Oregon Flex Program

Fiscal Year (FY) 2019 Significant Accomplishments, Best Practices, and Lessons Learned

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Program Area 1: CAH Quality Improvement

The Oregon Office of Rural Health (ORH) awarded five critical access hospitals (CAHs) during FY 19 with memberships to The University of Washington Tele-Antimicrobial Stewardship Program (UW TASP) to continue building their efforts to create and sustain successful Antimicrobial Stewardship Programs (ASPs). The goal of this activity was to see participating CAHs report at least six or more core elements on the National Healthcare Safety Network (NHSN) Annual Facility Survey by the following year.

ORH first began partnering with UW TASP in the fall of 2018 in collaboration with the Idaho and Washington State Departments of Health. At that time, the Federal Office of Rural Health Policy (FORHP) had recently announced that Antimicrobial Stewardship (ASP) would become a new Medicare Beneficiary Quality Improvement Project (MBQIP) measure. CAHs were given until August 31, 2021 to build capacity and become compliant by answering "Yes" to the seven core elements on their NHSN Annual Facility Survey. State Offices of Rural Health began providing technical assistance (TA) to CAHs across the country to assist in preparation for the newly added ASP MBQIP measure.

UW TASP provides core weekly sessions which are structured through case discussions and bring together UW infectious disease (ID) physicians, ID pharmacists, nurses, and clinical microbiologists to empower providers through infectious disease and stewardship education. The UW TASP web-based portal offers recorded didactic sessions, written resources such as order sets, formularies, antibiograms, and guidelines. In addition, UW TASP offers continuing education credits for physicians, nurses, and pharmacists for time spent in the weekly sessions. As an introductory offer to the tristate Flex programs, UW TASP provided free access to all CAHs in the tristate area to join their weekly core sessions. In FY18, ORH awarded two full CAHs memberships, and multiple CAHs took advantage of the free weekly sessions during that program year.

In FY 19, with the announcement from the Centers for Medicare and Medicaid Services (CMS) that the ASP requirement would now become a Condition of Participation for the

CAH program effective March 31, 2020, the interest in the program grew. UW TASP worked with Oregon, Idaho, and Washington to develop a CAH-only pricing structure that allowed CAHs that were not awarded memberships through the competitive cycle to receive a discount from joining UW-TASP. ORH solicited and awarded five full memberships.

For FY19, CAH memberships ran from December 1, 2019 to August 31, 2020 and began with a UW TASP introduction to Oregon-based CAHs in December. UW TASP monitored and reported participation of CAH as well as resources and information shared.

In early March, with the COVID-19 Public Health Emergency (PHE) and pandemic, UW TASP immediately switched gears and began offering their expertise in regard to COVID-related questions and concerns from hospitals in the tri-state region. They developed a COVID-19 resource page on their website, which housed resources and protocols for support hospitals with COVID-19 and began hosting core weekly sessions that focused on common issues hospitals were facing during the PHE.

The resources and tools available through UW TASP make it easy for facilities to write policies, implement order sets, formularies, and create antibiograms and guidelines while also having access to in-person TA from infectious disease experts. Among the seven participating CAHs, UW TASP shared 79 tools and resources with CAH staff on subjects specific to ASP. Additionally, this activity has shown, as an unexpected result, which is improved engagement by CAH pharmacists. Participation for four of the seven participating CAHs is being led by their pharmacists. For FY 20, ORH required that a pharmacist be an active participant in the program participation.

Lessons Learned and Best Practices

When implementing this activity, ORH planned to focus on CAHs that were low-performing and meeting six or fewer core elements. However, they did not account for the needs of those hospitals that were meeting all seven elements and still struggled to sustain their ASP programs. Four of the seven participating CAHs were meeting all seven of the NHSN Core Elements in FY18, but without the resources provided by UW TASP, they may have fallen backward in sustaining their ASPs. Further, some of the CAHs that were not meeting all seven elements had little to no interest in participating in UW TASP and ultimately did not apply for the activity due to a lack of internal staffing capacity to commit to the program.

Program Area 2: CAH Operational and Financial Improvement

The overarching goal for this program area was to provide enhanced and ongoing technical assistance (TA) and support to CAH-owned rural health clinics (RHCs). The number of RHCs in Oregon continues to climb, growing from 94 in January 2019 to 102 in October 2020. Due to this increase and the associated needs for training and TA, ORH hired an RHC program manager to work with RHCs to address challenges that were identified through a CAH-owned RHC survey in December 2018. As a result, ORH prioritized leadership and staff training, quality improvement, and TA for regulatory compliance as the top needs.

In September 2019, the RHC program manager was hired and began work to expand services to CAH-owned RHCs. Straightaway, the program manager began to strengthen existing partnerships with organizations, committees, and state offices, as well as the RHCs themselves. The RHC program manager established quarterly meetings with the Oregon Health Authority's (OHA) State RHC Surveyor to have ongoing discussions on survey deficiency trends to identify areas where RHCs require enhanced education and support related to compliance. The meetings have proven to be of great value to the RHC program manager, who conducts free mock surveys to assist clinics in preparing for a state survey. The RHC program manager has also enhanced collaboration and partnerships by meeting regularly with the OHA Safety Net Clinics Program Manager, Wipfli, LLC, and the OHA State Surveyor to review and discuss federal or state rule changes among other Oregon-specific issues. Additionally, biannual meetings have been established with the Oregon Primary Care Association (OPCA) to review changes and updates that occur throughout the year with FQHCs and Oregon's Alternative Payment Care Model (APCM) Program. The RHC program manager also serves on the Oregon Medical Group Managers Association (OMGMA) board of directors.

In November 2019, the CAH-owned RHCs were offered a competitive opportunity to compete for a practice innovation grant to improve operations, increase revenue, and improve workflows. Adventist Tillamook Medical Group was awarded the grant and completed their project, "Shared Medical Appointments for Lifestyle Changes." The goal of the project was to focus on the six pillars of Lifestyle Medicine by educating patients through group appointments on lifestyle and behavior changes to improve one's health. The American College of Lifestyle Medicine (ACLM) has identified six pillars that significantly impact an individual's health: nutrition, physical activity, stress management, quality sleep, healthy relationships and support systems, and avoiding tobacco and other harmful substances.

The appointments involved active learning, provided peer support, and community-building among participants. Presentations were made by health providers from the RHC and CAH, as well as health promoters from community wellness partners such as YMCA, Tillamook County Recreation District, and Food Roots. On completion of this program, the goal was to improve one's health through lifestyle changes. COVID-19 ultimately interfered with the completion of the final cohort groups. The program was successful and will continue once the pandemic is resolved.

ORH also offered one CAH-owned clinic a competitive professional development scholarship, which included an OMGMA membership as well as support to attend the Annual OMGMA Conference. The awardee reported that the OMGMA membership had offered her education through webinars and emails she would not have received otherwise. She states her membership has been beneficial over the past year, and her facility is renewing her membership in 2021. The OMGMA Conference was canceled due to COVID-19, and this portion of the programming is deferred to FY20.

ORH implemented bi-annual reminders to notify RHCs that were due for a re-survey within the next two years. ORH offers mock surveys to CAH-owned clinics to prepare for re-survey. In-person mock surveys were temporarily discontinued due to the COVID-19 pandemic and an institution-wide travel ban. The program manager is now offering virtual mock surveys, and three of these have been completed as of November 2020.

Lessons Learned and Best Practices

The RHC COVID-19 Listening Sessions offered some of the most significant lessons learned. ORH anticipated that these sessions would bring together CAH-owned RHC leaders and offer a time to share experiences, challenges, and build a new and coordinated CAH-owned clinic leadership community. Each session was led by a moderator who asked questions and offered polling to engage the participants. The first session was relatively well-attended, with approximately 25 participants, but there weren't many participants who actively contributed to the discussion. This trend continued, and attendance began to wane. After the third session of trying various ideas to involve the audience, the sessions lost steam and were discontinued. ORH will continue to work with the CAH-owned RHC leaders to build trust among this RHC community so that interactive listening sessions and round table discussions can be held with higher participation and more productive learning and idea-sharing within this community.

Another interesting lesson demonstrated that the CAH-owned RHCs that were initially visited in-person, prior to COVID-19, and as a result, had established relationships with the RHC program manager reached out with questions on a regular basis. The non-visited clinics reached out with questions very little, if at all.

One last lesson relates to virtual mock surveys. They have found that virtual mock surveys are not as thorough and effective as those conducted in person. This will resolve when the pandemic ends and in-state travel can resume. At that time, clinics that have received virtual mock surveys will be offered in-person mock surveys.

Program Area 3: CAH Population Health Improvement

One of the goals for this program area was to organize and host a CAH-centered Annual Forum on Aging in Rural Oregon to connect CAHs with subject matter experts, state, and local partners to collaborate on ways to address their regional aging community health needs based on CAH CHNA priorities. As a result of the pandemic, this in-person event was replaced with virtual learning sessions via webinars. Despite the virtual delivery mechanism, all of these goals were met, if not exceeded.

ORH coordinated and hosted five webinars between April and August 31, 2020, to disseminate content and to keep stakeholders engaged. An average of 32 participants attended each webinar (now housed on ORH's website for on-demand playback). Each session attracted attendees from CAHs (average of three), local public health departments (average of three), and minimal attendance from coordinated care organizations (CCOs) (average of one every other session). In future years, CCOs will not be a measured data point as they primarily serve those under the age of 65. By offering the Forum content virtually, ORH experienced good attendance by individuals from CAHs and local public health departments (LPHDs). As such, CAHs had (and continue to have via the on-demand playback option) access to content delivered by rural subject matter experts on timely COVID-19 related issues and behavioral health content.

Lessons Learned and Best Practices

Lessons learned and best practices from implementing the Forum as a series of virtual learning sessions was that topics could easily be disseminated statewide, allowing for better access to financially constrained organizations. There is also more opportunity to collaborate with other state offices of rural health (SORHs) and aging advocacy organizations that offer aging education.

Program Area 4: Rural EMS Improvement

ORH delivered programming designed to build on the FY18-19 Emergency Medical Services (EMS) Listening Tour (LT), establishing ORH as an active EMS resource. FY19 activities targeted EMS personnel at all levels—medical directors, emergency medical records (EMRs) through paramedic providers, and administrative billing staff. Work to continue to strengthen ORH's EMS role included: ongoing assessment of operational stability; targeted billing training; increased educational access; and strengthened partnership of rural and frontier EMS agencies and CAHs. This programming aimed to, and did for FY19, secure the participation of approximately 35% of the rural and frontier agencies in the state. While work was significantly impacted by the public health emergency (PHE), targets and goals were met and even exceeded. Most importantly, ORH's recognition as an EMS resource continued to grow.

ORH has endeavored to establish a role as an EMS resource. As a non-regulatory organization, focus on strengthening relationships with Oregon's EMS rulemaking and policy bodies has helped ORH align work with larger modernization and improvement efforts. ORH is now a requested attendee and presenter at statewide EMS bodies. During FY19, that included: Oregon Community Paramedicine/Mobile Integrated Health Coalition, Oregon Health Authority EMS and Trauma Systems (OHA EMS/TS) planning meetings; Oregon State Ambulance Association; Oregon State EMS Committee; and the Oregon Chapters of the National Association of EMS Physicians and National Association of EMS Officials. Additionally, ORH was a requested EMS presenter at the Oregon Health Authority's Health Security Preparedness and Response program, Oregon Medical Board EMS Advisory Committee, and the Flex Program's Reverse Site Visit.

Increased recognition of ORH as an EMS resource has resulted in the expansion of its EMS program reach. ORH was honored to receive a significant donation to fund its 2020 in-house Helping EMS in Rural Oregon (HERO) award program, based on the reputation and success of Flex-funded EMS programs. Agencies, member organizations, and state legislators consistently contact ORH to share information, and this helps ORH continue to meet a real need for agencies even when planned work has been disrupted by the COVID-19 pandemic.

Lessons Learned and Best Practices

As a non-regulatory partner, it can be challenging for a SORH to grow EMS programming. Working with regulatory and rulemaking partners is key to targeting programming and achieving credibility and buy-in. Most SORHs are uniquely positioned to help provide real-time communication and act as a convener for rural and frontier EMS

and state EMS bodies. A SORH's ability to connect with the pre-hospital, hospital and clinic providers helps to amplify issues important to this segment of EMS. SORHs are able to keep policymakers informed of real-time needs without agencies having to expend resources. The strong partnership remains the best way to provide and leverage resources for rural/frontier EMS. It also provides a strong foundational knowledge base from which to draw when plans change; the end of the FY19 Flex project period is a prime example.