Oregon Rural Hospital Sustainability and Transformation Recommendations

February 17, 2016

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Oregon Health Authority
SB 5507 (2015) included a budget note requiring:

- Oregon Health Authority to engage in a rural hospital stakeholder process to gather input on potential transformation strategies to ensure that Oregon’s small and rural hospitals continue to be sustainable in the future. And based on the work with stakeholders, OHA will develop a set of recommendations.

- OHA report during the 2016 Legislative Session on any hospital assessment revenues received for the 2013-15 biennium and available for use in 2015-17 which could be used to fund one or more the recommended strategies, not to exceed $10 million.
Revenue available from the 2013-15 Hospital Assessment Program

After final accounting of the hospital assessment program that ended at the end of September of 2015, OHA has $35 million of unallocated fund balance available for use in the 2015-17 biennium.

The current OHA Legislatively Approved Budget utilized $145 million of the carry-forward hospital assessment.

Of the $35 million, OHA recommends investing $10 million in one-time funding to implement rural hospital transformation and sustainability recommendations developed through stakeholder process.
Rural Hospital Stakeholder Process

- Rural Hospital Transformation Readiness Assessments
- Oregon Association of Hospitals and Health System (OAHHS) 4 Regional Meetings
- Hospital Rural Health Summit
- Oregon Office of Rural Health Listening Tour
- OHA & OAHHS Listening Tour
- Rural Hospital Stakeholder Group
DEVELOPMENT PROCESS TIMELINE

2014 Meetings
• HDS Meetings – March 18 & 27, May 14
• Regional Meetings (4) - June
• RHRI Meeting - Sunriver, July 16
• RHRI Meeting – Oct. 15
• ORH Listening Tour (27) – Nov.

2015 Meetings
• HDS Meeting – Jan. 30
• Assessment Tool completed by all hospitals - February
• Regional Meetings (4) – March
• Rural Summit – June 3-4
• RHRI Meeting – Sunriver, July 15
• SRC/ HDS Retreat – Sept.11
• RHRI Meeting – Oct. 28
• SRC endorsed - Nov. 11
• Small group vendor vetting webcasts – Nov.
• OHA Workgroup – Dec.

2016 Meetings
• Small group vendor vetting webcast – Jan. 7
• OHA Rural Hospital Sustainability stakeholder meeting – Jan. 11
• Presentation to Ways & Means subcommittee – Feb. 17

SRC: Small & Rural Hospital Committee (governing group of RHRI workplan)
HDS: Hospital Delivery Systems Taskforce (subcommittee of SRC)
RHRI: Rural Health Reform Initiative (strategic initiative began in 2012)
ORH: Oregon Office of Rural Health
Recommendation Criteria

- Provide Better Care: Prioritize and improve local access to care; address population health

- Provide Better Health: Bolster and grow primary care infrastructure and services

- Enable Sustainable Costs: Multiple options for rural communities, one time state funding
Recommendation 1: Establish best practice-based Transitional Post-Acute Care option for Critical Access Hospitals (CAHs)

Create access at CAHs for more complex patients to be transferred from large hospitals for post-acute care in CAH swing beds.

- Increased volume of swing bed days supports local rural access and CAH financial sustainability; utilizes existing capacity resources in rural markets
- Based on best practices in developing and implementing Transitional Post-Acute Care model in CAHs in MN, WI and IA
- Improved quality scores related to patient satisfaction and reduced hospital readmissions and associated costs
- Positively impact ability to care for more patients locally, avoiding unnecessary travel and expense of specialty visits back to urban hospitals and thereby improve patient compliance and experience (establish metrics in year 1 to track impact)
- Goal is to reduce overall length of stay in urban settings and transfer care for quicker recovery, closer to home. This improves hospital through put and reduces overall cost for system and patients

**Timeframe and Funding:** Approximately $4-7 million to implement over 3 years depending on the number of participating hospitals

**Per hospital commitment:**
- Project manager to commit up to 10 hours per week
- Extensive training for staff both virtual and on-site by clinical team
Recommendation 2: Support the work of the Oregon Graduate Medical Expense (GME) Consortium

Make strategic investment in the Oregon GME Consortium, which is focused on expanding graduate medical education capacity and residency slots in rural Oregon, to bolster the workforce long-term.

- Increase primary care GME slots in Oregon through successful partnership with Consortium
- Increase the number of primary care residencies and providers in Oregon focused on rural training tracks

**Timeframe and Funding:** Approximately $1-2 million funding allocated in 2016
Recommendation 3: Education modules regarding Population Health and social determinants of health for all rural provider types and health systems leaders - certification

Build a shared statewide platform of knowledge about population health to stimulate effective investment and learn actionable steps for implementing strategies aimed at improved population health.

- Addresses knowledge gap regarding population health and social determinants of health
- Supports further transformation in rural setting by aligning definitions and opportunities for action(s) related to population health
- Potential to align with public health modernization effort

**Timeframe and Funding:** Approximately $0.1 million for web-based education and facilitated small-group coaching to be offered in 2016

**Per hospital commitment:** 6-8 hours of educational content and small group coaching, plus homework
Recommendation 4: Establish virtual clinics in rural communities with acute primary care shortages to extend service hours and broaden geographic reach.

Implement model that can quickly bolster urgent care and/or after-hours access to care without additional brick-and-mortar facilities.

- Increase primary care support and reduce Emergency Department burden with a network of providers to serve patients via 24/7 clinic
- Help rural providers who are struggling to meet patient access and Emergency Department utilizations CCO performance measures
- Clinics staffed around the clock and patients can visit quickly and easily on site (kiosk model) or from home
- Visits available via teleconference or telephone; flexible implementation and coordination with hospitals and clinics
- Model utilizes already licensed clinical staff to support local providers and overall care coordination in communities

- **Timeframe and Funding:** Up to $1.1 million in setup costs depending on number of participating rural hospitals

- **Per hospital commitment:** Need to budget for ongoing operational funding, upfront costs would be covered
Questions?