

The Oklahoma Rural Health Care Plan 2000

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Executive Summary

This plan communicates a strategy for improving the health of Oklahomans. The long-term goal is to effect positive change in the population's health status. Short-term objectives focus on implementation of the Medicare Rural Hospital Flexibility Program and related activities, such as designating critical access hospitals, networking rural health care resources, and providing information and technical support for local action. The Office of Rural Health within the State Health Department works as the primary organizational resource for plan implementation, but it cannot accomplish the desired goals and objectives without active community involvement. Community participation is the essential means for perfecting change in public reimbursement policy, in the design and use of local health resources, and in local acceptance of prevention and health education activities.

Key factors that have influenced the development of the Oklahoma Rural Health Plan are:

- the need to ease the disproportionately heavy burden of disease and disability carried by the population of Oklahoma;
- the opportunity to improve Oklahoma's rural health system by providing information and technical assistance to rural communities;
- the opportunity to designate Critical Access Hospitals and provide support for networking and quality assurance; and
- the opportunity to coordinate and interface rural health development programs with other initiatives such as the Oklahoma Turning Point program and the Community Access Grant program.

A critical access hospital is a rural hospital located more than 35 miles by primary road, or more than 15 miles by secondary road, from any other hospital. (A hospital located less than 35 miles by primary road, or 15 miles by secondary road, from the closest hospital can participate if the State Health Department designates the hospital as a necessary provider.) The critical access hospital must make emergency care services available at all times, and must meet staffing requirements similar to those for rural primary care hospitals. It is limited to providing care in no more than 15 beds, or 25

beds if the hospital has swing beds. Inpatient stays in the critical access hospital must average no more than 96 hours.

This plan recommends the following activities:

- Oklahoma should continue to secure federal support for the Medicare Rural Hospital Flexibility Program originally approved in 1998.
- The Oklahoma State Department of Health should continue to designate critical access hospitals and other necessary providers.
- Progress should continue on emergency response systems development.
- Linkages should be promoted between all providers for transportation, communication, and patient care data.
- The redefined health care delivery system should be moved toward economic self-sufficiency by promoting the participation of a broad range of third-party payors to provide access to health care at an affordable rate.
- The Department should coordinate task forces, committees, agencies, private groups, associations and others moving towards a comprehensive delivery system.
- Programs of prevention and health education should be emphasized to gain full use of available resources by combining, coordinating and strengthening health resources.
- The Department, the State Board of Health, the Oklahoma Turning Point Initiative, and other partners should annually review the health status of Oklahomans and should review progress in the development of the health care system, to ensure that the goals and objectives of the Oklahoma Rural Health Care Plan are kept current.
- The Department should continue with periodic updates of the Health Status Indicator Profiles database.
- The Department and other partners should encourage all payors to recognize critical access hospitals and to influence revisions in reimbursement programs to ensure equity for critical access hospitals.
- The Department and other providers should increase primary health care services in medically underserved rural areas.

Oklahoma's Health and Rural Health Planning

Recent initiatives by the Oklahoma State Board of Health and by the federal government present a unique opportunity for substantial improvements in the health of Oklahomans and in delivery of rural health care. The Board of Health has called for renewed efforts to improve the health status of the State's citizens. At roughly the same time, the federal government has begun reimbursing critical access hospitals based on what it costs the critical access hospitals to deliver services. Additionally, the federal government has expanded its support for community-based health planning and coordination.

State of the State's Health

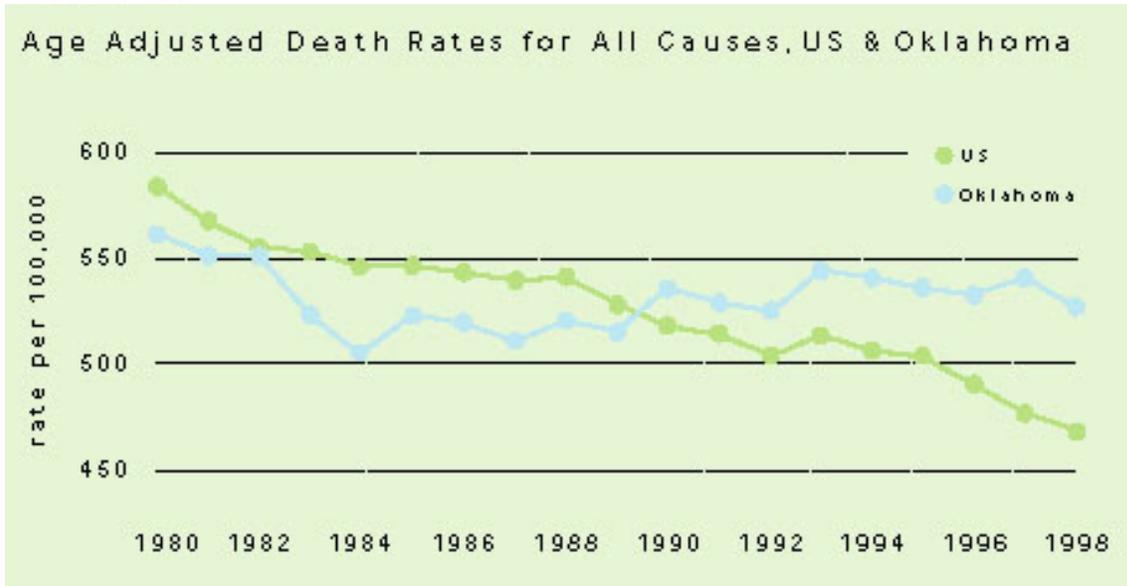
"... Oklahoma's leading causes of death are heart disease, cancers, injuries, stroke, and chronic obstructive pulmonary disease. Unfortunately, Oklahomans die from these causes at a higher rate than the rest of the nation. Taking all causes of death into account, Oklahoma's 1998 age adjusted death rate per 100,000 population was 530.2 compared to a national average of 470.8 (CDC, *National Vital Statistics Report*, 10/5/99). This 11.3 percent higher rate is absolutely unacceptable. Because of our high death rates, we have far too many years of productive lives being lost in Oklahoma."

State of the State's Health 2000, Oklahoma State Board of Health, p. 5

In January 2000, the Oklahoma State Board of Health noted that Oklahomans were dying at a rate about 11% higher than the national average. This means that each year at least 1,200 more Oklahomans die than would be expected based on national statistics. Figure 1 shows Oklahoma's relationship to the national average on all causes of death from 1980 to 1998.

The Board of Health surveyed reasons for the state's high death rates, and noted that Oklahoma is higher than the national averages on key behavioral risk factors: lack of seat belt use, lack of exercise, overweight,

Figure 1. Age Adjusted Death Rates for All Causes, US & Oklahoma



Source: *State of the State's Health 2000*, p. 5

and smoking. Additionally, the Board cited these reasons: Oklahoma's relatively low personal income levels, the lack of access to health care, and inadequate community health resources. In a 1997 report, the Board noted that elderly, poor and rural residents historically have relied on public hospitals, community health centers, public health departments and rural physicians as providers of last resort. The Board wrote that cost containment efforts and eroding revenue streams were threatening the existence of those traditional public health resources. The Board concluded that the loss of public and community health providers would likely worsen health care in Oklahoma.

As one of its solutions to Oklahoma's poor public health, the Board in its 2000 report endorsed the Oklahoma Turning Point Initiative. The Board wrote:

“Based on the notion of shared responsibility for health, Turning Point seeks to impact health at the community- level, through the active participation of physicians, public health professionals, business leaders, state government, our faith leaders and other community partners in decisions about public health and prevention activities. The foundation for restructuring public health in Oklahoma through community-

based decision making has been established in the Oklahoma Public Health Innovation Plan prepared by the Oklahoma Turning Point Advisory Committee and the Oklahoma community Turning Point partners. This plan, with its recommendations, should be fully implemented with the emphasis of assisting other communities in developing Turning Point partnerships across Oklahoma.”

State of the State's Health 2000, Oklahoma State Board of Health, p. 13

The Oklahoma Turning Point Initiative and the community assistance activities proposed under this plan are consistent and mutually supportive. These two cooperative activities may be brought to bear on the task of improving rural health care delivery.

Common Goals from Oklahoma Rural Health Plans

Recent federal initiatives for small rural hospitals bring new hope for innovations in the delivery of hospital services, but the concept of a redefined rural health system is not new to Oklahoma. The goal of changing rural health care from a loose collection of fragmented institutions to an integrated system of quality services has been a topic of interest in Oklahoma since at least the mid 1970s.

In more than 20 years of work preceding the State Health Department's 1998 Rural Health Care Plan, Oklahomans developed at least four rural health plans.¹ The plans are notably consistent. Each plan advocated a new role for the community hospital. Additionally, each plan encouraged flexibility for communities and for the government. The plans proposed that each rural hospital should be permitted to adjust services to meet the needs of its community. The plans all promoted changes in licensure programs and in third-party reimbursement practices to recognize and support the development and implementation of the evolving rural hospital.

¹ Rural health needs were included as chapters or sections in the “1976-1977 Oklahoma Interim Health Plan and Data Guide,” the “1985 Oklahoma Triennial State Health Plan,” the “1986 Supplement” and the “1988 State Plan for Achieving Excellence in Health.” A statewide multidisciplinary task force on rural health was convened to develop the 1986 Supplement. The Oklahoma Health Planning Commission, Oklahoma City, published all of these.

Other common goals in the succession of rural health care plans were the following:

- Improve coverage in underserved, typically rural, areas;
- Improve provider efficiency and productivity;
- Emphasize prevention and health education to gain fuller use of available medical resources; and,
- Educate populations on what services their local facilities can provide and when to use those services.

Another common theme in the plans was the recognition that reimbursement policies during the last half-century encouraged the development of full-service general hospitals. The federal government from 1946 through 1983 advocated institutional health care as a national priority and provided vast capital infusions. Capital for construction was available for general hospitals, and for nearly 20 years general hospitals were reimbursed under Medicare on a “cost plus” formula. Capital reimbursement was intended to improve access and availability to health care and to improve the health status of the population. Unfortunately, federal funds motivated the development of full-service hospitals in some communities with insufficient local demand to keep the hospitals financially viable on a long term basis.

The overdevelopment of services became painfully obvious after 1983, when Congress passed legislation implementing a prospective payment system for hospital services. Through prospective payment, general hospitals are reimbursed for Medicare patients based on a flat rate for 384 Diagnosis Related Groups. The reimbursement changes have been particularly telling for rural hospitals. Often as many as 80% of their patients are Medicare beneficiaries and small hospitals have less opportunity for cost shifting than their larger urban counterparts. Unfortunately, Medicare under the prospective payment system requires hospitals to be full-service providers. The results have been large operational deficits, and hospitals in Mooreland, Marlow, Afton, Collinsville, Wewoka and Jay have closed.

The federal government was not alone in implementing the prospective payment system. Other major third-party payors have installed reimbursement arrangements based on capitation. Consequently, a dramatic decline in hospital admissions and patient days nationwide has occurred in

the last 17 years. The decline is affecting both the availability and quality of primary health care in the state's smaller communities. Rural communities are now urgently asking whether they should develop transportation resources and send people elsewhere for health services, or whether they should redefine and reinforce their community-based health systems. Most Oklahoma communities have chosen the latter. They are concerned about the out-migration of physicians, pharmacists, and other health professionals and the eventual collapse of all health resources if the local hospitals close. The loss of health care resources in a community could be catastrophic to the area's economy, jeopardizing recruitment of new industries and future growth and development. The prospect is a downward spiral, in which deteriorating health resources and declining personal income will work to their mutual detriment.

Besides the obvious economic impacts, the loss of health care resources may have other profound negative effects in an area where the small hospital is an integral part of its county government infrastructure. In particular, county seats are the sites of district courts, sheriff departments, jail facilities, health departments, and other institutions that are essential to public health and safety in rural Oklahoma. A county seat is fundamental to the continued availability of government services for a geographic area that extends well beyond the community's immediate boundaries. Despite sometimes relatively small populations, towns that are county seats serve as hubs for services in surrounding areas and attract citizens for a variety of needs including health care. Therefore, special consideration needs to be given to the assurance of local hospital services to support the public health and safety infrastructure in communities that are designated county seats.

Owing probably to the consistency in our general understanding of the enormous influence of reimbursement practices, the goals of the various planning efforts over the last three decades remain current. In 2000, following the Board of Health's interests in core public health functions and in active community involvement, additional emphasis should be placed on these activities:

- Working to reduce rural Oklahoma's burden of death and disability;
- Ensuring the availability of primary care in rural areas;

- Coordinating and integrating service delivery across the spectrum of professional disciplines, provider types and geographic areas; and
- Ensuring adequate resources for health promotion, prevention and education.

Characteristics of Oklahoma's Rural Population

Rural Counties

Sixty-three of Oklahoma's 77 counties are located outside metropolitan statistical areas (MSAs) and therefore are considered rural. The State of Oklahoma also considers those areas of the state that are located outside urbanized lines of designated metropolitan statistical areas (MSAs) to be rural for program designation including Critical Access Hospital, Sole Community Hospital, Medicare Dependent Hospital or rural referral center. This designation is in keeping with Section 401, Balanced Budget Relief Act.

Almost 33% of Oklahomans live in rural areas, according to 1990 census data. Nationally, about 25% live in rural areas. While the proportion of the United States population living in rural areas has declined over the last 20 years, the rural population in Oklahoma grew from 1970 to 1990. (See Figure 2 for comparative data on Oklahoma's and the nation's urban and rural populations.)

Changes in federal law in 1999 expanded the definition of "rural" to allow additional communities to participate in the Medicare rural hospital flexibility program. The new law directly affects several Osage County towns, such as Pawhuska, which were considered urban under the MSA-based definition. Additionally, the new law authorizes the state to designate other rural areas. To take advantage of the federal changes, the Department will examine the demographic features of communities that are located in MSAs but that have small hospitals with resources and challenges similar to critical access hospitals in non-MSA areas.

The Health Status Indicator Profiles database

In 1993, the Oklahoma State Department of Health initiated an information project called PLUTO, a reverse acronym for "On Towards

Understanding Local Priorities.” The Department worked with key decision-makers and opinion leaders in communities throughout Oklahoma to develop a comprehensive health database. PLUTO included health status indicators such as morbidity and mortality rates. It also reported capacity and utilization data for the health care delivery infrastructure in each county. The purpose of PLUTO was to assist communities in identifying their own local needs, opportunities and priorities.

In 1998, PLUTO gave way to Health Status Indicator Profiles. The Health Status Indicator Profiles database represents the latest generation of county-based health information. The data is easily accessible through the Internet.² Work on the Health Status Indicator Profiles database continues, as the Health Department’s staff updates previously reported data and works with communities to identify new information needs.

Oklahoma’s Rural Health Networks

Patient Origin Data from the Hospital Utilization and Plan Survey

In the mid 1970s, health planners in Oklahoma were asking these questions:

- Where are Oklahomans traveling in order to receive hospital care?
- What distances do they travel for various levels of care?

These questions remain relevant in 2000, and the patterns revealed by patient travel data in the early 1980s are remarkably similar to the travel patterns shown in current data.

A unique feature of travel for health care in rural Oklahoma is the absence of direct links between hospitals via primary routes such as interstate, turnpike, controlled access, and other multilane highways. Instead, all links between rural hospitals roads require at least some travel on secondary or lesser roads, such as state-maintained two-lane roads or city- or county-maintained single-lane hard-surface all-weather roads. Typically, the links between hospitals in rural areas are entirely via secondary or lesser roads. Historically, health planners have recognized this unique feature of travel in Oklahoma, and the standard for access to hospital care has been a drive of 30 minutes or less.

² The Internet address is: <http://www.health.state.ok.us/PROGRAM/planning/hsip/index.html>

In 1978, a patient origin survey instrument was designed and implemented. Information to answer these questions continues to be collected in the Health Department's Center for Health Statistics through the annual Hospital Utilization and Plan Survey. The annual data include breakdowns of each hospital's patients by county of patient residence. Data compiled for each hospital show where a hospital gets its patients. Data aggregated for the state show where Oklahomans travel for care.

Early analysis of the patient origin data resulted in the delineation of trade areas. Trade areas were county groupings of hospitals and reflected travel patterns for hospital care. Trade areas depicted the optimum set of groups that minimized any one area's dependence on other areas to satisfy the demand of its residents for hospital services.

The trade area groupings suggested some natural divisions of general hospitals in three broad categories: primary, secondary and tertiary. As the service level moved from primary to secondary to tertiary hospitals, the availability of more sophisticated technologies and procedures increased. Although some hospitals fell between categories, those three were the most commonly used to describe levels of care.

Through analysis of the data, 22 secondary trade areas in Oklahoma and two tertiary areas were identified in the early 1980s. The trade areas reflected the movement of patients, usually from primary hospitals in several counties, toward a hospital or hospitals in a community within the trade area. A community toward which patients flowed was called a centroid. Centroids were characterized by a hospital or hospitals that had a mix of specialty physicians and that were equipped and staffed to provide medical diagnostic and treatment services. Centroid hospitals were typically secondary hospitals.

The hospital trade areas and centroids developed from those early efforts are depicted in Table 1.

Table 1. Oklahoma's Hospital Trade Areas--1982

Trade Area	Centroid	Trade Area Counties
1	Oklahoma City	Blaine, Canadian, Logan, Oklahoma
2	Tulsa	Craig, Creek, Delaware, Mayes, Okmulgee, Osage, Pawnee, Rogers, Tulsa, Wagoner
3	Enid	Alfalfa, Garfield, Grant, Kingfisher, Major, Woods

4	Muskogee	Adair, Cherokee, Haskell, McIntosh, Muskogee, Sequoyah
5	Lawton	Comanche, Cotton, Kiowa
6	Norman	Cleveland, McClain
7	Ardmore	Carter, Garvin, Jefferson, Johnston, Love, Murray
8	Ponca City	Kay
9	Shawnee	Hughes, Lincoln, Okfuskee, Pottawatomie, Seminole
10	Bartlesville	Nowata, Washington
11	Stillwater	Noble, Payne
12	Ada	Atoka, Coal, Pontotoc
13	McAlester	Latimer, LeFlore, Pittsburg
14	Chickasha	Caddo, Grady
15	Duncan	Stephens
16	Miami	Ottawa
17	Elk City	Beckham, Custer, Dewey, Roger Mills, Washita
18	Altus	Greer, Harmon, Jackson, Tillman
19	Durant	Bryan, Marshall
20	Idabel	Choctaw, McCurtain, Pushmataha
21	Shattuck	Beaver, Ellis, Harper, Woodward
22	Guymon	Cimarron, Texas

Map 2 illustrates the secondary trade area migration patterns. Map 3 illustrates the highest percentage alternate migration patterns for hospital care services. The alternate migration patterns in Map 3 reflect travel to tertiary hospitals.

Data from the 1998 Hospital Utilization and Plan Survey reveal strikingly similar patient travel patterns. Map 4 shows patient origin clusters developed using a statistical factor analysis. With a few exceptions, the 1982 trade areas are the same as the 1998 patient origin clusters. The notable differences between the two reports may be attributable to something as simple as missing data.³

³ Hospitals and counties that filed surveys but were missing the 1998 patient origin data were: Arbuckle Memorial Hospital, Murray; Muskogee Regional Medical, Center, Muskogee; Intensive Hospital of Oklahoma City, Oklahoma; Renaissance Womens Center of Edmond, Oklahoma; Lakeside Women's Center, Oklahoma; Cleveland Area Hospital, Pawnee; Cancer Treatment Center, Tulsa. Hospitals that did not file 1998 surveys were: Memorial Hospital of Stilwell, Adair; Mary Hurley Hospital, Coal; Integris Clinton Regional Hospital, Custer; Mercy Love County Health Center, Love; McCurtain Memorial Hospital, McCurtain; Creek Nation Community Hospital, Okfuskee; Bone And Joint Hospital, Oklahoma; The Children's Center, Oklahoma; Pawhuska Hospital, Osage; Sequoyah Memorial Hospital, Sequoyah; American Transitional Hospital, Tulsa; Jane Phillips Medical Center, Washington.

Instead of identifying a centroid for each cluster, Map 4 indicates with a box and "x" each county with one or more hospitals providing more than the state average count of specialized hospital services. The specialty services that counted towards this designation included angioplasty, cardiac catheterization, cytology lab, Level 1 & 2 emergency room service, trauma center, lithotripsy, genetic counseling, histopathology, oncology, open heart surgery, organ bank, podiatry, premature nursery, transplant, radiation therapy, CT scan, diagnostic radioisotope, MRI, PET Scan, SPECT, ultrasound, EEG and dialysis.⁴ Within a patient origin cluster, travel patterns would probably show a tendency towards the counties with higher than average availability of specialty services.

The similarity of patient travel patterns derived from data sets separated by some 20 years suggests that this is reliable and stable information that may be useful in identifying potential network affiliations.

Improvement of Access to Hospitals and Other Services

Demonstrated patient travel patterns can be drawn on in an effort to maximize use of existing health care resources. Of course, the trade area patterns are not mandatory referral patterns, but they suggest opportunities for combining, coordinating and strengthening health service delivery resources. The patterns also suggest natural linkages between primary, secondary and tertiary care providers.

The existing travel patterns in some cases indicate patient flows that are not immediately obvious from looking at a road map. Patient travel tendencies may not be to the closest hospital; instead, patients may go to a larger secondary or tertiary facility that is at a greater distance. Careful consideration of local data and community preferences is essential to ensure that rural health networks are consistent with and do not contradict the reality of patient movement in Oklahoma.

By building on existing resources and taking advantage of information about actual hospital use patterns, the delivery system for health care can be directed towards a goal of complete, affordable and comprehensive services, with minimal duplication or fragmentation. The components of the system should be integrated to meet the needs of the population in Oklahoma.

⁴ Each specialty service was counted each time it was reported by a hospital in a county. The average count of speciality services reported per county was 11.

One vision for an improved delivery system can be described as follows. Medical services should be developed into a system of organizations, facilities, personnel, and training opportunities. The system should be so well integrated that each need is met in a setting and within a time frame that is appropriate to that need. For example, needs for preventive health services could be channeled to local health departments and primary care providers. Urgent care needs could be referred to the primary care provider, not to the emergency room. Acute or emergency care needs could be referred to the local ambulance service or a critical access hospital. More serious or complicated physical or mental health needs should be met in a shorter period of time with stabilization, treatment, diagnosis, monitoring or other procedures initiated by appropriate personnel. If a patient emergency exists, action should be started immediately by local personnel under the direction of appropriate practitioners, with the support of an comprehensive integrated communication and transportation system. Perhaps local physician assistants, nurses or other trained specialists could be the initial point of entry into the system. In an emergency, the initial entry to the system from remote, isolated or rural areas might be through a transportation system of ground or air vehicles tied into a central communication system.

Primary facilities are usually locally based. They should be staffed and organized to offer entry level care, diagnostic tests and treatment procedures. Primary care should be available within 30 minutes travel time from any point in the state. The secondary facilities should be more comprehensive, including more highly specialized testing or diagnostic capabilities and treatments. Additional travel time from primary facilities to secondary or tertiary facilities is expected.

The tertiary or highly specialized facilities include all of the services found in primary and secondary facilities. In addition to patient care, however, they may also play a role in teaching, research and database development. In most cases, they are more fully equipped than the other facilities and are often staffed with specialists not found in other facilities. Tertiary facilities are usually located in urban counties.

Such a system could provide a complete array of health services in increments ranging from education and prevention, to primary care, to simple first aid in minor emergency units, to the most sophisticated diagnostic and treatment services and finally to teaching and research.

Inherent in such a system would be communication, transportation and the coordination of services for the greatest overall benefit.

The following list is not exhaustive, but represents systems or subsystems necessary in order to make the delivery system operate to the optimum.

- Transportation
- Communication
- Patient information
- Health education
- Personnel
- Training
- Resource directories
- Financing
- Community involvement and commitment

The efficient and effective delivery of health services is impeded by the continued fragmentation of services. Fragmentation involves unnecessary duplication that contributes to a lack of continuity in the delivery of services. This in turn adds to the inappropriate use of health resources by the consumer. Fragmentation implies a lack of coordination of services on behalf of those in need and can be found in both the private sector and government programs.

Appropriate government regulation is a significant factor in the effective delivery of health services. Regulation should be flexible to encourage innovations in the delivery of services. Added flexibility in the application of regulations should help reduce fragmentation in the delivery system.

Institutional health services should be provided in each community in accord with that area's needs and resources. Rural communities might retain a viable local health service with less broad services than the typical hospital. Supporting the local, limited service facility would be an institution in the region that could provide diagnostic laboratory and radiology services, surgical facilities and specialized treatments. Through an

organized communications and transportation network the patients would enter the system at its nearest point and be cared for by the facility providing the needed services. At the earliest practicable time the patient could be returned to the entry point for nursing care and recovery.

Emergency transportation services for rural Oklahomans are available only to a limited degree and include the MAST helicopter system and the possible development of a program through the Air National Guard. The Governor's Trauma Systems Plan may be viewed as a resource in the examination of emergency transportation issues.

Planning in Oklahoma historically has been based on a 30-minute travel standard. This is not merely a matter of convenience. The dispersion of the population and the cost of bringing the users and providers together affect the economics of health care. Should large numbers of rural hospitals close, the separation of health care users from a source of providers increases the cost of obtaining health care. Maintenance of the 30-minute travel standard will serve to contain the cost of health care in rural Oklahoma.

Contributions of Critical Access Hospitals

Critical access hospitals can contribute to the development of an integrated rural health care system by the activities described in this section.

Each critical access hospital should enter into a patient referral and transfer agreement with at least one secondary or centroid hospital, preferably in the same trade area. The agreement with the secondary hospital should include provisions for further referral and transfer to a tertiary hospital, preferably in the same trade area.

Each critical access hospital should participate in the development and implementation of a communication system with its area secondary and tertiary hospitals.

Each critical access hospital should cooperate in the development and implementation of a trauma care system in its area in compliance with the Oklahoma Emergency Response Systems Development Act in Title 63 of the Oklahoma Statutes.

Each critical access hospital should provide or arrange emergency and nonemergency transportation.

Each critical access hospital should ensure the quality of its services. Quality assurance and credentialing may be performed by a secondary or tertiary hospital with which the critical access hospital has contracted or by a professional review organization, or other independent quality review organization approved by the Department. The quality examination shall be performed at least once every three years and more often if determined necessary by the Department. The process for quality examinations is described in detail in Appendix A.

Office of Rural Health

Background

The Oklahoma Office of Rural Health was established in 1991. The Office of Rural Health coordinates, plans, and advocates for quality health care and improved delivery systems for rural Oklahoma's through education, service, research, analysis and development. The Office of Rural Health staff includes the director and three full-time staff members.

Clearinghouse Activities

The Office of Rural Health serves as a point of contact for Oklahoma's rural health professionals who need resources and information concerning rural health care issues. The Office of Rural Health has a generous collection of resource guides, mailing lists, directories, and statistics relating to all facets of rural health. The Office of Rural Health staff has a continuing obligation to Oklahoma's rural population to keep them informed of issues that will directly affect rural Oklahoma.

The Office of Rural Health provides ongoing technical assistance to Oklahoma communities participating in the strategic planning process. Assistance is also provided to critical access hospitals and communities that may be considering the potential for conversion to critical access.

The Office of Rural Health, the Turning Point Partnership, and Rural Health Projects, Inc. collaboratively produce a quarterly newsletter, "AHEC NEWS," which is distributed to more than 15,000 rural Oklahoma health leaders. The newsletter serves as a forum for discussion on rural health issues and activities. Information is disseminated through the Office of Rural Health office regarding the Rural Health Outreach and Rural Network Development grants, rural health clinics, rural based free medical clinics, and other issues vital to rural health.

The Office of Rural Health regularly coordinates with the Department's Office of Primary Care, the group having the responsibility for updating information for Health Professional Shortage Areas and Medically Underserved Areas. Of Oklahoma's 77 counties, 23 are fully designated and 17 are partially designated as Health Professional Shortage Areas. Forty

counties are fully designated and 23 counties are partially designated as MSAs. Eighty-one rural health clinics operate in Oklahoma.

The Office of Rural Health collaborates with the Rural Health Association of Oklahoma to host workshops which focus on issues affecting rural health care in Oklahoma. Attention is given to current legislation, rural hospital alternatives, and new delivery systems such as critical access hospitals and telemedicine. An annual conference is held which addresses state and national rural health issues. Health professionals representing the federal, regional, state and local levels attend Office of Rural Health-sponsored workshops.

The Office of Rural Health obtains mailing lists from national, state and local conferences and workshops and maintains them for rural health professionals and consumers. Lists of groups and organizations having a direct impact on rural health care delivery in Oklahoma are also maintained. Demographic data, health statistics, and impact analysis reports are developed and made available to all Oklahoma counties. The Office of Rural Health uses the Internet and the RICHS Web site to gather and disseminate information, and to communicate with others interested in rural health issues.

Coordination Activities

The Office of Rural Health supports collaborative relationships with the Oklahoma Rural Development Council, the Oklahoma Area Health Education Centers, the Oklahoma State University College of Osteopathic Medicine, the Oklahoma Hospital Association, the Physician Manpower Training Commission, the National Health Service Corps, Oklahoma Primary Care Association, Oklahoma Rural Research and Demonstration Center, and the University of Oklahoma Health Sciences Center.

County health departments also benefit from the Office of Rural Health through the bolstering of pilot programs, providing information on legislative issues, facilitating community development modules and offering grant finding/writing assistance.

In addition, the Office of Rural Health works closely with other divisions of the Oklahoma State Department of Health such as the Office of Minority Health, Office of Primary Care, Medical Facilities, Local Health

Services, and Special Health Services. This is in effort to avoid duplication of services and to better ascertain the health care needs of rural Oklahomans.

The Office of Rural Health serves as the managing organization for the Rural Health Association of Oklahoma, Inc., co-sponsoring an annual meeting each fall at which a variety of rural health issues such as minority health, telemedicine, grant availability, critical access hospitals, and recruitment and retention are discussed. Moreover, the Office of Rural Health uses the annual conference to put rural providers in contact with large national providers of goods and services. Relationships are maintained through the Office of Rural Health with major funding organizations.

Rules pertaining to rural Health clinics are constantly changing. The Office of Rural Health addresses the needs of rural health clinics with appropriate regulatory support from the Medical Facilities Service at the State Department of Health.

Available funding sources are advertised to rural communities through press releases appearing in the AHEC News and in other local and state news media.

Technical Assistance

Since Oklahoman's adoption of a managed care product for its Medicaid population through a 1115 (B) waiver, the Office of Rural Health has been active in providing technical assistance to those with rural health interests. The Office of Rural Health contributed to the provision of forums for discussion of this and other programs in terms of implementation and subsequent operation. While reviews at this time are mixed, it is essential that program operators keep an open line of communication with rural providers and citizens. Such communication has been facilitated by Rural Health Association of Oklahoma. The Office of Rural Health supports and provides technical assistance to the Oklahoma State Legislature, the four sites creating Oklahoma, Rural Health Association of Oklahoma, Oklahoma Primary Care Association, Oklahoma Hospital Association, Oklahoma State medical Association Physician Manpower Training Commission, and entities within the State Department of Health. The Office of Rural Health will continue to provide technical assistance to individuals and communities that are involved in community health planning, the establishment of rural

health clinics, the assessment of critical access hospitals, and other rural health activities.

Recruitment and Retention

The Office of Rural Health coordinates with the Physician Manpower Training commission, Oklahoma Primary Care Association and Oklahoma Area Health Education Center. Oklahoma State University College of Osteopathic Medicine, University of Oklahoma Health Sciences Center, and the Office of Primary Care in a statewide effort to place and keep primary care providers in rural Oklahoma. A recruitment committee continues to meet to identify and address strategies to increase and retain physicians, physician assistants, and nurse practitioners in rural communities. A rural rotation for students and residents at the state medical schools has been established as a core curriculum component. These programs have proven to be successful in introducing the positive aspects of rural practice to future and new resident physicians. The “State 20” J-I Visa Waiver program is potentially an additional source from which to draw for placement of physicians in underserved rural Oklahoma communities.

Future Activities

The ultimate outcome to be derived from the activities of the Office of Rural Health is rural health delivery systems which effectively and efficiently meet the health needs of rural citizens.

The Office of Rural Health will continue to utilize the Internet, RICHS, and other resources to assist in the acquisition of information. The Office of Rural Health will improve upon its current system for updating its web site, allowing interested individuals easier access to information pertaining to Office of Rural Health activities.

Communication is an important factor contributing to the success of any program. Better communication between the Office of Rural Health and rural providers in Oklahoma is essential to Office of Rural Health effectiveness in meeting rural Oklahoma’s health care needs. Grant information and on-site assistance will be provided to all rural providers requesting grants through the Office of Rural Health. The Office of Rural Health will develop a closer, more productive relationship with county health department administrators, personnel and other rural health leaders.

More proactive communication must take place among these groups to ensure quality rural health systems in Oklahoma.

The Office of Rural Health is a crucial participant in the implementation of the critical access hospital program in Oklahoma. This program promotes integrated health services delivery and improves the availability of health services in Oklahoma's rural communities. A key component of this program is the designation of critical access hospitals to serve as entry points for acute care services in areas without a sufficiently large population to support full service health facilities.

The Office of Rural Health will continue to manage and sponsor the Rural Health Association of Oklahoma, Inc. Associated activities will include the annual meeting, day conferences held at sites outside the metropolitan area to discuss rural health issues, staff support for the Board of Directors and Executive Council, and attention to other needs which arise. Workshops will offer insight into health delivery changes in rural Oklahoma; especially those changes brought about by the state's Medicare managed care waiver. The Office of Rural Health will continue to coordinate and collaborate with its current partners and will seek additional linkages with other parties having an interest in rural health. The Oklahoma Office of Rural Health will continue to advocate for rural health issues before legislative bodies and policy and will continue to encourage citizen participation in these activities.

Medicare Rural Hospital Flexibility Program

- **Flex Program Overview**

Oklahoma's Office of Rural Health in the Oklahoma State Department of Health has been awarded funding from the Federal Office of Rural Health Policy to implement the Medicare Rural Hospital Flexibility Program (Flex Program). This initiative has the potential to assist eligible communities to design, build and maintain health care delivery systems tailored to local needs, local expectations, and local resources while being responsive to local control. While this program is far-reaching in scope, it is relatively simple in its application.

The principal core of the Oklahoma program and the Act that authorized this program is the realization that small rural hospitals are the hub of health care delivery in our rural communities. While other components play vital and important roles, the hospital is the keystone of the rural health delivery system. Studies have demonstrated that the rural hospital is also a key to economic survival of rural communities. Often the largest or second largest employer, the hospital serves as the lynch pin of the health services system.

Rural hospitals have been especially hard hit by the Balanced Budget Act of 1977. While trends show decreased utilization of inpatient beds and services, the Balanced Budget Act results in decreasing revenues for those declining services. Many rural hospitals provide a combination of services including emergency services, home health services, skilled nursing services and outpatient clinical services in addition to their inpatient services role. The Balanced Budget Act has resulted in decreasing revenues for all these services. Rural residents are generally older and have less resources for health care services than their urban counterparts, so it is small wonder that rural hospitals are experiencing difficult financial times. The Oklahoma Hospital Association has issued a report estimating that at least twenty-three rural hospitals are in danger of closing within the next three years if solutions for their financial insolvency are not found.

The Flex Program attempts to reinstate the financial stability of the smallest rural hospitals. To be eligible, hospitals must be separated a certain mileage distance from other hospitals, must reduce their inpatient bed capacity to no more than fifteen beds plus ten swing beds, limit their length of stay to no more than an average of 96 hours with a very tight exception

process, maintain and work to integrate emergency services into the rural health care fabric, form networking arrangements for referring patients for which the hospital does not offer services, and develop quality improvement plans and programs. The state has the flexibility to accept certain other rural hospitals that do not meet the specific federal mileage requirements. Hospitals that comply are rewarded with a relaxing of the staffing requirements. for Medicare participation and are reimbursed on a reasonable cost basis for both inpatient and outpatient services. These hospitals are surveyed by the State Health Department and are then designated as critical access hospitals after the department receives approval from the regional Health Care Financing Administration.

Implementation of the Oklahoma Flex Program takes on four distinct processes. They are State Plan Development, Financial Feasibility Determination, Network Development, and Community Health Planning.

The first process requires the Office of Rural Health in conjunction with the Oklahoma Hospital Association and rural hospitals to develop a state rural health plan that defines state requirements for a critical access hospital. The state plan must be approved by the regional Health Care Financing Administration (HCFA) office. The plan should also list or in other ways identify potentially eligible hospitals and their communities. This is the initial step required to enable state hospitals to participate in the Flex Program. This initial step has been completed. The plan is reviewed an at least an annual basis. Significant changes will be submitted to HCFA.

The second process requires analysis to determine if cost reimbursement is advantageous versus the prospective payment system. This involves not only analysis of financial data but also analysis of utilization to determine the type and volume of admissions that would result from restrictions imposed by the critical access hospital designation. This requires in-depth analysis of admissions by type and diagnosis, resulting personnel requirements, length of stay, severity of illness and payor mix. Hospitals with low Medicare utilization might not find the critical access hospital designation to be advantageous. Because this analysis requires very specialized skills, this responsibility should be performed by staff or consultants with the required knowledge and experience to make reasonably accurate projections. While there is no penalty for reconverting from a critical access hospital to a full service hospital, there may be considerable

expense involved in moving to full service status. Thus, this process must be carefully considered.

Hospitals generally fall into two categories. The first is the small hospital that has a very high Medicare utilization. Hospitals in this category have already restricted their service menu, offering few if any of the more complex inpatient services. These hospitals perform few surgeries or deliveries. Financial analysis for these institutions is fairly simple. The facility typically has an average census of ten or less patients with a length of stay that is already within or very close to the 96-hour average.

Hospitals in the second category are larger and offer a wider array of services. These hospitals would have to downsize some service capacity to meet either the fifteen bed acute care restriction or the 96-hour average length of stay restriction. These facilities would require a more in-depth analysis that would include reduction in the number of acute beds, analysis of space utilization and analysis of admissions that would not be appropriate using the 96-hour average length of stay and the resulting business loss. Both situations require an analysis of community needs and expectations.

The third process in the Flex Program concerns the network arrangements necessary to provide a broad continuum of services to rural residents. While it is unrealistic to believe that a small rural hospital can provide every service required by community residents, it is reasonable to provide for networking arrangements that can extend such service potential offered through referral arrangements with other providers. The integration of emergency services into the local fabric of care is a critically important factor in providing health care services to rural residents and in maintaining appropriate transfer and referral avenues. This process must also be responsive to developing and maintaining quality of care issues. Again, since this analysis requires very specialized skills, these responsibilities should be given to staff or consultants with the required knowledge, experience and success in network development in the rural health environment.

The Oklahoma Flex Program emphasizes the integration of Emergency Medical Services into the local community health care delivery system. The Office of Rural Health is working with hospitals to assist in purchasing training for Emergency Medical Services personnel to upgrade the skill level for basic Emergency Medical Technicians training to

Intermediate Emergency Medical Services status and on to Paramedic Emergency Medical Services status. It is anticipated that this will include a minimum of five individuals per hospital. The training will be accomplished through the Oklahoma State Vocational Technical Education System . Training will be accomplished through local campuses that are certified for such training. Most of the training should be accomplished in the rural communities.

The Oklahoma Flex Program includes provision for financial analysis, system development and quality assurance. The Office of Rural Health is preparing to contract with a statewide organization to provide such services. The contractor will be responsible for assisting communities in planning for system development that arise out of the community development process described above. The contractor will use the participatory planning process to help communities reconcile competing expectations with limitations imposed by reality. The contractor will be expected to use the planning process to help community members reach consensus about the future configuration of their community health service delivery systems. The planning process used by the contractor will include steps to assist participants to) make explicit their ideas about a "better system" and ii) share their ideas for a better system with other stakeholders. The contractor will include a step in the process to educate the participants about the nature of their system based on objective data and what this evidence suggests for the future of the system.

Quality of care is a significant issue in both the community development process and the Oklahoma Flex Program. Quality shall not be sacrificed for rural Oklahomans. The contractor will assist critical access hospitals in developing quality assurance programs. During the contract period, the Office of Rural Health estimates that the contractor will assist up to 10 critical access hospitals with quality assurance preparations or examinations.

The fourth process in the Flex Program involves assessing community needs, expectations and capacities. This process seeks to inform, educate, and involve the community in the health system development process. Community members must have sufficient data and information to understand health systems and the manner in which the system related to delivery of services that are locally required and desirable. Community members must be given the opportunity to express their needs and desires

for health services as well as their preferences as to how those services are to be provided. This is a real partnership with health providers. This partnership seeks to maximize local utilization of the health care delivery while providing increased access to at least preventive and primary care services for the entire community. Any community process that is successful must be broad based and must include virtually every segment of the community. Examples include providers, public health advocates, environmental health advocates, business leaders, community representatives, minority community members, education, consumers, safety and fire representatives, political leaders, and other interested parties. This should be a shared, inclusive process where diversity is valued and no one sector dominates. The Office of Rural Health will provide assistance with the Oklahoma State University Cooperative Assistance Service to facilitate this community health development process.

The community health development process involves a team approach that serves as the staff for a community. The partners include the Office of Rural Health, Oklahoma State University Cooperative Assistance, the Oklahoma Office of Primary Care, and the Oklahoma State Department of Health. This group is known as the resource team. The resource team operates under three basic caveats. First, the resource team must be invited into a community. This invitation can come from the hospital, the health department, the business sector or other interested parties. But the invitation must come from someone in the community. Second, the resource team is not a decision maker but serves as staff to the community process. Decisions regarding the community health delivery system must be made by the community. The resource team will assist the community with process and data but will not be the decision maker. It should be emphasized that it is not the intention of the resource team or the process to effect any pre-conceived product or outcome through the community development process. Certain areas of analysis may be suggested in order to provide the participants a broader scope of health and related services for intensive review. Third, any community health development process must be broad-based including all the diversity in the community. For example, this should include the hospital and other health providers, the business community, the local political leaders, the faith community, minority community representatives, consumers, and others that have an interest in the health delivery system. There is no charge to the community for the services of the resource team or the products described below. This process involves a simple, short term planning grid. The community is asked to identify a large

planning group, generally 25 to 50 community residents. The resource team schedules a series of four to five meetings over an approximate three months period of time. The resource team brings data and analysis and asks the community group for decisions regarding that data. The meetings are generally an hour in length, except for the first meeting of the Steering Committee which generally lasts an hour and a half.

The Office of Rural Health has contracted with Oklahoma State University Cooperative Assistance Service to provide certain services to communities that have a potentially eligible hospital under the critical access hospital program. These services will seek to promote a better understanding of the health care delivery system, highlight and develop local needs assessments, identify community desires regarding health care delivery, and maximize local utilization for appropriate services. These services include several products. The first product is an analysis of the impact of the health care sector on the local economy. This is an in-depth study that uses the Implan data to predict both jobs and revenue attributed to the health care sector locally. This analysis includes demographic data indicating population trends, sources of income, and other statistical information regarding the community. The second product is a directory of all health and human services available locally. This directory is furnished to the community in a word processor format that is easily duplicated for wider distribution in the community. The third product is a multiple table report regarding health indices of the community. These data then are compared to state and available national data for comparative purposes. The fourth product is a completed survey of community residents to determine attitudes and usage patterns regarding health care services. This survey is conducted by telephone and is anonymous. The survey utilizes a statistically significant number of responses to questions developed by the resource team. The community groups then review, modify and approve the survey questions. The community group provides for local publicity for the survey prior to the survey being conducted.

The Office of Rural Health anticipates the need for planning processes leading up to the decision to commit to critical access hospital conversion in a minimum of 10 communities, with an additional twenty communities by the end of FY 2001. The Office of Rural Health anticipates the need for full planning processes, including development of networks and integration of services on a regional basis, for 20 communities. The development process and not necessarily the decision to convert is seen as the critical issue.

While there are approximately seventy hospitals that might potentially be eligible for CAH status, it is anticipated that conversion to this status will be a viable option for approximately twenty hospitals. The determination process is seen as beneficial to all communities and their hospitals.

Hospitals seeking critical access hospital status are not required to submit to the community development process. Moreover, these hospitals will be expected to comply with all regulatory process including quality of care issues. All hospitals will be offered the community development process. If the community is not prepared to participate, the Office of Rural Health will defer to a time when the community commits to participate. Because of the extremely fragile position of many of Oklahoma's rural hospitals, it is not considered prudent to prevent or delay the decision to seek critical access hospital status on the basis of the availability of or the commitment of the community to immediately begin the community development. However, the Office of Rural Health will continue to work with these communities to make such a process both available and acceptable to the community as soon as possible.

The Office of Rural Health will continue contact with hospitals that convert to assist with the stabilizing of the health care infrastructure. This may include extending the community development process, performing feasibility studies, or further community education and development as is deemed necessary and prudent by the community. Also, a community that reviews the status of their hospital and decides not to convert at a particular time is not precluded from making that decision at a later date. The Office of Rural Health will continue a relationship with these communities as well to assist in any way possible to the stabilization of the local health delivery system infrastructure.

Designation of Critical Access Hospitals

Process for designating critical access hospitals

Since the original approval of the Medicare Rural Hospital Flexibility Program, eight rural hospitals have been certified as critical access hospitals. To maintain this process, the Department shall continue to identify and designate critical access hospitals according to the following procedures.

Step 1. Identifying Eligible Facilities

At least annually and more often if necessary, the Department shall prepare a list of potential eligible hospitals. The list is composed of those facilities that appear to be consistent with the provisions of the plan. Information used to develop the list comes from the following sources:

- Oklahoma State Department of Health, annual hospital utilization and plan survey;
- Oklahoma State Department of Health, Health Status Indicator Profiles, State of Oklahoma;
- Oklahoma State Department of Transportation, State Highway Map.

The list should include any general acute care hospital with an average daily census of less than 15 patients. Although this method will incorrectly include some facilities that cannot meet the 15 acute care inpatient limit, it will ensure that a list of potential eligible hospitals is developed.

The list will be updated annually and disseminated to potentially eligible facilities. Those facilities will be advised of the designation requirements, and they will be provided instructions on applying for designation.

Step 2. Request for Designation as a Critical Access Hospital

Each hospital intending to participate as a Critical Access Hospital under Oklahoma's Medicare Rural Hospital Flexibility Program shall submit a written request to the Department. The request shall provide the following information:

- The legal status of the hospital’s licensed operating entity;
- The mileage distance from the applicant hospital to the nearest acute general care hospital, and an indication of whether travel via secondary roads is required;
- An operational narrative demonstrating the hospital’s capability to ensure the following:
 - The availability of emergency services at all times;
 - The hospital shall not provide acute care service to more than fifteen (15) acute care inpatients at any time;
 - The hospital shall meet staffing requirements that closely parallel Rural Primary Care Hospital requirements; and
 - The hospital shall maintain an average length of stay of not more than ninety-six (96) hours, unless specific exemption requirements are met;
- Information showing the hospital’s conformity to the “Contributions of Critical Access Hospitals” section of this plan; and
- Such other information specified in the Oklahoma Rural Health Plan for designation of a critical access hospital, including information demonstrating that the hospital is essential to the welfare of its community, if the distance to the nearest general acute care hospital is less than 35 miles by primary road, or less than 15 miles if travel by secondary road is required.

Step 3. Department Review of Request

The Department shall review the written request for consistency with the Oklahoma Rural Health Plan 2000. If the Department finds that the request meets the requirements for designation and the request is consistent with the provisions of the Plan, the Department shall designate the requestor as a critical access hospital. Written confirmation of the designation shall be sent to the requestor and to the Regional Office.

If the Department cannot find that the request is consistent with the Oklahoma Rural Health Plan, the Department shall advise the hospital of additional information needed to perfect the request for designation.

The Department shall approve the designation within thirty (30) days after receipt of the written demonstration that the hospital is consistent with the provisions of the Plan.

Hospitals that appear to meet the criteria for critical access hospitals are reflected in Table 2.

Criteria for Necessary Providers

Facilities that do not meet the distance criteria for critical access hospitals may be appropriate for designation as necessary providers. Necessary providers are considered essential to the welfare of their communities. Closure of a necessary provider would pose a threat to the health of the residents of an area.

A hospital may be considered for designation as a necessary facility if it meets one or more of the following criteria:

- It is located in a designated medically underserved area;
- It is located in a designated health professional shortage area;
- It is located in a seat of county government, is an integral part of its county government infrastructure, and is essential to the continued availability of public health and safety services in the area;
- It is located at a distance of more than 35 miles by primary road, or more than 15 miles by secondary road, from the closest hospital in the direction of patient flow, based on documented patient origin patterns for the geographic area;
- It is located in a county that has death rates higher than state averages on at least three of the five leading causes of death: heart disease; cancer; chronic obstructive pulmonary disease; stroke; and unintentional injuries;
- It is located in a county that has a death rate that exceeds the state average for all causes of death.

Hospitals that may qualify as necessary providers are also shown in Table 2.

Additional requirements for critical access hospitals

In addition to other requirements for critical access hospitals, to be considered for approval a facility must demonstrate that it satisfies the “Contributions of Critical Access Hospitals” section above.

Goals and Implementation Objectives

Based on the foregoing information and issues, the following are the goals and implementation objectives under this plan

- Oklahoma should continue to secure federal support for the Medicare Rural Hospital Flexibility Program originally approved in 1998.
- The Oklahoma State Department of Health should continue to designate critical access hospitals and other necessary providers.
- Progress should continue on emergency response systems development.
- Linkages should be promoted between all providers for transportation, communication, and patient care data.
- The redefined health care delivery system should be moved toward economic self-sufficiency by promoting the participation of a broad range of third-party payors to provide access to health care at an affordable rate.
- The Department should coordinate task forces, committees, agencies, private groups, associations and others moving towards a comprehensive delivery system.
- Programs of prevention and health education should be emphasized to gain full use of available resources by combining, coordinating and strengthening health resources.
- The Department, the State Board of Health, the Oklahoma Turning Point Initiative, and other partners should annually review the health status of Oklahomans and should review progress in the development of the health care system, to ensure that the goals and objectives of the Oklahoma Rural Health Care Plan are kept current.
- The Department should continue with periodic updates of the Health Status Indicator Profiles database.
- The Department and other partners should encourage all payors to recognize critical access hospitals and to influence revisions in reimbursement programs to ensure equity for critical access hospitals.
- The Department and other providers should increase primary health care services in medically underserved rural areas.

Periodic Review and Evaluation of the Plan

The Department annually shall review the status of the health of Oklahomans and the development of the health care system. The purpose of the annual review is to ensure that the goals and objectives of the plan are kept current. The annual review shall include the following:

- Analysis of data on key health indicators to determine overall improvement in the health of Oklahoma's citizens;
- Review of patient origin data to verify the currency of network and regional health care patterns;
- Review of each designated hospital's support for the development of an integrated rural health network, including participation in:
 - Credentialing and quality of care agreements;
 - System development activities, including efforts to develop and implement the following linkages:
 - Transportation;
 - Communication;
 - Patient information;
 - Trauma and emergency services;
 - Personnel;
 - Health education and outreach;
- Assessment of progress towards full implementation of regional health networks, and in particular the development of comprehensive linkages in Oklahoma's health system, ranging from education, preventive services, primary care, and critical access hospitals in local communities to secondary and tertiary providers of specialty services on a regional or statewide basis.

Appendix A. Quality of care examinations

(a) The Department shall examine the quality of a critical access hospital's health care services at least once every three (3) years and more often if necessary for the protection and in the interest of the people of Oklahoma and patients of the critical access hospital.

(b) The Department may conduct the examination or the Department may require the critical access hospital to contract for the examination. If the Department requires the critical access hospital to contract for the examination, the critical access hospital shall select an approved independent quality examiner from a list maintained by the Department.

(c) The Department shall maintain a list of approved independent quality examiners who have demonstrated conformity to the following requirements:

- (1) The examiner has written criteria and standards for assessing the quality of clinical care and the availability, accessibility and continuity of care;
- (2) The examiner limits clinical judgements to physicians with experience in the delivery of health care, and all final conclusions, opinions and recommendations shall be made or endorsed by physicians;
- (3) The examiner has a training program for review team members to ensure uniform application of standards;
- (4) The examiner ensures the confidentiality of medical and health care information; and
- (5) The examiner institutes reasonable measures to ensure that review team members and their families have no financial interest in the critical access hospital being examined or in any other critical access hospital competing in the geographic area served by the critical access hospital being examined.

(d) Any person may file a request to be included on the Department's list of approved independent quality examiners. The request shall be in writing and shall demonstrate conformity to the requirements in (c) of this Section. The Department shall respond in writing within thirty (30) days after receiving the request. The Department at any time may remove approval status from an examiner for failure to maintain compliance with (c) of this Section, or for providing to or accepting from a critical access hospital any gift or favor other than a reasonable and usual charge for the performance of a quality examination.

(e) The quality examination shall include assessments of the following:

- (1) The adequacy of involvement of the critical access hospital's governing body and medical director in quality assurance activities;

- (2) The scope and content of the critical access hospital's quality assurance program; and
 - (3) The adequacy of the critical access hospital's medical records.
- (f) The examination process shall include:
- (1) Preliminary reviews to familiarize the examiner with the critical access hospital;
 - (2) A site visit to review records and to interview critical access hospital officers, the medical director, a member of the governing body, members of the quality assurance committee, the patient care coordinator, a customer service representative, and other providers, governing body members, and critical access hospital personnel;
 - (3) An on-site summation; and
 - (4) Written preliminary and final reports.
- (g) The critical access hospital and the quality examiner shall provide the Department access to observe record reviews, interviews, and the on-site summation.
- (h) The quality examiner shall prepare a report based upon the assessment team's findings. One (1) copy of each report shall be submitted to the Department. The report shall contain, at a minimum, the following information:
- (1) A description of the critical access hospital's quality assurance program;
 - (2) An evaluation of recent quality assurance activities undertaken by the critical access hospital, and the degree of implementation of the written quality assurance plan;
 - (3) A description of the types and numbers of medical records reviewed, selection criteria, and review methods;
 - (4) A summary of charts that met and did not meet the established review criteria;
 - (5) Recommendations for follow-up, when indicated; and
 - (6) A list of the names and titles of individuals that conducted and analyzed the review.
- (i) The critical access hospital shall forward to the Department a complete and unaltered copy of the final report within five (5) working days after the critical access hospital receives the report from the quality examiner.