Statement of

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President, Good Shepherd Health Care System
Hermiston, Oregon

before

Senate Special Committee on Aging

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Chairman Kohl, Ranking Member Smith, and distinguished members of the committee: Thank you for the opportunity to provide testimony on behalf of our hospital and community. I hope my testimony is representative of many smaller hospitals in America and contributes to improving healthcare for all Americans living in rural communities, including our senior populations.

My name is Dennis Burke. I am the president of Good Shepherd Health Care System in Hermiston, Oregon, where I have had the pleasure of serving for the past 20 years. I am also the current finance section chair of the Small and Rural Hospital Committee of the Oregon Association of Hospitals. This committee focuses on financial issues of Oregon's smaller hospitals.

Hermiston is a rural community located in north central Oregon, near the Columbia River and the Washington state border. We enjoy a mild desert climate and have a strong, diverse economy. While Hermiston itself has approximately 17,000 residents, Good Shepherd Health Care System serves an area population of about 50,000.

Surrounding hospitals range in distance from 30 miles east to Pendleton to over 100 miles west to The Dalles. The closest tertiary referral hospital is Kadlec Medical Center, 40 miles to the north in Richland, Washington.

Part of the mission of Good Shepherd Health Care system is to improve community access to healthcare services. In doing so, we have attempted to offer as broad a spectrum of ancillary and acute medical services as we can competently provide in a financially feasible manner. Good Shepherd Health Care System is accredited by the Joint Commission and offers general medical, OB/GYN, pediatric, critical care and surgical services. We have a busy 24/7 Emergency Room that is designated as a Level 3 trauma center. Our emergency room also serves as a major primary care safety net for our region. Our health care system also provides home health and hospice care, a retail pharmacy and a transportation service. We also offer or sponsor approximately 600 health education programs per year, focusing on improving and maintaining the health of our community.

Our community has seen a significant growth in the number of seniors targeting Hermiston and the vicinity for retirement. In fact, the city of Hermiston and our Chamber of Commerce actively promote Hermiston as a destination retirement community. We now have six assisted living facilities and very active area community senior center programs. From my 20-year vantage point, service availability and access to care has greatly improved in Hermiston and our surrounding communities.

I would like to take this opportunity to express my appreciation to you, our government leaders and to CMS for the supportive programs and grants that have strengthened America's smallest hospitals that serve its most vulnerable communities.

The Critical Access Hospital program is a prime example of this support. Prior to the Critical Access Hospital (CAH) program, Good Shepherd Health Care System suffered financial losses for several straight years. Following our enrollment in the CAH program 2 ½ years ago, Good Shepherd Health Care System is now on solid financial footing.

This improvement in financial position has allowed us to keep our technology reasonably current, enhance our facilities to meet our current needs, and to compete more successfully for scarce professional and technical talent.

We also appreciate the Rural Hospital Medicare Flexibility Program grants that have been provided to assist rural hospitals in improving quality, safety and education. We are a very supportive member of the Oregon Rural Health Quality Network. This consortium of rural hospitals, combined with the State Office of Rural Health and other quality stakeholders, was formed to help Oregon's smallest hospitals work in a collaborative environment to improve health care for all our citizens. The FLEX grants have been instrumental in providing resources to assist the network in achieving its goals. The Oregon Rural Health Quality Network has become a very effective forum assisting Oregon's rural hospitals in measuring their quality performance and developing best practices.

OPPORTUNITIES FOR IMPROVEMENT

While much is good, there are opportunities for improving healthcare in rural America. I would like to focus on our two top opportunities in Hermiston.

1. **Recruitment and retention of professional and technical personnel is our foremost day-to-day challenge.** There is no question that shortages of key health care professionals and technical personnel exist, and unless there are system changes, this problem is only projected to get worse. In our experience, it's not for a lack of applicants. There are many interested and qualified students that cannot get into healthcare programs due to a lack of capacity within the education system.

Our local college - Blue Mountain Community College in Pendleton - has three qualified applicants for every available position in their nursing program. We work closely with Blue Mountain Community College as a clinical site and rely heavily on them for qualified nurses. Several years ago, Good Shepherd Health Care System and St. Anthony Hospital in Pendleton partnered with Blue Mountain Community College to help fund an additional faculty position to increase the enrollment size of the nursing program. This has provided an additional 6-7 nursing graduates per year, which has been very favorable for our hospitals and communities.

We are excited about our partnership with the new medical school in Yakima, Washington. The Pacific Northwest University of Health Sciences will enroll its first class of medical students this September. In two years, we will begin participating as a site for their clinical rotations. Part of the mission of this new medical school is to focus on local, qualified applicants who hopefully will have a high penchant for returning to their local communities. We, as well as many other rural communities in our region, look forward to an increase in the number of local students who will be able to achieve their healthcare dreams and hopefully return to their local communities.

While these programs are a positive step, they are but a small contribution toward solving the health care professional shortage problem. Much more needs to be done across our country to increase access and availability for qualified students who wish to pursue health care careers.

2. Secondly, **I would like to speak to the Critical Access Hospital Program 25-bed cap.** Good Shepherd Health Care System runs an average census of approximately 17 patients per day. But that census has varied this past year from a low of 10 to a truncated high of 25, the point at which, in order to be compliant, we must transfer patients to other

hospitals—patients that we could otherwise care for within the community. While we have been successful in minimizing the number of transfers through careful utilization review and discharge planning, transfers are becoming more frequent as our population continues to grow. Good Shepherd Health Care System's large obstetrics program compounds the problem. Many CAHs do not provide OB services; therefore, all of their beds are available to the community for other medical and surgical services. Good Shepherd Health Care System performs approximately 600 deliveries per year—about twice the average number of annual deliveries for a hospital of our size. This is due to a younger workforce population and a significant migrant population in our service area. Our obstetrical census varies widely. Over the past year, our OB daily census has ranged from 0 to 11 patients. OB patients count toward the CAH 25-bed cap. This means that beds available for other acute patients vary from 25 beds down to 14, depending on the daily OB census. While OB services generally have little to do with Medicare patients, they certainly have an impact on our seniors' access to care depending on "the luck of the draw" when they present for acute services.

Since our inception as a Critical Access Hospital, we have had 17 transfers due to the 25-bed limitation. In addition to being disruptive and inconvenient for the patient and the patient's family, a transfer involves a high degree of unnecessary risk to the patient and adds significantly to the cost of care. GSHCS and our community have been fortunate in that I do not have examples to share of patients encountering acute problems while in transport. Other CAHs have not been so lucky. But, we believe that none of the transfers that we have made resulted in a significant cost savings at another facility, especially when coupled with the cost of transporting the patient—a minimum of $1,200—to our closest receiving facility.

We strongly feel that increased flexibilty would greatly benefit all CAH communities, placing access on an equal footing in those communities that choose to maintain local OB services.

I want to thank our Oregon Senators Smith and Wyden for their understanding of the problems that the 25-bed cap has caused and their collective efforts in developing the Critical Access Hospital Flexibility Act. This bill provides for use of an annual average daily census as a determinant for Critical Access Hospital eligibility. We believe this would be a far better delimiter. We encourage this committee to support the intent of this legislation: allowing critical access hospitals to discontinue our current counter-intuitive approach of transferring patients when our facilities have the ability to provide the service. This modification will strengthen America's smallest hospitals, and enable them to fulfill their missions in serving their communities as they are prepared to do.

I appreciate the opportunity to present this testimony before you today and certainly would be willing now or at any time to take questions on the views I have expressed or on other questions pertaining to small and rural hospitals. Thank you.