario and Pendleton.

### *A Medical Assistant can be credentialed by:*

1. Graduating from an accredited MA program. This qualifies students to take an exam to become credentialed by the accrediting body affiliated with their program.

There is no single, standard accrediting body for certified MA education programs. Tuition costs for these programs ranged from approximately \$4,400 to \$15,000 in 2016.

2. Previously licensed and working but non-credentialed MAs may take some accrediting organizations’ credentialing exams if they meet requirements. Exams need to be taken at a test center that provides proctoring, most of which are in urban areas.

To help reduce the travel costs for MAs wishing to take credentialing exams, facilities such as Harney District Hospital and Winding Waters Clinic have found accrediting organizations that certify facility staff as proctors and enable facilities to become approved testing sites.

## WORKFORCE:

# Health Information Technology

A fundamental Health Information Technology (HIT) challenge in rural and frontier Oregon is a lack of broadband availability and limited internet access. Examples of challenges for facilities included: limiting simultaneous internet users to ensure there is enough bandwidth for critical functions, frequently losing internet access due to seasonal weather, an inability to provide direct-to-home telehealth services or for patients to access their records electronically because of little or no internet access in outlying communities.

Facilities raised multiple HIT concerns impacting providers and care coordination. They included:

- The need and cost to increase IT staff to manage HIT components of work and keep pace with an evolving HIT environment;
- Limitations of Electronic Health Records and frustrations with prohibitive costs to upgrade or improve functionality;
- The lack of system interoperability between facilities and referral networks, including behavioral health and Home Health Agencies;
- The need for improved electronic health information exchange (including across state borders) for care coordination.

*“One of the first questions I get asked by potential recruits is “what EHR do you use?””*

— HOSPITAL DIRECTOR OF HUMAN RESOURCES

## Oregon Health Authority Information Technology to Support Providers:

**The Oregon Prescription Drug Monitoring Program (PDMP)** to support the appropriate use of prescription drugs. Pharmacies submit prescription data to the PDMP system for all Schedule II, III and IV controlled substances dispensed to Oregon residents.

**The Emergency Department Information Exchange (EDIE)** to enable emergency department clinicians to identify patients who visit the emergency room more than five times in a 12 month period or patients with complex care needs. EDIE alerts hospitals in real time through the EHR or fax, enabling instant viewing of patient information.

**PreManage** to leverage the EDIE data and send hospital utilization information, as well as care guidelines to pre-defined health plans, CCOs, and provider groups (including behavioral health and long-term care) on a real-time basis for specified member or patient populations.

**The Oregon Common Credentialing Program (OCCP) (expected in 2018)** to minimize health care practitioner burdens and credentialing organization redundancies. Under the OCCP, providers must submit their credentialing information to a web-based system which all credentialing organizations will be required to use, rather than each organization collecting and verifying it separately.

**Oregon’s Provider Directory (expected in 2018)** to serve as an accurate source of healthcare practitioner and practice information needed for operations, analytics and health information exchange.

*“I feel like our EHR vendor has a gag order on me.”*

— A HOSPITAL CFO ON THE NEED FOR STATE OVERSIGHT OF EHR VENDORS TO CONTROL COSTS AND QUALITY OF SERVICES PROVIDED

*“We’re doing a lot of faxing...”*

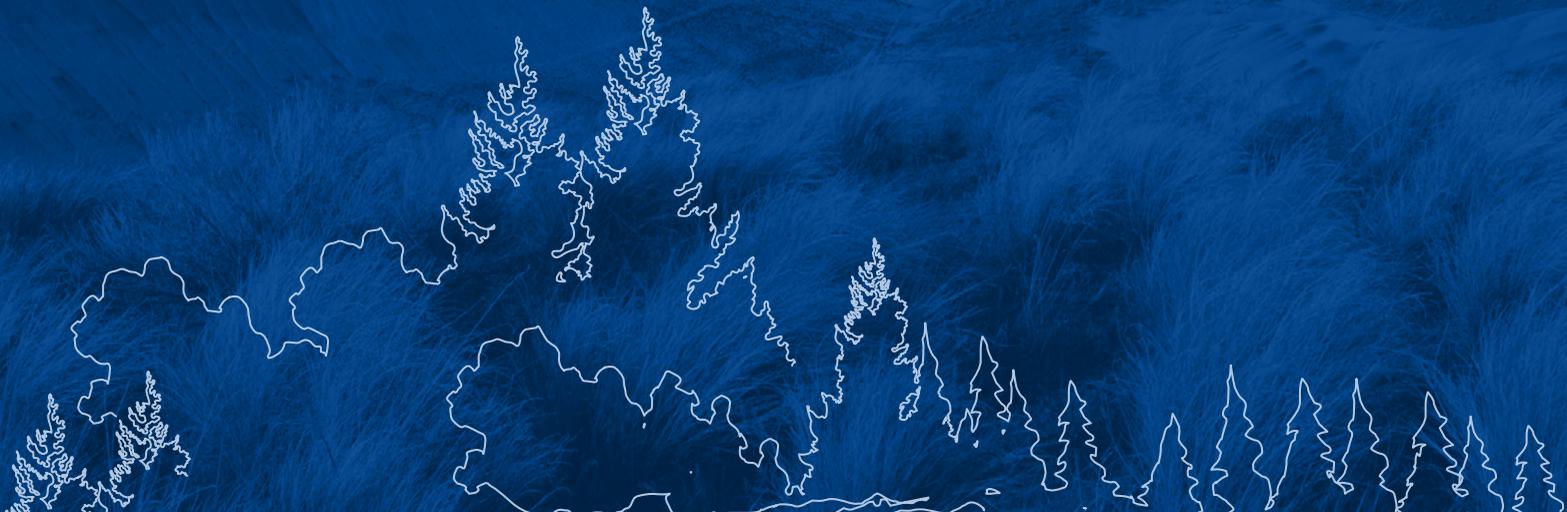
— A CLINIC PROVIDER ON THEIR INTERNET CONNECTIVITY



# ACCESS

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Access to primary care providers, specialists and acute care placement options remains a challenge that contributes to changing service delivery models.



*“We are in the messy middle between volume and value.”*

— CEO OF A CRITICAL ACCESS HOSPITAL

### Specialists and Primary Care Providers

It is not feasible for many remote, low volume hospitals to hire full-time specialists. Rural and frontier facilities often depend on primary care providers for an expanded scope of services. Many facilities discussed efforts to educate their patients and communities about the services primary care providers can provide locally, to try and deter patients from traveling far distances to see specialists (e.g. pediatricians).

However, many facilities continue to have difficulty recruiting and retaining primary care providers. At the time of the listening tour visit, one hospital had recently published a letter to the community apologizing for the high turnover in primary care providers and explaining the changes they were making to improve recruitment efforts.

Other avenues to provide specialist access include telehealth programming and traveling or contracted specialists. The lack of telehealth reimbursement, available specialists and slow Medicaid pre-authorizations were commonly identified barriers.

### Lack of Acute Care Placements

A consistently discussed challenge for facilities was the lack of acute care availability in their areas. This included:

- **Acute mental health care beds**  
Many hospitals continue to report significant difficulty finding inpatient treatment for mental health patients, necessitating lengthy stays in emergency department hold rooms.
- **Substance abuse treatment**  
Many facilities referenced the lack of coordination between mental health and addiction services in their county and the growing need for addiction and substance abuse resources- including specialized mental health providers, treatment facilities and medical interventions such as Suboxone.
- **Long-term care**  
Facilities reported that the lack of Home Health Agencies and residential long-term care facilities makes it difficult for patients to find care close to home. Two facilities highlighted that Traumatic Brain Injury and aging dementia patients continue to be brought to hospital hold rooms due to a lack of memory care unit beds.

### New Models of Care

Many of the independent and smaller hospitals discussed recent transitions in their service models, partly as a result of access challenges. Specifically, they are shifting towards outpatient and urgent care, with concerns about how to use shrinking revenue to build stronger ambulatory programs.

#### In 2017, the Oregon Health Authority plans to release:

1. Recommendations from the Behavioral Health Collaborative on building a 21st Century Behavioral Health System.
2. A report, with recommendations, to the Oregon legislature regarding the problem of boarding patients with mental illness in hospital emergency departments.
3. A behavioral health mapping tool.

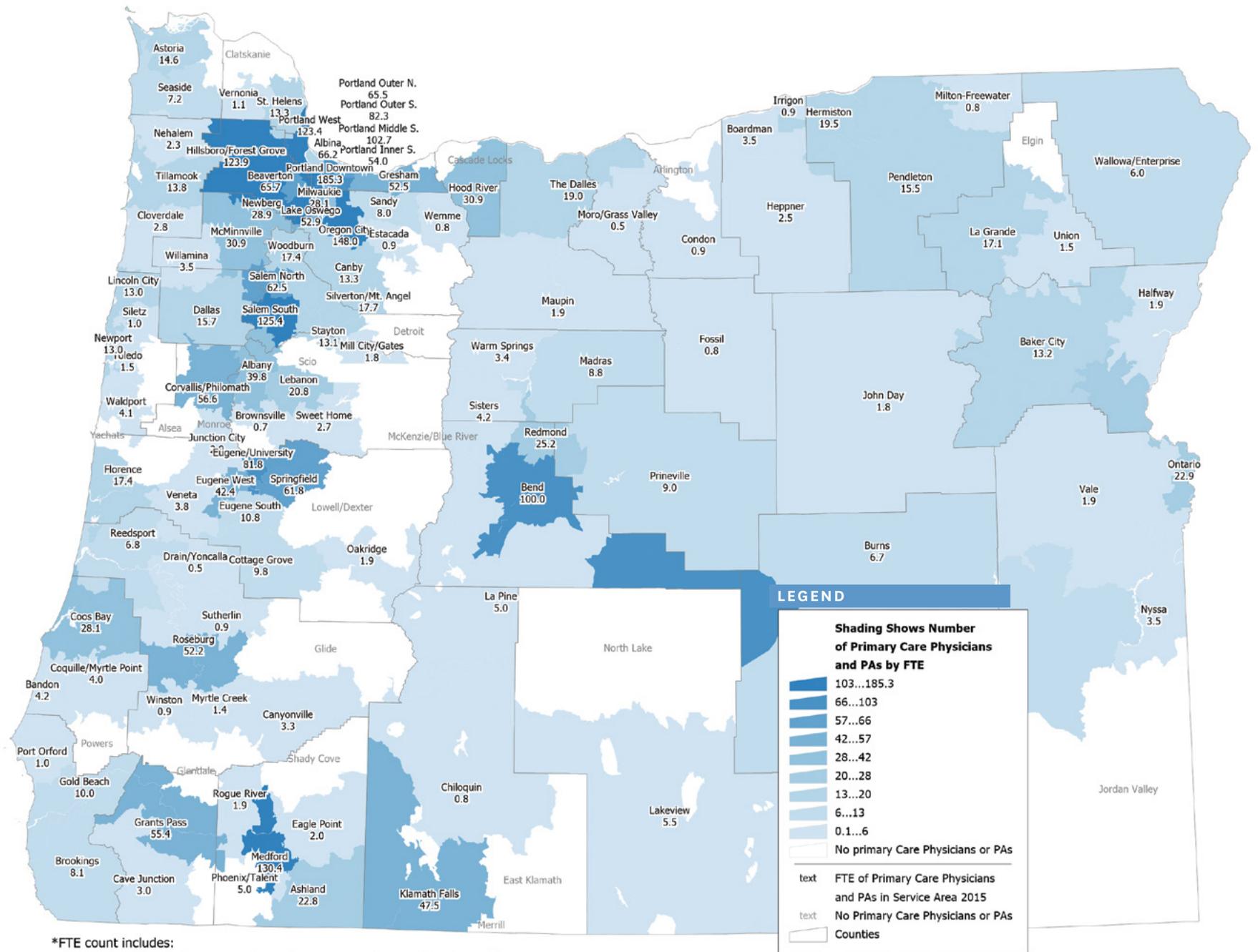
*These will be accessible on the ORH website once they are made available.*

*The primary care and specialist maps include physicians and physician assistants (PAs). In rural and frontier Oregon PAs often manage full patient caseloads under their supervising physician. Additionally, specialists from larger epicenters often travel to small communities to see patients. Many specialists have integrated PAs into these rotations.*

**Primary Care Physicians and Physician Assistants FTE by Service Area, 2015**

The percentage of rural Oregonians with insurance coverage has increased since the introduction of the Affordable Care Act as has the number of physicians practicing in Oregon. While not reaching optimum per capita levels, the increase of physicians in rural and frontier Oregon is encouraging.

<i>Key Statistics</i>	2013	2015	% Change
<b>OREGON</b>			
<b>Primary Care Physicians</b>	2,247.9	2,417.2	7.5
<b>Population</b>	3,898,000	3,975,135	2.0
<b>URBAN</b>			
<b>Primary Care Physicians</b>	1,619.9	1,772.6	9.4
<b>Population</b>	2,480,504	2,549,131	2.8
<b>RURAL</b>			
<b>Primary Care Physicians</b>	532.3	548.3	3.0
<b>Population</b>	1,324,196	1,333,205	0.7
<b>FRONTIER</b>			
<b>Primary Care Physicians</b>	47.9	48.1	0.4a
<b>Population</b>	93,300	92,799	-0.5

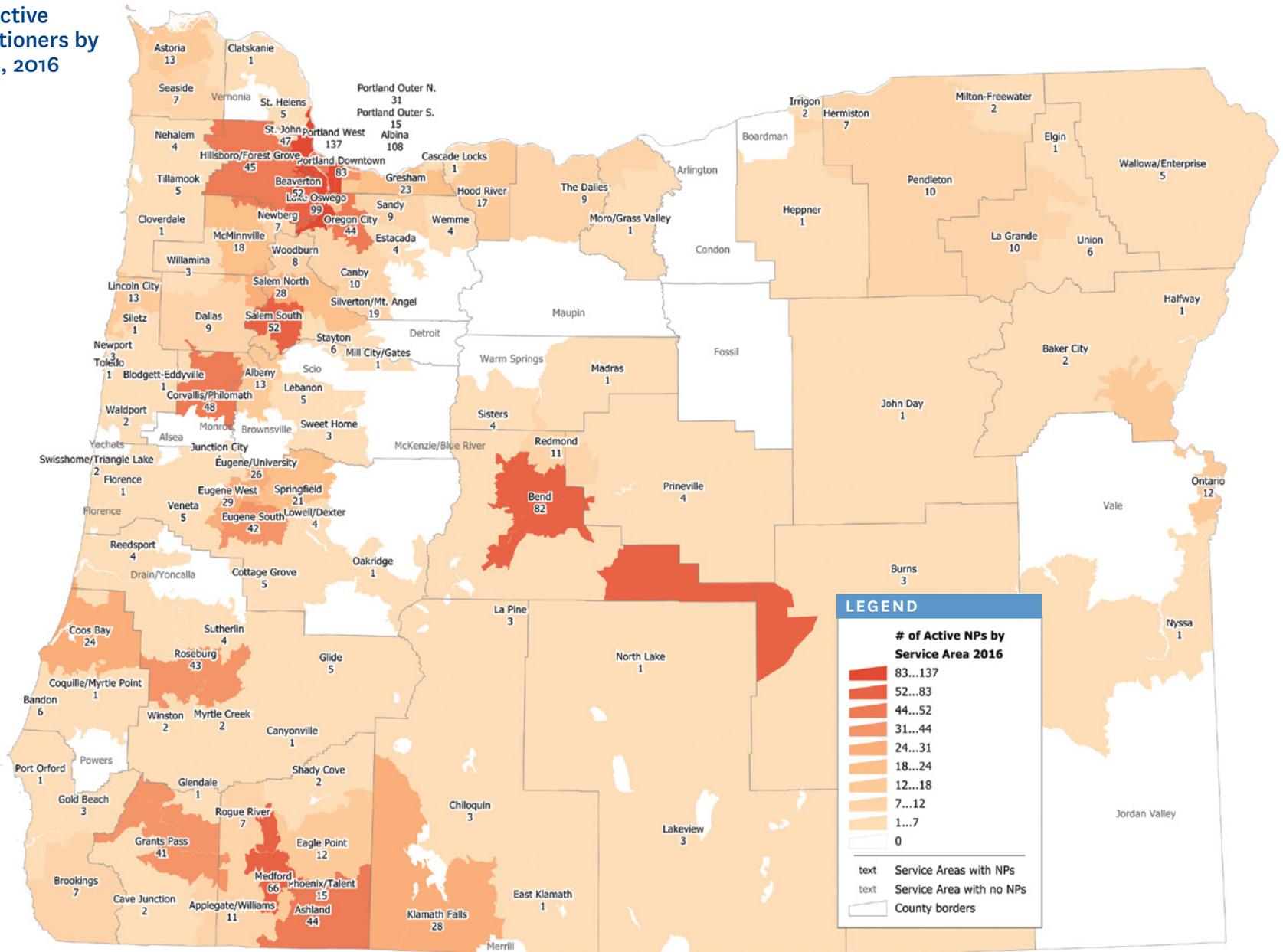


\*FTE count includes:  
 Family Medicine, Family Practice, General Practice, and Internal Medicine 2015

SOURCE: Oregon Medical Board, 2015

# ACCESS: Primary Care Providers

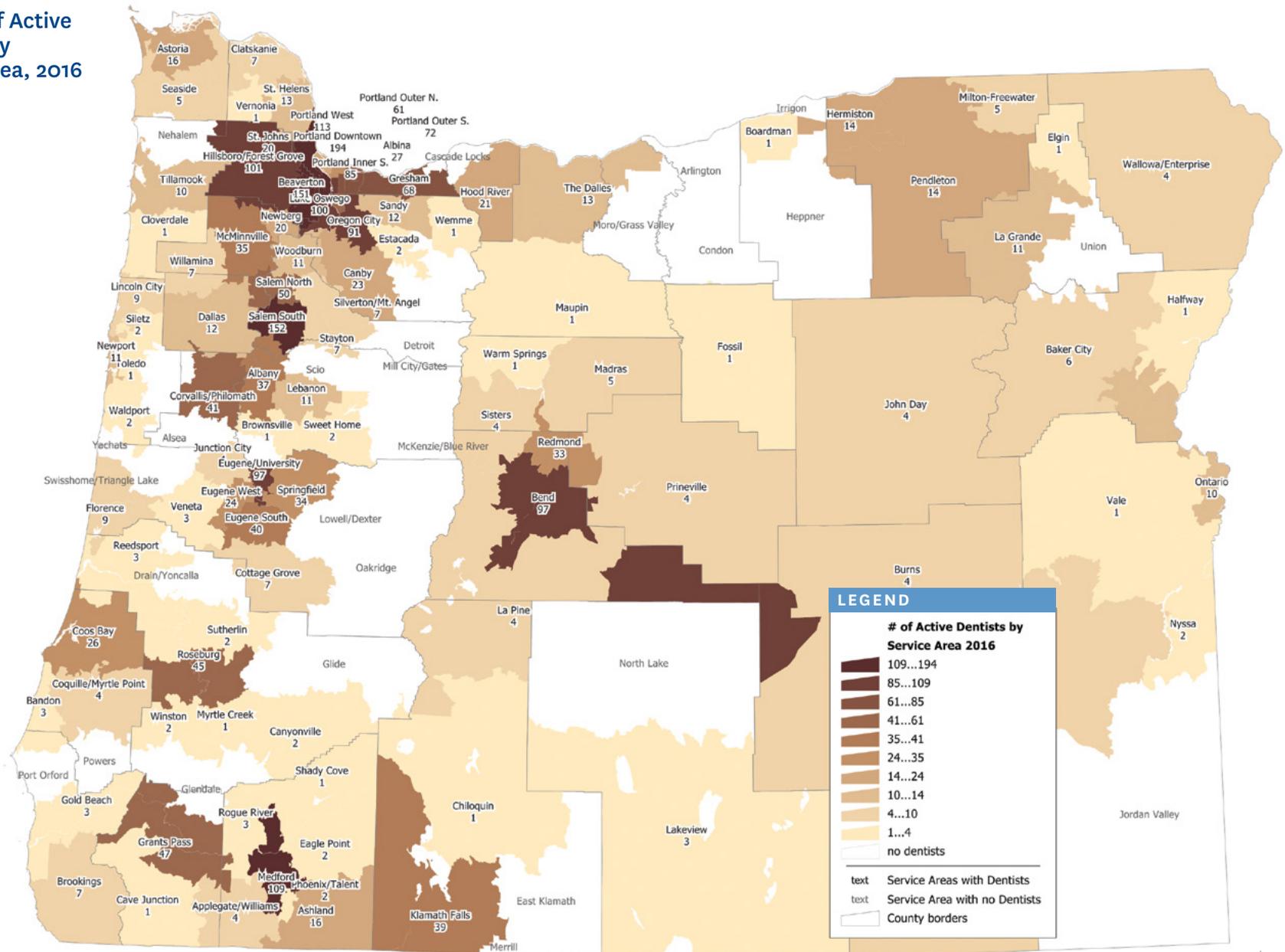
## Number of Active Nurse Practitioners by Service Area, 2016



\*NP licensure data only contains NPs who have not opted out of being listed.  
 NP counts are mapped according to mailing address as work addresses are not available.

# ACCESS: Primary Care Providers

Number of Active Dentists by Service Area, 2016

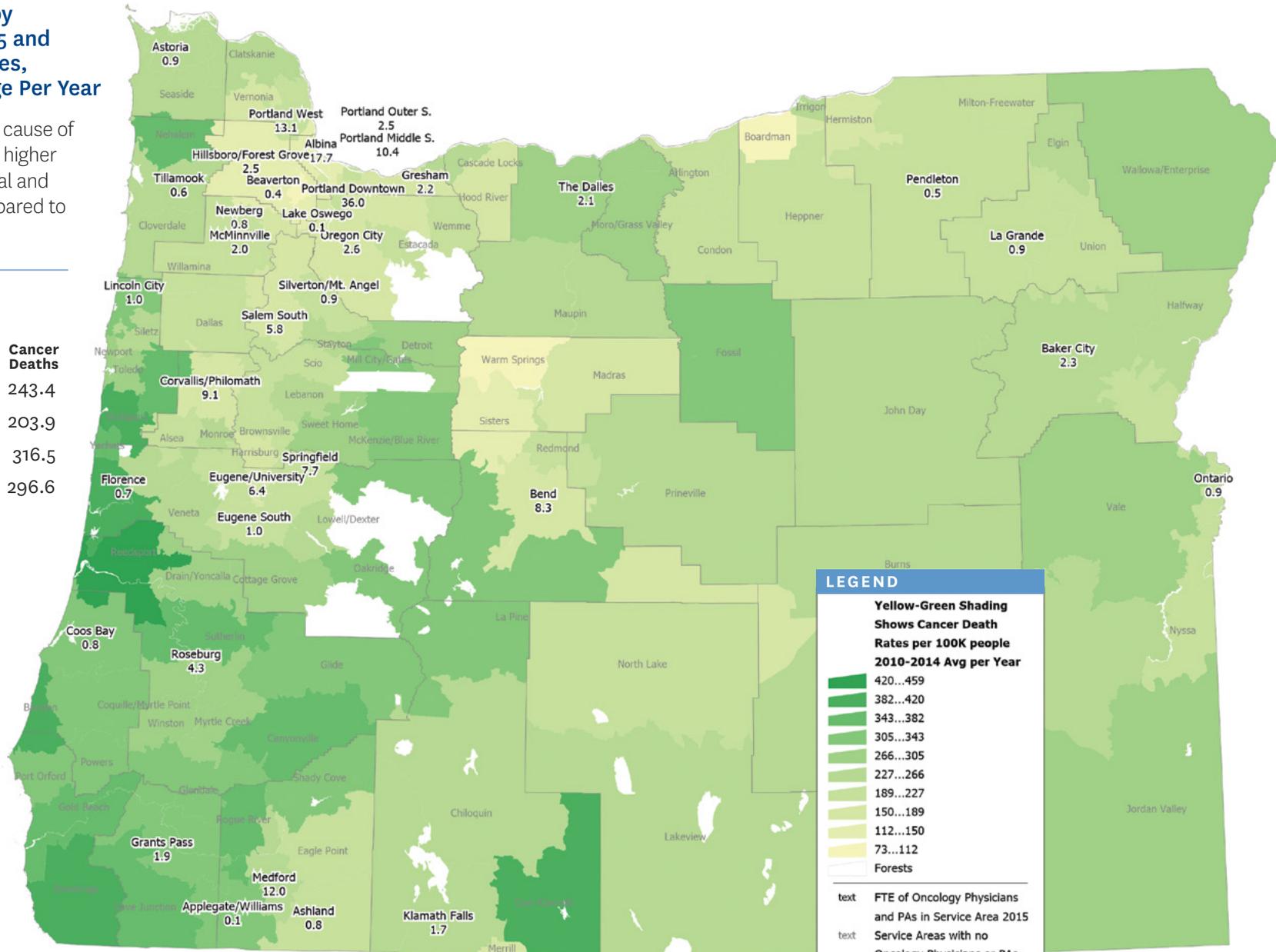


### Oncologists FTE by Service Area, 2015 and Cancer Death Rates, 2010-2014 Average Per Year

Cancer is the leading cause of death in Oregon with higher mortality rates in rural and frontier Oregon compared to urban areas.

#### Key Statistics

	Total Deaths Per 100,000 People	Cancer Deaths
<b>Oregon</b>	820.9	243.4
<b>Urban</b>	708.1	203.9
<b>Rural</b>	1,020.9	316.5
<b>Frontier</b>	1,051.1	296.6



**LEGEND**

**Yellow-Green Shading Shows Cancer Death Rates per 100K people 2010-2014 Avg per Year**

- 420...459
- 382...420
- 343...382
- 305...343
- 266...305
- 227...266
- 189...227
- 150...189
- 112...150
- 73...112

Forests

text FTE of Oncology Physicians and PAs in Service Area 2015

text Service Areas with no Oncology Physicians or PAs

Counties

\*Oncology FTE includes: Gynecologic Oncology, Medical Oncology, Oncology, and Radiation Oncology

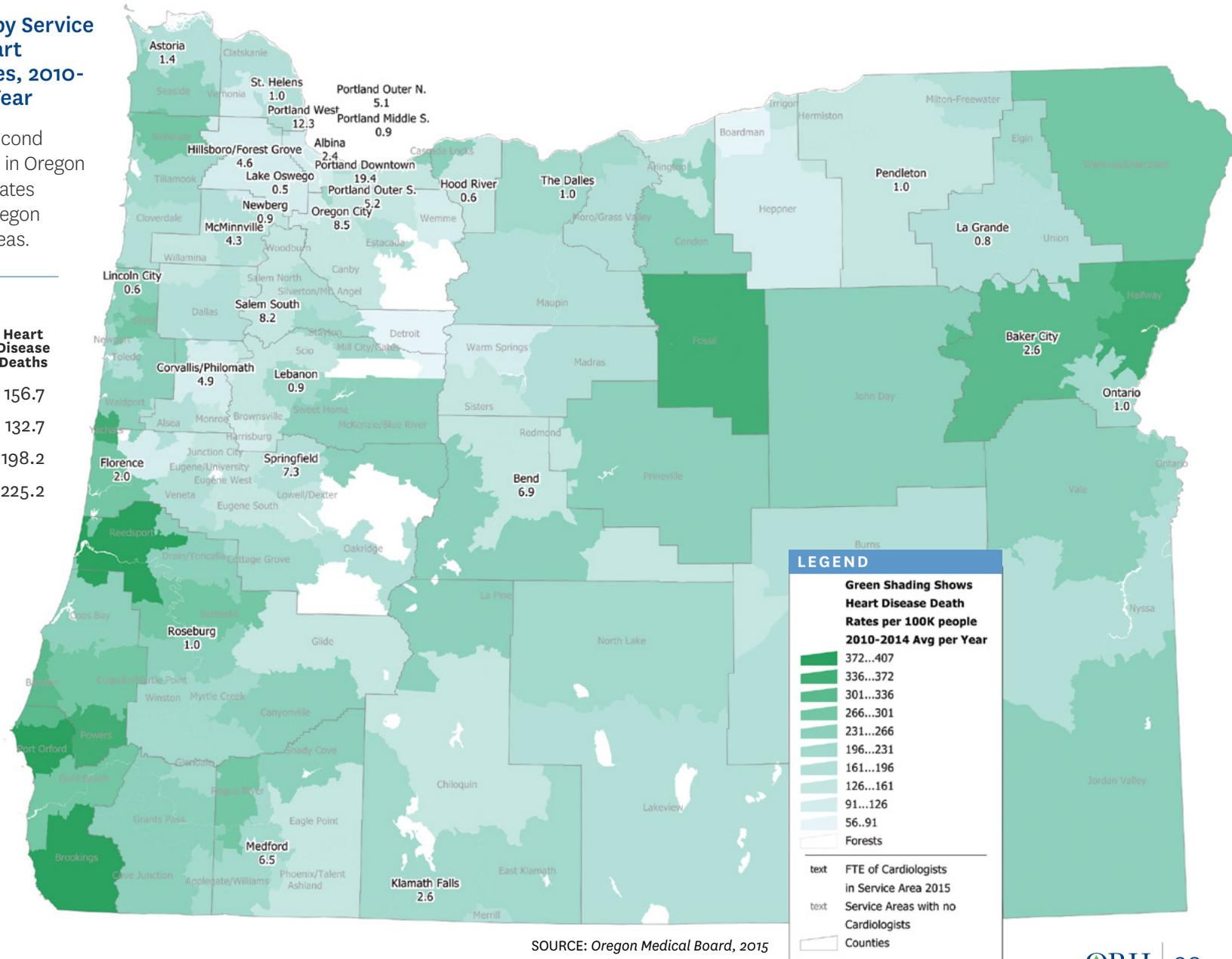
SOURCE: Oregon Medical Board, 2015

**Cardiologists FTE by Service Area, 2015 and Heart Disease Death Rates, 2010-2014 Average Per Year**

Heart disease is the second leading cause of death in Oregon with higher mortality rates in rural and frontier Oregon compared to urban areas.

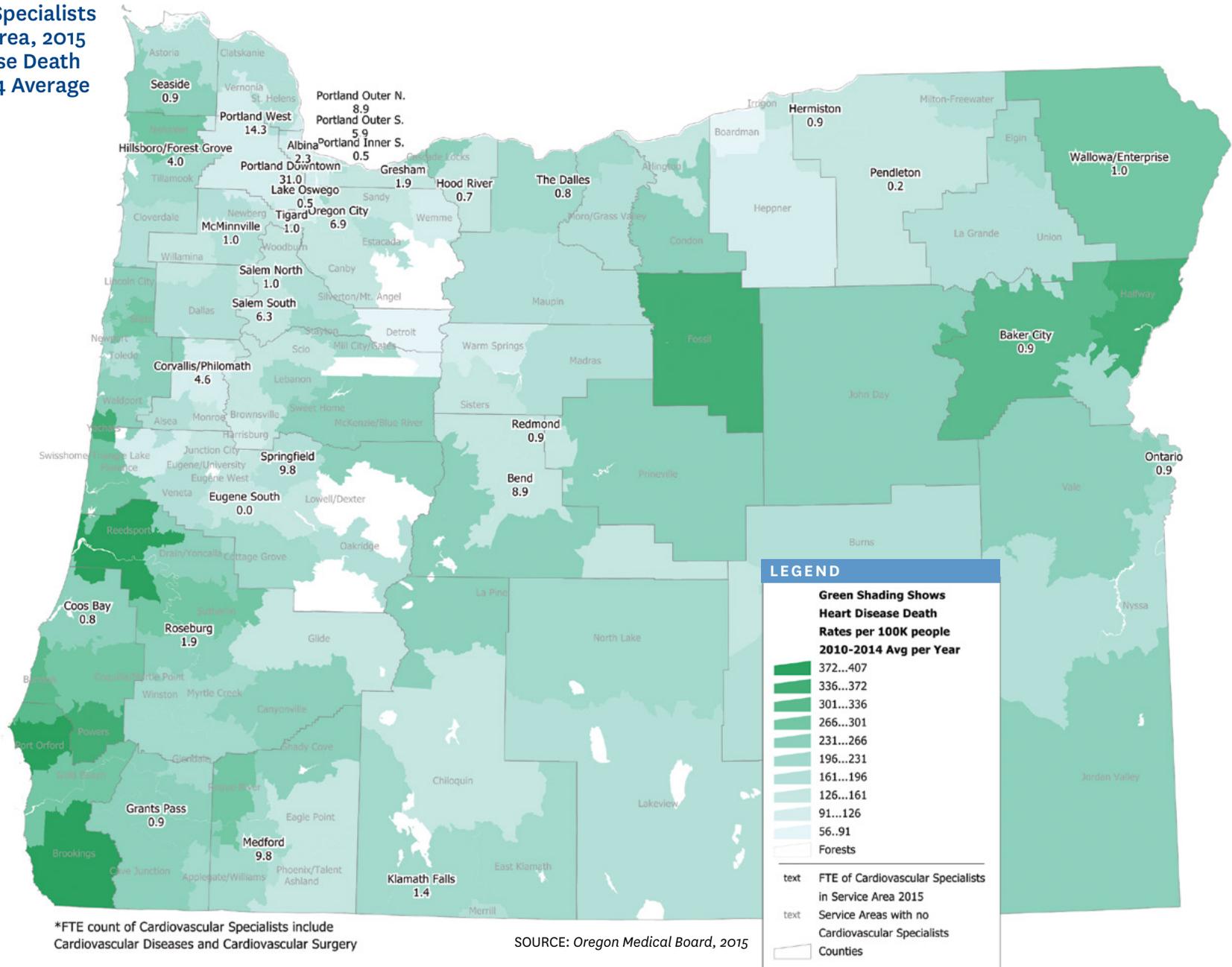
*Key Statistics*

	Total Deaths Per 100,000 People	Heart Disease Deaths
<b>Oregon</b>	820.9	156.7
<b>Urban</b>	708.1	132.7
<b>Rural</b>	1,020.9	198.2
<b>Frontier</b>	1,051.1	225.2



SOURCE: Oregon Medical Board, 2015

Cardiovascular Specialists FTE by Service Area, 2015 and Heart Disease Death Rates, 2010-2014 Average Per Year



\*FTE count of Cardiovascular Specialists include Cardiovascular Diseases and Cardiovascular Surgery

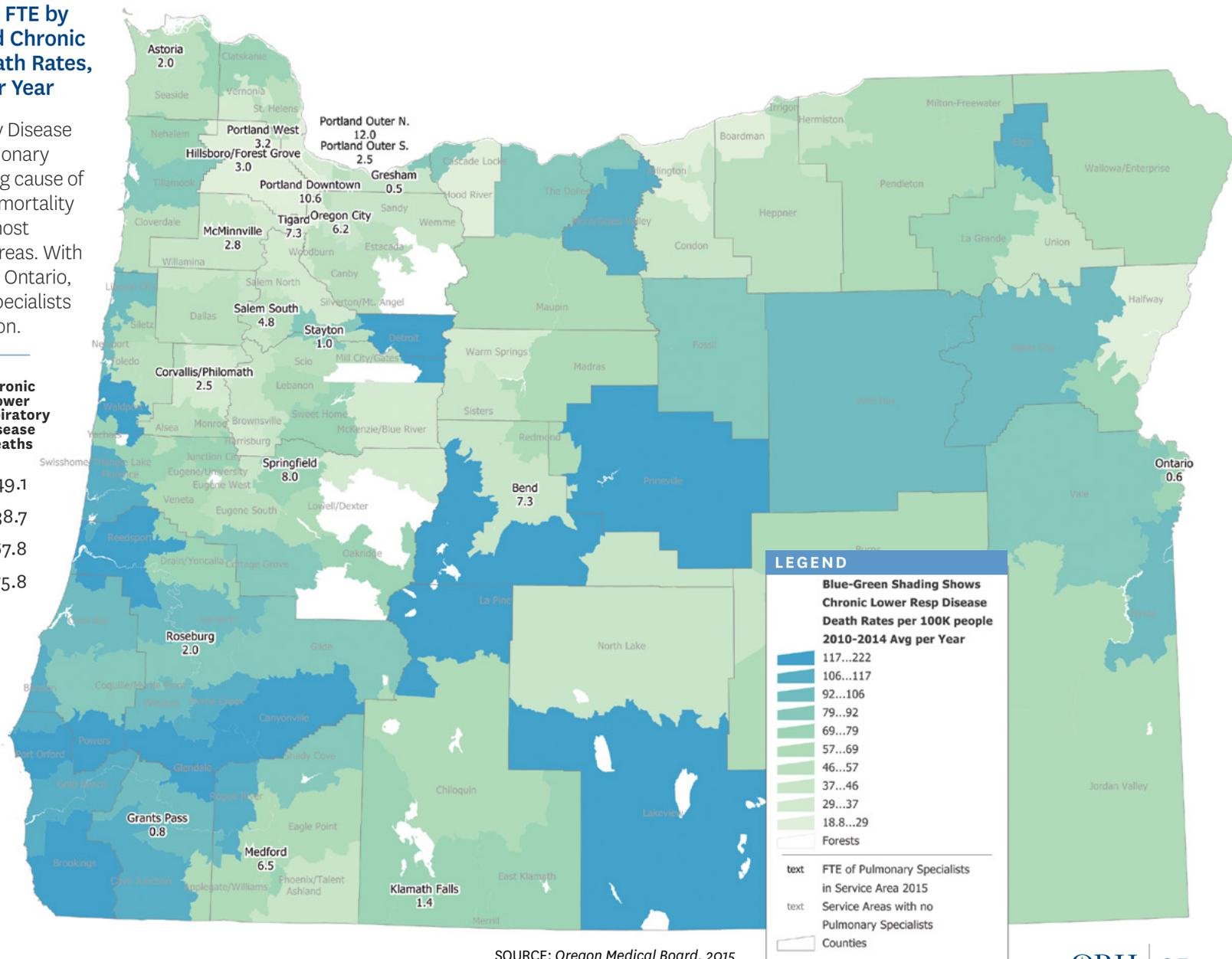
SOURCE: Oregon Medical Board, 2015

**Pulmonary Specialists FTE by Service Area, 2015 and Chronic Lower Respiratory Death Rates, 2010-2014 Average Per Year**

Chronic Lower Respiratory Disease (Chronic Obstructive Pulmonary Disease) is the third leading cause of death in Oregon, with the mortality rate in frontier Oregon almost double the rate of urban areas. With the exception of Bend and Ontario, there are no pulmonary specialists in central or eastern Oregon.

*Key Statistics*

	Total Deaths Per 100,000 People	Chronic Lower Respiratory Disease Deaths
<b>Oregon</b>	820.9	49.1
<b>Urban</b>	708.1	38.7
<b>Rural</b>	1,020.9	67.8
<b>Frontier</b>	1,051.1	75.8



SOURCE: Oregon Medical Board, 2015

A recent telehealth pilot project, funded by the Oregon State Innovation Model funds, may offer assistance to rural and frontier Alzheimer's patients and their caregivers:

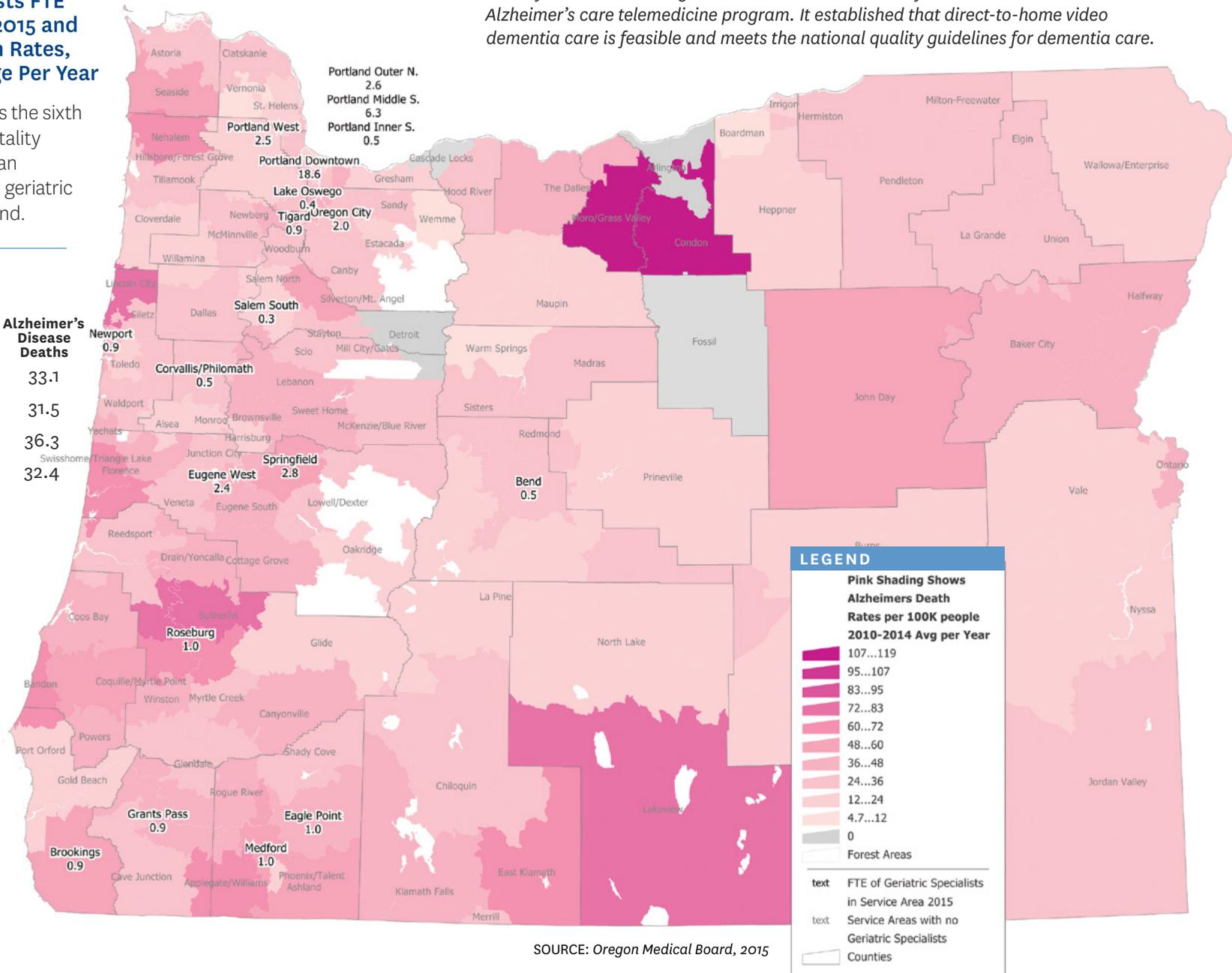
The Layton Center at Oregon Health & Science University created a direct-to-home Alzheimer's care telemedicine program. It established that direct-to-home video dementia care is feasible and meets the national quality guidelines for dementia care.

## Geriatric Specialists FTE by Service Area, 2015 and Alzheimer's Death Rates, 2010-2014 Average Per Year

Alzheimer's Disease is the sixth leading cause of mortality in both rural and urban Oregon. There are no geriatric specialists east of Bend.

### Key Statistics

	Total Deaths Per 100,000 People	Alzheimer's Disease Deaths
<b>Oregon</b>	820.9	33.1
<b>Urban</b>	708.1	31.5
<b>Rural</b>	1,020.9	36.3
<b>Frontier</b>	1,051.1	32.4



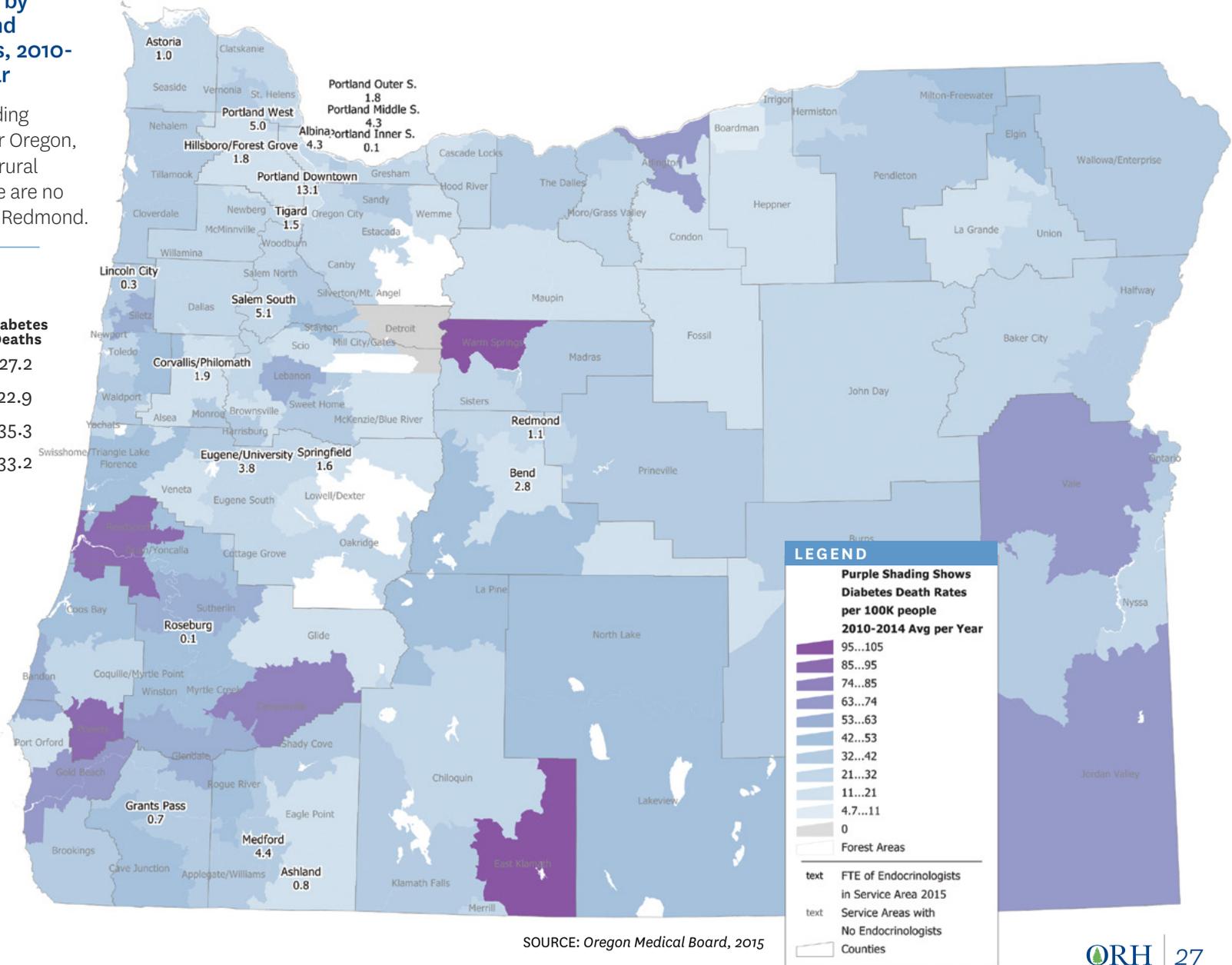
SOURCE: Oregon Medical Board, 2015

## Endocrinologists FTE by Service Area, 2015 and Diabetes Death Rates, 2010-2014 Average Per Year

Diabetes is the sixth leading cause of death in frontier Oregon, and the seventh in both rural and urban Oregon. There are no endocrinologists east of Redmond.

### Key Statistics

	Total Deaths Per 100,000 People	Diabetes Deaths
<b>Oregon</b>	820.9	27.2
<b>Urban</b>	708.1	22.9
<b>Rural</b>	1,020.9	35.3
<b>Frontier</b>	1,051.1	33.2



SOURCE: Oregon Medical Board, 2015

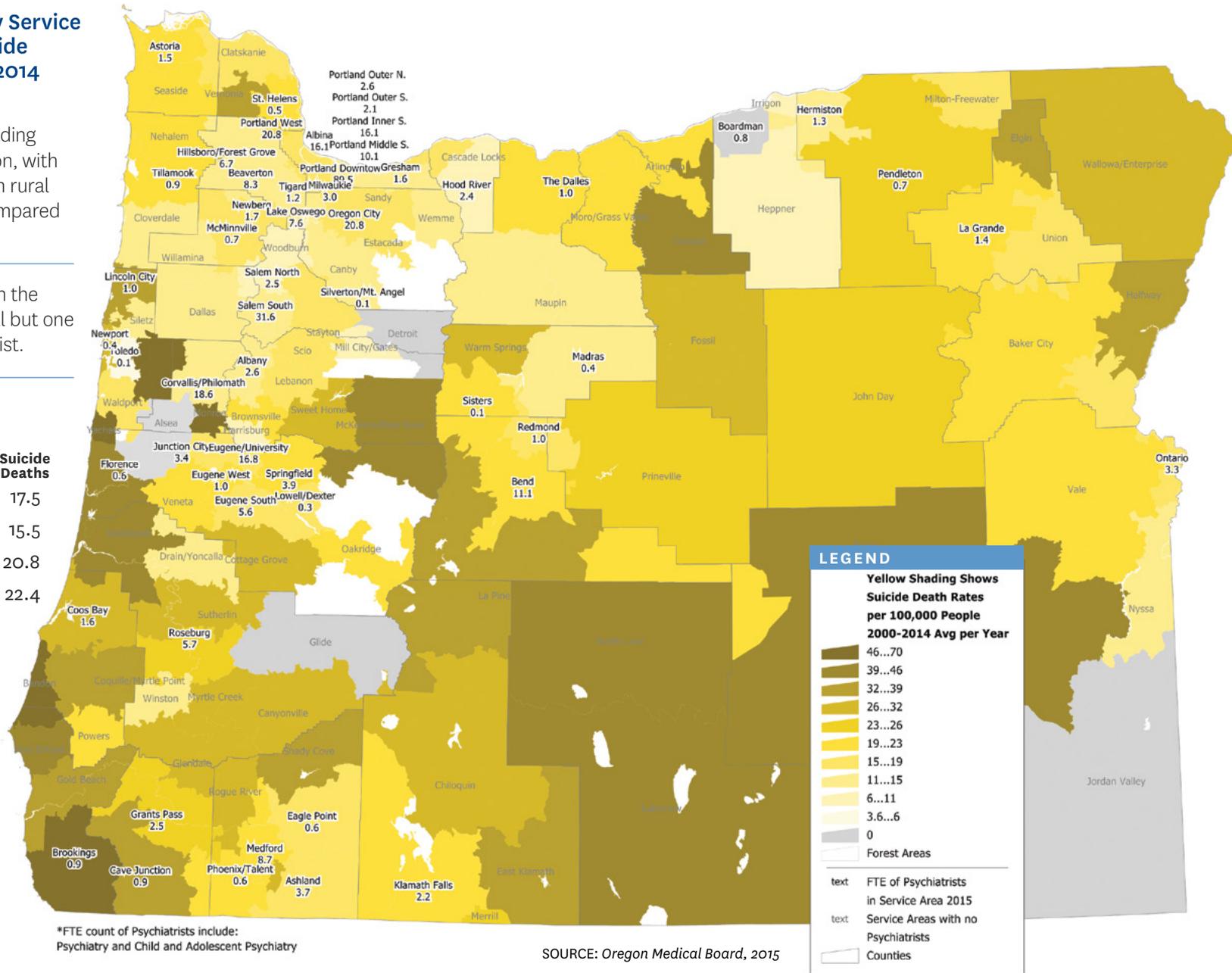
**Psychiatrists FTE by Service Area, 2015 and Suicide Death Rates, 2010-2014 Average Per Year**

Suicide is the eighth leading cause of death in Oregon, with higher mortality rates in rural and frontier Oregon compared to urban areas.

In the service areas with the highest suicide rates, all but one do not have a psychiatrist.

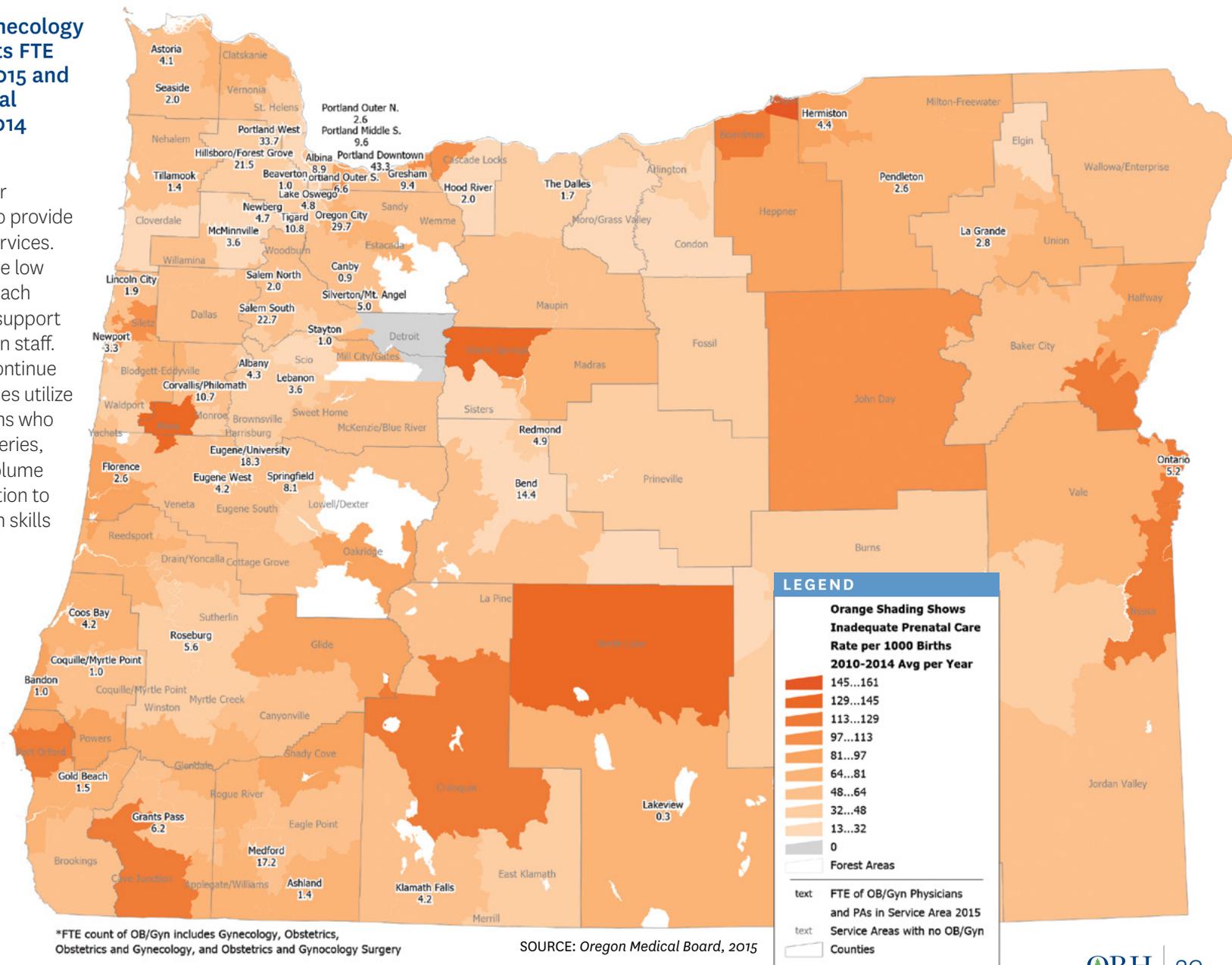
*Key Statistics*

	Total Deaths Per 100,000 People	Suicide Deaths
<b>Oregon</b>	820.9	17.5
<b>Urban</b>	708.1	15.5
<b>Rural</b>	1,020.9	20.8
<b>Frontier</b>	1,051.1	22.4



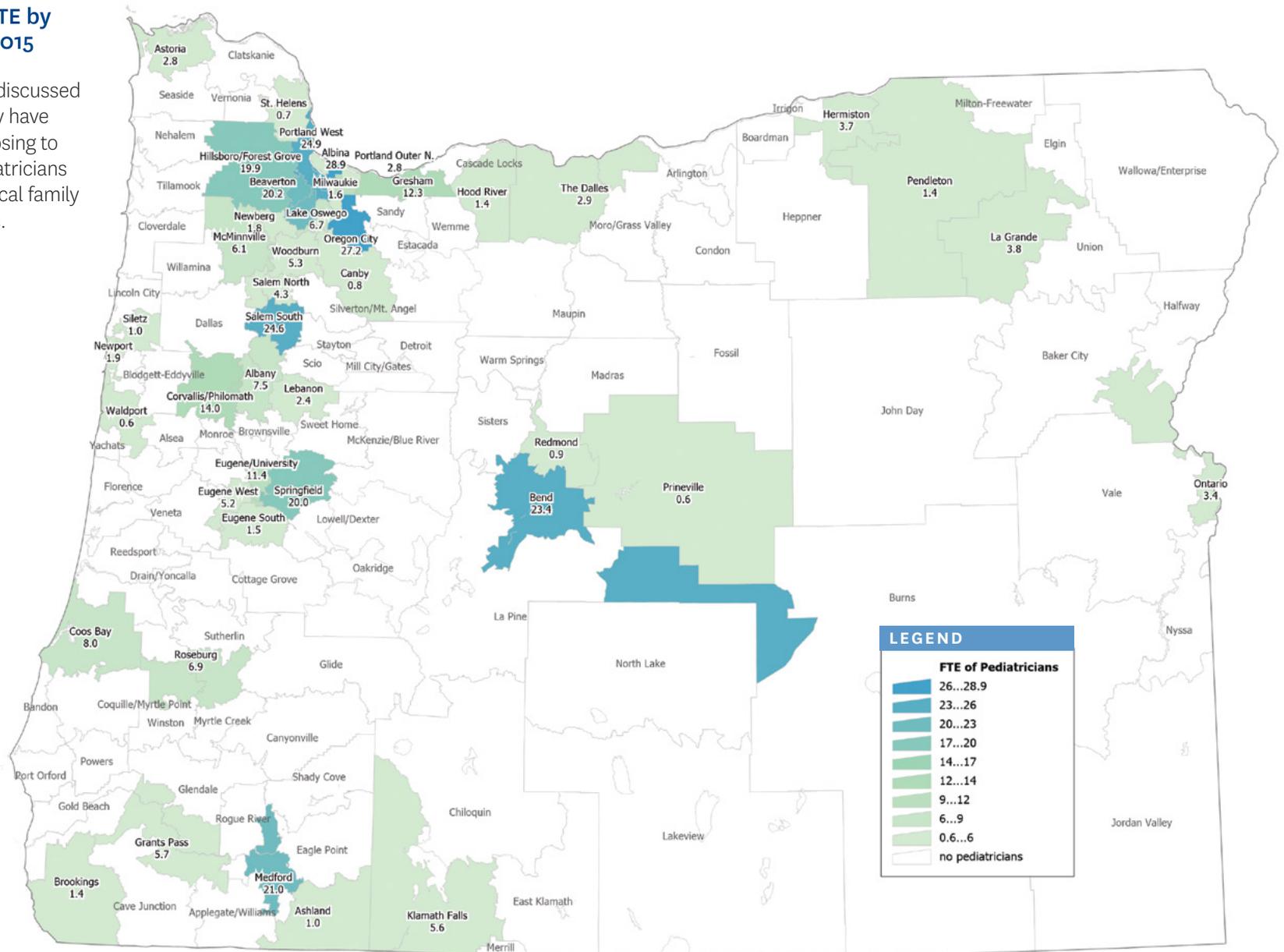
**Obstetrics and Gynecology (OB/GYN) Specialists FTE by Service Area, 2015 and Inadequate Prenatal Care Rate, 2010-2014 Average Per Year**

Many rural and frontier hospitals are unable to provide obstetrical delivery services. For some hospitals, the low number of deliveries each year is not enough to support an OB/GYN specialist on staff. Many hospitals that continue to offer delivery services utilize primary care physicians who are trained to do deliveries, but lack the patient volume and continuing education to keep cesarean-section skills up to date.



**Pediatricians FTE by Service Area, 2015**

Multiple facilities discussed the challenge they have with families choosing to travel to see pediatricians rather than use local family practice clinicians.



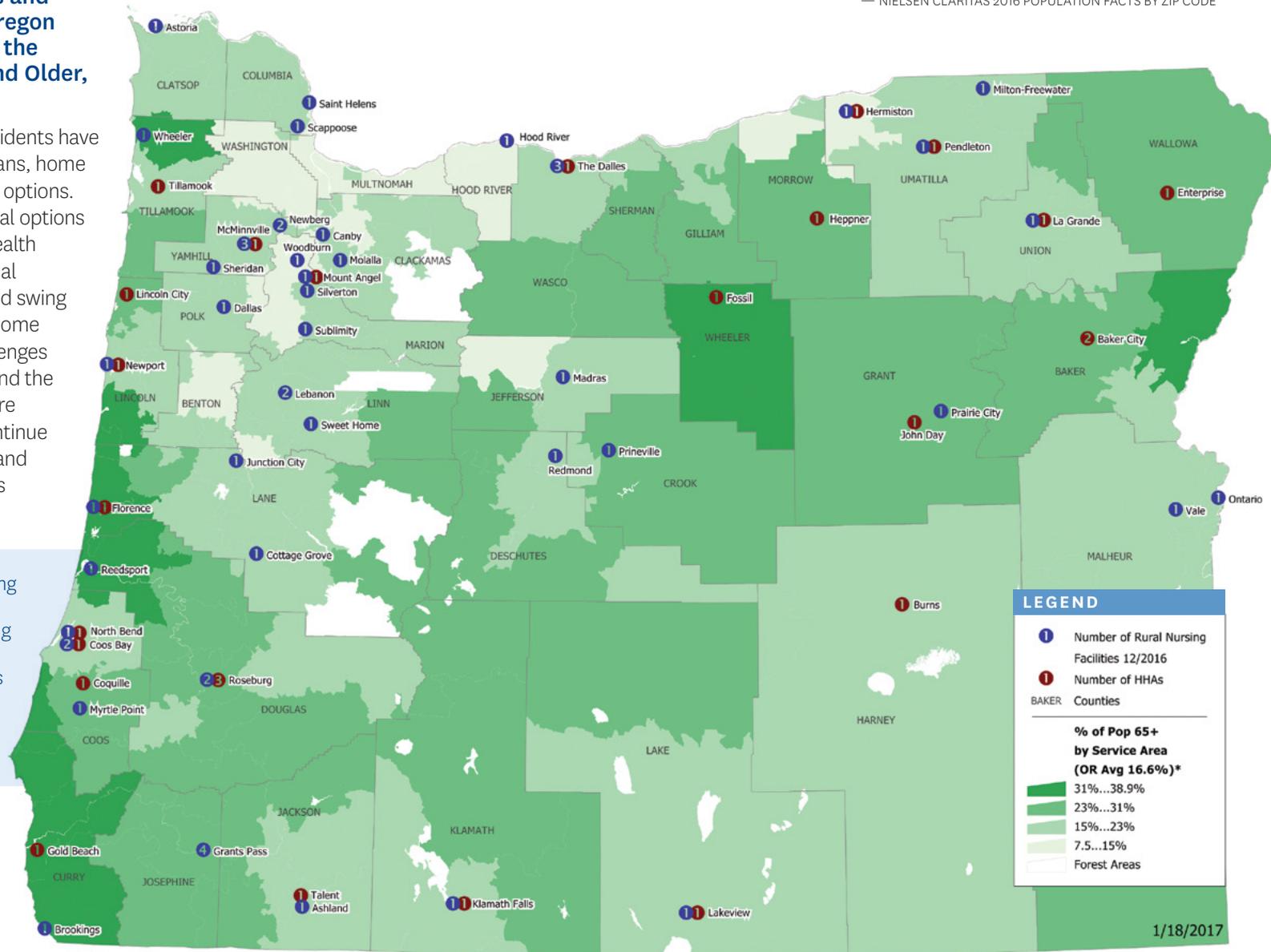
Oregon is home to 667,498 persons 65 years or older.  
Of these, 43.5% live in rural and frontier areas.

— NIELSEN CLARITAS 2016 POPULATION FACTS BY ZIP CODE

### Home Health Agencies and Nursing Facilities In Oregon and the Percentage of the Population 65 Years and Older, by Service Area, 2016

Older rural and frontier residents have limited access to geriatricians, home health and residential care options. Many hospitals provide local options through affiliated Home Health Agencies or for some Critical Access Hospitals, expanded swing bed programs. However, Home Health Agencies face challenges meeting patient demand and the availability of long-term care residential placements continue to be a challenge for rural and frontier healthcare facilities and communities.

For more information on aging services in rural and frontier Oregon, the challenges facing Home Health Agencies, and assistance available to CAHs to expand their swing bed programs, please visit: [www.ohsu.edu/orh](http://www.ohsu.edu/orh).



SOURCES: Nielsen Claritas 2016 Population Facts by ZIP Code  
Centers for Medicare and Medicaid, Home Health Compare Datasets, 2016



## Get in touch

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