Statement of

Konnie Martin

Chief Executive Officer, San Luis Valley Health, Alamosa, CO

Committee on Finance

U.S. Senate

"Rural Health Care in America: Challenges and Opportunities"

May 24, 2018

Thank you for the opportunity today to share our healthcare story. I am the CEO of a small health care system located in the San Luis Valley, which is a rural, agricultural-based community in southern Colorado. We serve 6 counties, an area roughly the size of Massachusetts, and are the safety net for our nearly 50,000 community members. Two of our counties are the poorest in Colorado; nearly 70 percent of our patients are covered by Medicare or Medicaid, with less than 20 percent having commercial insurance. With this challenging payer mix, we constantly struggle to remain financially viable. SLVH and rural hospitals around the country are appreciative of this Committee's commitment to rural communities, and we are hopeful that meaningful help is on the way.

Our system is comprised of a 49-bed sole community hospital and a 17-bed Critical Access Hospital. We operate 5 rural health clinics -2 of which are provider-based. This past year we provided 2,500 hospital visits, 58K outpatient services, and over 65K clinic visits. We are a Level III trauma center and the only facility that delivers babies, provides surgery or any type of specialty care for 120 miles in any direction. We serve veterans, farm workers, college students, tourists and our own friends and family. We are a resilient and creative team of health care providers.

We are the largest employer in our region and employ over 800 staff. Many of them have lived in our community their entire lives - and their families for generations. As for me, I moved to the Valley in 1985, and began my healthcare career in an entry-level IT position - back when the personal computer was new technology - and have worked my way into my current CEO role.

Our staff struggles with the costs of meeting regulatory requirements, which are often different – and sometimes conflicting across payers. Our system must report on dozens of measures for the Medicare quality and pay-for-performance programs. However, our private insurers ask us to report yet more – some on the very same topic, but using different definitions. This complex and confusing data reporting takes time away from what really matters –delivering on our health care mission.

Recruiting and retaining a qualified workforce is another major challenge for rural providers. We have been fortunate to form partnerships with local and state schools that help develop and maintain our workforce. Specifically, we have multiple "grow your own" programs – from

paramedic training, hosting medical students, internships, and mentoring those pursuing a healthcare MBA. We collaborate with the local community health center to host a Rural Residency Training Track Program. We are set to have the first 2 physicians complete their training in June 2019.

We have our own work force success story to celebrate with two family medicine physicians who returned to their childhood homes to care for their friends and neighbors. And, we have a physician who came during college to serve as a volunteer at a local shelter, and today he's a surgeon in our organization.

Rural communities pride themselves on hard work and taking care of their own. However, federal payment systems and delivery models must recognize the unique circumstances of providing care in rural communities, and must be updated to meet the realities and challenges of how health care is delivered today and in the future. About 10 years ago, the critical access hospital that is part of our system approached us for help. Nearing closure and in dire financial condition, we entered into a partnership to provide management services and financial support. Then, in 2013, this CAH fully merged into the system that is today, SLV Health. This type of arrangement prevented a hospital closure, but such partnerships are not available to many rural hospitals. And we see the result with 83 rural hospitals closing since 2010 and 12 CAHs in CO currently are operating in the red today.

Therefore, I am here today to ask for your support and consideration for new financial models that consider our needs, including the creation of a 24/7 rural emergency medical center designation, such as the AHA has recommended, and that Sen. Grassley has championed. And I ask you to provide appropriate resources, flexibility, and ongoing dialogue with those of us in rural America who stand ready to innovate, work hard, and meet the current challenges of caring for our friends and neighbors. In a country as great as ours, where you live should not determine if you live.

Again, thank you for having me here today.

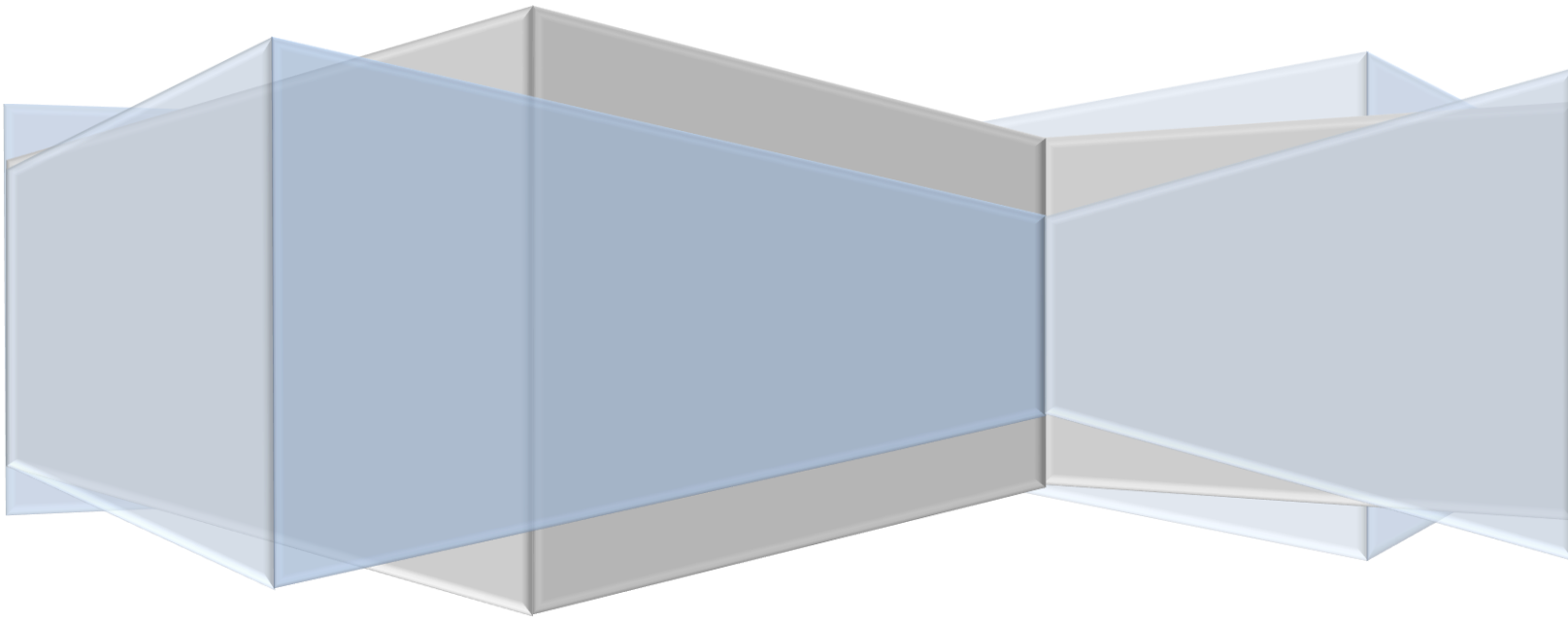
San Luis Valley Health

Rural Health Care in America: Challenges and Opportunities

Testimony to the United States Senate Committee on Finance

Ms. Konnie Martin
Chief Executive Officer
San Luis Valley Health
Alamosa, CO

May 24, 2018



Thank you for the opportunity today to share our healthcare story. I am the CEO of San Luis Valley Health (SLVH), a small health care system located in the San Luis Valley, which is a rural, agricultural-based community in southern Colorado. We serve six counties, an area roughly the size of Massachusetts; and are the safety net for our nearly 50,000 community members. Two of our counties are the poorest in Colorado. Nearly 70 percent of our patients are covered by Medicare or Medicaid, and less than 20 percent have commercial insurance. With this challenging payer mix, we constantly struggle to remain financially viable. SLVH and rural hospitals around the country appreciate this Committee's commitment to rural communities, and we are hopeful that meaningful help is on the way.

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Rural Hospitals are facing significant challenges across the country with 83 rural hospitals closing since 2010. Currently 12 CAHs in Colorado are operating in the red. Regulatory burden, limited resources, challenging payer and patient mix, and geographic isolation are among the key hardships facing rural hospitals. For example, our staff struggles with the costs of meeting regulatory requirements, which are often different – and sometimes in conflict across payers. We must report on dozens of measures for the Medicare quality and pay-for-performance programs. However, our private insurers ask us to report on yet more measures – some on the very same topic, but using different definitions. This complex and confusing data reporting takes time away from what really matters –delivering on our health care mission.

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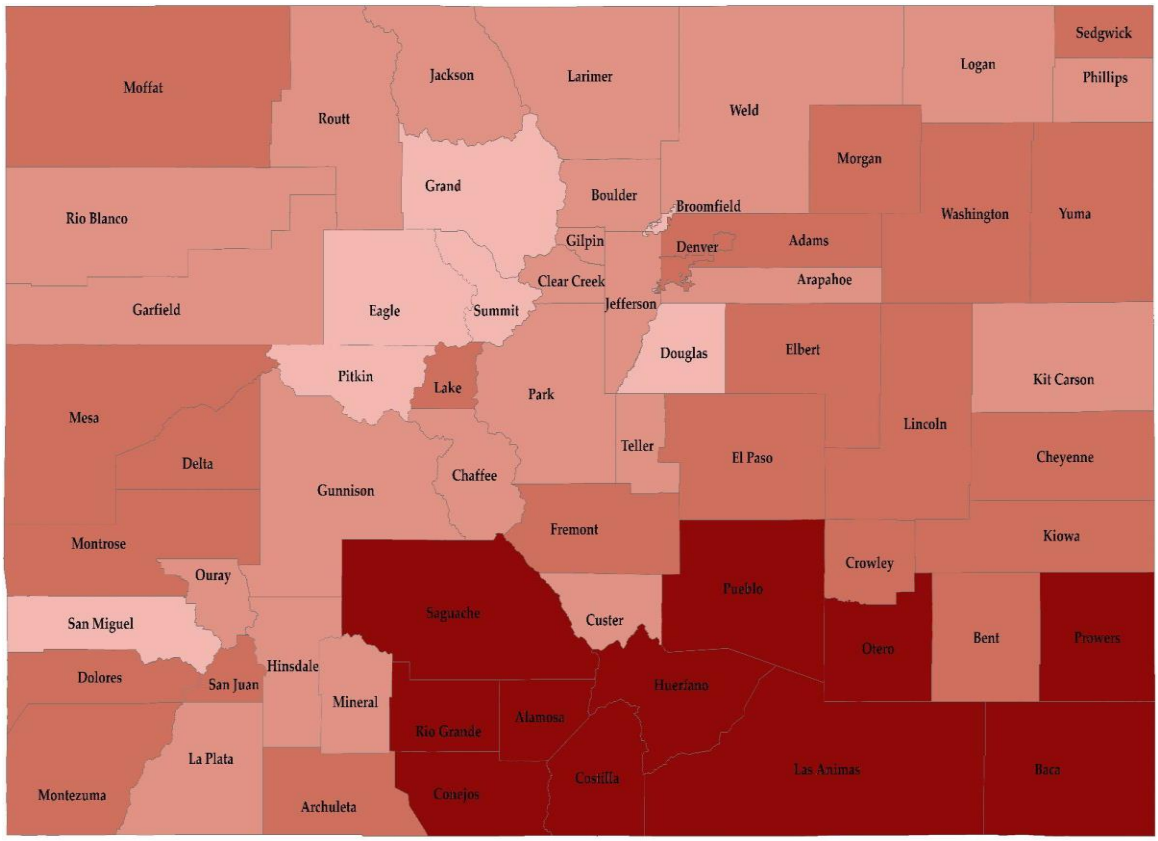
Overview of Health Care in Rural Colorado

- Nearly 750,000 people live in Colorado's 47 rural counties.
- CAHs and Rural Health Clinics (RHC) were established to provide access to care in rural communities. Rural Colorado has older, sicker, poorer patients than its urban counterparts. CAHs and RHCs do not have a high-volume patient population to provide care without cost-based reimbursement.
- In Colorado's rural counties 30% – 60% of patients are on Medicaid and Medicare, and some facilities see upwards of 70% Medicare and Medicaid patients (78% in Costilla County, 68% in

Huerfano, 54% in Delta County – see dark red counties below, data is from County Health Rankings, geocoded by Colorado Rural Health Center, the State Office of Rural Health as of May 2016).

Colorado: Medicaid Enrollment by County



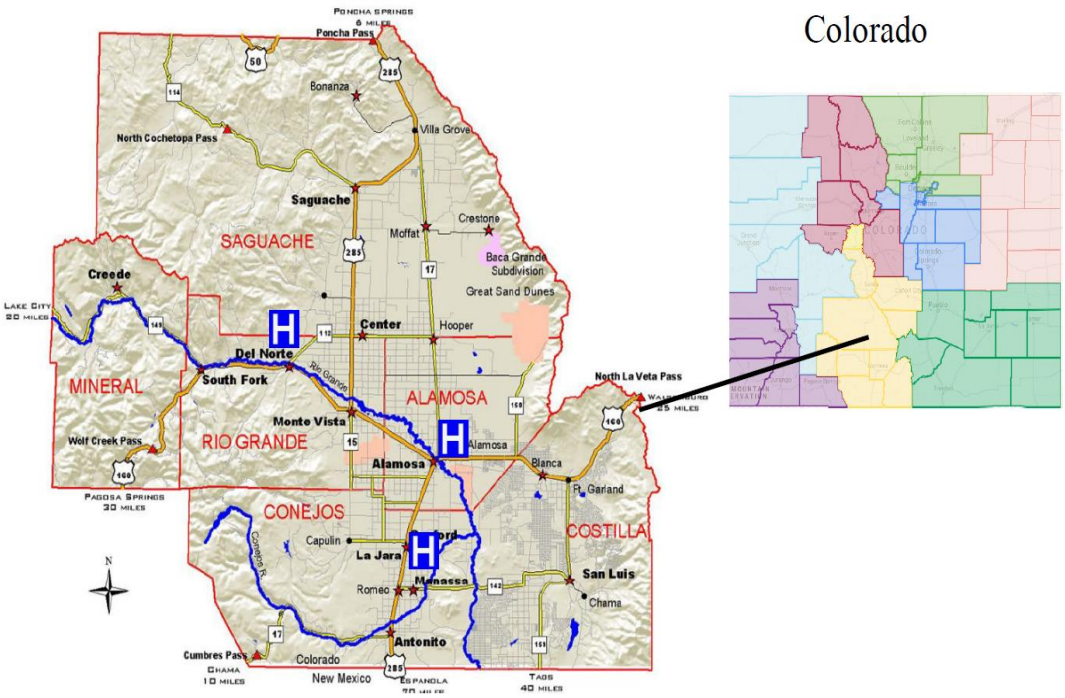
Overview of San Luis Valley Health System

SLVH is an essential health care system with roots tracing back to the 1920s when a group of concerned Lutherans accepted the responsibility of management and operation of Alamosa Community Hospital. The organization's mission, "To be a premier, fully-integrated rural health care system providing exceptional, patient-centered services to the San Luis Valley," directs its partnerships between patients, families, and health care providers and the strategies that drive current organizational priorities and program services.

SLVH is a non-profit, 501(c)(3), that provides various forms of health care services to nearly 50,000 residents who make up the total population. SLVH Regional Medical Center (RMC) offers the only nearby Level III Trauma Center that offers 24/7 access to orthopedic and general surgeons. SLVH RMC also offers the only labor and delivery unit within 120 miles, which means that patients do not have to travel over a mountain pass to deliver their newborns. SLVH Conejos County Hospital (CCH) Emergency Department (ED) uniquely serves residents in two of the state's poorest counties, Conejos and Costilla,

and northern New Mexico. Rio Grande Hospital distinctly serves the west end of the SLV. Three counties in the SLV region do not have a hospital.

SLVH also includes a physician service practice that provides primary and specialty services, behavioral health, and other ancillary services—three of its five clinics are designated as RHCs and two are designated as provider based. SLVH partners and collaborates with each SLV hospital, all local clinical providers and nursing staff, in addition to other relevant community partners such as behavioral health, law enforcement, health and human services, to ensure that resources are maximized and not duplicated in a manner that benefits optimal patient outcomes. The true beneficiaries of this level of care are all the residents who have access to a reliable health care system that provides quality health care services to all patients, regardless of where they live or ability to pay. A geographic illustration of the SLV region and SLVH hospital designations are provided below:



Community and Geography

The SLV is the largest and highest valley in North America, surrounded by three mountain ranges that effectively isolate the Valley from the rest of Colorado. The region spans 8,194 square miles and is comprised of six counties covering Alamosa, Conejos, Costilla, Mineral, Rio Grande and Saguache Counties. According to the 2017 U.S. Census Bureau Population Estimates Program, the total population is 47,204, with rich diversity represented by a sizeable Hispanic population (41% compared to 21% statewide) as well as a significant population of indigent and migrant farm workers. Close to one third of the population (28%) speaks a language other than English at home, compared to a rate of 17% in

Colorado (U.S. Census Bureau, American Community Survey {ACS} and Puerto Rico Community Survey {PRCS], 5-year Estimates).

Three of our six counties are designated rural and three are frontier. Frontier areas are sparsely populated rural areas, which are isolated from population centers and services and are defined as counties having a population density of six or fewer people per square mile. This definition does not take into account other factors that may isolate a community such as challenges in accessing public transportation, affordable housing, health and human services, and other social support. Of the six counties in the region, two are among the five poorest counties in Colorado. 22% of the population lives below poverty level (compared to 11% for Colorado), and (in 2016 dollars) median household income levels of $35,897 fell short of the state's comparable $62,520 (U.S. Census Bureau, ACS and PRCS, 5-Year Estimates). Economic, cultural and other social determinants of health exacerbate geographic and other challenges of providing health care services. The number of persons in the SLV without health insurance, under age 65 years averages 12.5%, compared to the state average of 8.6% (U.S. Census Bureau, QuickFacts). Seventy-one% of patients served at SLVH in 2017 were enrolled in Medicare and/or Medicaid. In fiscal year 2016-17 SLVH provided $1,126,323 in charity care, not including $1,758,532 in bad debt. Importantly SLVH provides services to all patients regardless of their ability to pay.

Social determinants of health, the geographic expanse of the SLV region, inadequate reimbursements, regulatory burden and other factors pose public health challenges for residents and the health care system. Coordinating health care services across the continuum of care is mired with complications rooted in these factors as well as information gaps occurring at the point of service and siloed information systems. Additionally, there are significant costs associated with maintaining and updating aging facilities (dating back to the 1920s (RMC) and 1960s (CCH)) and outdated equipment, which are not factored into reimbursement. Through all of this, SLVH perseveres in its goal of providing health care services that meet the needs of its community while also meeting the standards of care in line with Colorado's other health care providers, hospitals, and designated trauma centers.

Aligning Services with Community Needs

SLVH and rural hospitals around the country constantly work to match the services they provide to the needs of their communities. Every three years, SLVH conducts a community health needs assessment involving community stakeholders and patient feedback. The primary need identified during the 2016 survey was addressing substance abuse and mental health. This aligned with an analysis commissioned by the Colorado Office of Behavioral Health regarding substance use disorder services that documents gaps and needs that are significant and varied, and underlines that nearly every population (in Colorado) is underserved. These needs correlate directly with current demographics that indicate residents in the SLV report a higher incidence of poor mental health days compared to state and national rates. [Robert Wood Johnson Foundation, 2017 County Health Rankings and Roadmaps]. Ranking data also shows SLV counties have fewer mental health provider ratios (except for Alamosa County).

In addition, just as in the rest of the nation, an increasing number of residents in the SLV are experiencing opioid dependence, abuse or misuse, and/or addiction, and many are turning to heroin and other cheap alternatives. These disorders are often associated with chronic physical illnesses such as heart disease and diabetes, and when one is out of control, it affects the other. These disorders also increase the risk of physical injury and death through accidents, violence, and suicide. Overall, only about half of those affected receive treatment according to the National Institute of Mental Health.

SLVH has provided Behavioral Health (BH) services in its busiest primary care clinic since 2011, and has increased BH staffing throughout primary care clinics, including the use of Care Coordinators, who help connect and engage patients in their own self-management beyond clinic exam rooms. Currently all SLVH primary care clinics provide Screening Brief Intervention Referral and Treatment (SBIRT), Drug Abuse Screening Tests (DAST), Pain Management Agreements, prescription drug monitoring, referral to medication assisted treatment, social supports and care coordination for patients who are at risk or are already abusing substances. Other ancillary supports include physical therapy and chiropractic treatment. BH staff participate in the development of integrated BH treatment plans and follow up on emergency room and hospital admissions in order to positively impact clinical outcomes, patient-provider satisfaction, and cost of care. SLVH EDs are implementing clinical guidelines for alternatives to opioids to help address the opioid epidemic and prevent future misuse. (Please see the attached SLVH Opioid Puzzle.)

Commitment to Quality and Safety

SLVH is dedicated to providing high quality care to our patients, and participates in many quality measurement and improvement efforts. While we are proud of our performance, many of the current measures and methods of publicly reporting our quality data do not fully reflect the quality care our patients receive in our facilities. SLVH provides safe and high quality clinical services and demonstrates superior outcomes by assessing performance with objective and relevant measures, however not all mandated measures are applicable or reflective of true patient care services.

SLVH's Quality and Safety Plan is a collaborative effort with SLVH's Quality and Safety Department, Risk Management, all clinical services, and the medical staff. All departments of the organization develop annual goals to address and support improvement of the care, treatment, service, efficiency, and safety of outcomes that align with the organization's overall mission.

The Quality and Safety Department utilizes many resources to identify areas of improvement for SLVH, such as: Event Reporting System, HAC, Culture of Safety Survey, Core Measures, HCAHPS/CGCAHPS, MACRA/MIPS, HQIP, MBQIP, QualityNet, etc. The chart on the following page helps illustrate the number of regulatory agencies to which SLVH reports, as well as the number of initiatives and metrics on which we report. It also provides a crosswalk of the number of metrics reported to multiple agencies. As this chart clearly illustrates, the staff time required for data input, the time required for manual abstraction, and other administrative resources needed to fulfill the reporting requirements render these metrics and methods of reporting antiquated and ineffective.

Targeted regulatory reform is needed to allow rural hospitals to report meaningful, accurate quality measures aligned with the services provided and that account for the challenges of measuring in the rural environment, including low patient volumes, the wide variation in service mix and socioeconomic factors. Rural hospitals want to be recognized for the quality of care we are providing, however we need the right measures and methods for reporting. (Please see the Metric Crosswalk on the following page.)

Metric Crosswalk

Required Reporting Metrics

	NHSN	MIPS	HQIP	HIIN	CPC +	eCQM	i-Care	WSM	IQR	OQR	Hos Compare	Readmission Penalty	MBQIP	VBP
7-day Readmissions								x						
All-Cause Readmissions		X	x	x				x			x	x		x
AMI Measures										x		x	x	
Breast Ca Screening		X			x									
Cataract Surgery		X								x	x			
CAUTI	x			x					x		x			x
C-diff	x			x					x		x			x
CLABSI	x			x					x		x			x
Closing the referral Loop		X			X									
Colon Follow-up		X								x	x			x
Colonoscopy Return		X								x	x			
Colorectal Screening		X			x									x
CP										x		x	x	
C-Section Rate		X	x											
CT MRI		X									x			
Culture of Safety			x	x										
Diabetic -A1C		X			x									
Diabetic Eye Exam		x			x									
ED Throughput						x				x		x	x	x
EDTC													x	
Employee FLU	x									x				
Falls, Risk Assessment		x			x									
HCHAPS			x				x	x			x			x
HF D/C							x							
High BP		X			x									

(AMI – Acute Myocardial Infarction; CAUTI – Catheter Associated Urinary Tract Infection; CLABSI – Central Line Associated Blood Stream Infection; CP – Chest Pain; EDTC – Emergency Department Transfer Communication; HF D/C – Heart Failure Discharge Communication)

Rural hospitals face the same complex reporting and regulatory requirements as larger urban facilities, but with fewer available technology supports and financial and staff resources. As mentioned above, data submitted through registries and vendors requires hours of manual abstraction. One-size-fits-all metrics are not an accurate way to measure clinical care, nor do they add value to health delivery processes in rural areas. Oftentimes the metrics do not apply to low-volume service lines or match the needs of the community identified in the health needs assessment. For example, SLVH maintains an average daily census of less than one in its Intensive Care Unit (ICU), but is still required to report specific ICU measures, such as infections from catheters and central lines. Although the organization has been fortunate to report no central line infections in several years, SLVH is still required to use a registry to identify all eligible patients and to abstract data from their charts into a national reporting system. There is no applicability, and this information does not provide a meaningful comparison against similar organizations. These metrics are based upon volume standards much larger than SLVH.

Another example, in the last year: SLVH had one catheter associated urinary tract infection in its ICU, but because patient days are so low, the overall rate of infections looks disproportionately high. This causes confusion and frustration among caregivers and instills a lack of confidence in our patients

seeking safe and reliable care. These metrics also impact SLVH's CMS star rating and potentially reimbursement through programs like Value Based Purchasing.

SLVH remains completely committed to providing safe and effective health care and to being accountable for the delivery of quality health care services through established metrics. However, rural providers need the flexibility to report data on measures which reflect its services and patient population. An example of a meaningful quality improvement metric is the reduction of early elective deliveries. SLVH RMC serves as the only hospital in the SLV that delivers babies. A few years ago, staff recognized an uptick in early elective deliveries. Providers and nurses developed a process improvement plan and over the course of 18 months reduced early elective deliveries from 10% to 0%. This is great example of a quality metric that was meaningful, relevant and resulted in safer and more affordable patient care. Each rural hospital has their own unique story about their patient population and needs the flexibility to identify priorities based upon data, patient population and community health needs assessment data to identify a menu of reporting metrics. Rural providers also need to be benchmarked against similar peers so that the ratings are more meaningful and add context.

Meaningful Use and Electronic Health Records

Meaningful Use (MU) reporting is another area that deserves careful consideration. SLVH implemented its Electronic Health Record (EHR) in 2013, and 2018 will be the sixth year of reporting. We initially participated in the program because of the opportunity it held for improving patient care and shared investment in the adoption and use of EHRs. For example, the incentive potential was meaningful as both RMC and CCH Hospitals are dual eligible, which means incentives were possible under both Medicare and Medicaid. However, the incentive funds were not enough to address the ongoing costs of the program, including updating and maintaining the technology. Currently, SLVH attests to Medicare MU because reporting is required to avoid payment penalties. We no longer report to Medicaid MU.

MU criteria is constantly changing, which presents challenges for any provider, but especially rural providers. SLVH's EHR vendors struggle to provide adequate updates to our system to pull the required information. Each time there is a criteria change, an EHR update is required and SLVH must invest more time, resources and funding in order to meet MU requirements or face a penalty. Furthermore, pulling reports from Practice Partner (outpatient EHR) for eligible clinicians is time consuming. And not all meaningful use measures are relevant to SLVH, particularly at CCH where patient volume results in a low denominator for the calculation. The only electronic clinical quality data SLVH submits for CCH are ED throughput and VTE measures.

Additionally, the EHR has presented unintended challenges for clinicians, who now must report in the MACRA system. Physician attention is too often focused on clicking certain fields in the EHR instead of focused on the patient. Several measures hold the physician accountable for actions outside of the physician's control—such as the Patient Portal and Secure Messaging.

Flexibility and Alternative Payment Models for Critical Access Hospitals and Small Rural Hospitals

About 10 years ago, Conejos County Hospital (CCH), the critical access hospital that is now part of our system, approached us for help. Nearing closure and in dire financial condition, we entered into a partnership to provide management services and financial support. Then, in 2013, this CAH fully merged into the system that is today SLVH. This type of arrangement prevented a hospital closure, however it is important to note that such partnerships are not available to many rural hospitals.

The frontier county CCH serves is home to 8,200 people in an agricultural dependent area, larger in square miles than the state of Rhode Island. The poverty rate for Conejos County is just above 22%, and the payer mix of CCH is 80% Medicare and Medicaid. Cost based reimbursement has allowed the hospital to reduce its financial vulnerability and maintain access to essential services in a vulnerable area of the state. This reimbursement model has also provided flexibility in staffing and services, access to Flex Program resources and grants, and the inclusion of capital improvement costs in allowable expenses. By maintaining a modest, but positive margin, CCH has been able to make improvements in its existing facility, replace vital patient care equipment, and meet regulatory requirements. SLVH CCH has also been able to recruit health care professionals to an underserved area. Again, these partnerships are not available to all struggling CAHs who are facing decisions about reducing or eliminating services or even closing.

Because of our partnership, SLVH has been able to streamline CCH and RMC services and costs to ensure the highest quality of services and efficiencies, with an eye toward providing services within CCH that meet the community's unique needs. With its aging population, the needs for diagnostic services, therapy, past-acute rehabilitation (swing beds), and 24-hour emergency services have emerged as the community's most pressing needs. The number and type of inpatient services offered at CCH have declined over the last ten years. This dramatic decrease in market share for inpatient services is illustrated in the chart below, which highlights the decline in inpatient services and rise in demand for ED patients, swing, observation, and other outpatient services.

Year Reported	**2014**	**2016**	**2017**
Inpatient Market Share	37.1%	23.8%	15.4%
Outpatient Market Share	37.5%	48.1%	49.3%

As rural healthcare facilities continue to adapt to the changing needs of our patient population, we need the tools and flexibility necessary to innovate and respond. Alternative payment models, such as a 24/7 rural emergency department designation would provide an option for certain small rural hospitals struggling to maintain access to care in their communities. The creation of a 24/7 rural emergency medical center designation, has been recommended by the American Hospital Association (AHA) Task Force on Ensuring Access in Vulnerable Communities. Senators Chuck Grassley and Amy Klobuchar have introduced bipartisan legislation in the Senate to establish such a designation under the Medicare

Program. Similar bipartisan legislation has also been introduced in the House by Representatives Lynn Jenkins and Ron Kind.

Workforce Challenges

Recruiting and retaining a qualified workforce is another major challenge for rural providers. SLVH has been fortunate to be able to develop partnerships with local and state schools to help develop and maintain our workforce. Specifically, we have multiple "grow your own" programs – from environmental systems maintenance programs through technical school education to nurse professional programs through our local junior college and Adams State University. We partner with medical schools, advance practitioner training programs, physical therapy and pharmacy schools, and many others. We use innovative strategies to educate and train those who desire to work and live in a rural community. This partnership provides meaningful employment opportunities while serving our community's healthcare needs.

SLVH collaborates with the local community health center to host a Rural Training Track Residency Program. We are set to have our first two physicians complete their education in June 2019. We have around 100 physicians in our community; only two of those are in private practice: the other 98 are employed. We are at the forefront of provider-hospital integration driven by the financial necessity of collaborating.

Federal programs currently exist to help make it easier for physicians to practice in rural areas. It would be helpful for Congress increase the number of Medicare-funded residency positions and extend the Conrad State 30 J-1 visa waiver program.

Conclusion

Rural hospitals and communities pride ourselves on hard work and taking care of our own. However, federal payment systems and delivery models must recognize the unique circumstances of providing care in rural areas, and be updated to meet the realities and challenges of how health care is delivered today and in the future.

SLVH's two hospitals are the anchors of the health care infrastructure in our region. However, the fixed costs of providing care in rural communities is an ongoing challenge. We must maintain and update our facilities, and medical equipment and hire, train and retain highly skilled staff. Additionally, regulatory burden, geographic isolation, low patient volumes, limited resources and a challenging payer and patient mix are also hardships we deal with every day. Some recommendations to address these challenges are listed below.

- Support models allowing for adjustments in what defines a CAH**,** including the creation of a 24/7 rural emergency medical center designation, such as the AHA has recommended.
- Reduce the number of metrics, streamline metrics across regulatory agencies, and establish clear definitions of the metrics required.
- Change the regulations to allow true integration of care. Clarify the unnecessarily burdensome regulations around co-location, removing those that serve as barriers to integrating care in rural communities. Co-location saves the system resources and allows rural facilities to offer a broader range of serves in a cost effective manner.

- Support flexible models for telehealth: In order to help deal with the severe workforce shortages allow rural facilities to be an originating site for telehealth. Remove barriers so that rural facilities may fully utilize telehealth services.
- Support existing federal programs to help make it easier for physicians to practice in rural areas: increase the number of Medicare-funded residency positions and extend the Conrad State 30 J-1 visa waiver program.

I thank this Committee for the opportunity to speak today and appreciate your commitment to deliver meaningful reforms and resources that will help us in rural communities meet the current challenges of caring for our friends and neighbors. In a country as great as ours, where you live should not determine if you live.

San Luis Valley HEALTH

Helping Solve the Opioid Puzzle

SanLuisValleyHealth.org

San Luis Valley Health is taking a deliberate path, using up-to-date clinical and operational tools for the safe and appropriate management of opioids in health care settings.

APPROPRIATE PAIN MANAGEMENT & OPIOID PREVENTION

Primary Care Clinic Visits

- Use of Current Evidence-Based Guidelines
- Screening, Brief Intervention, and Treatment (SBIRT)
- Safe Treatment Plan Development (slow tapering and discontinue when appropriate)
- Drug Abuse Screening Test (DAST)
- Pain Management Agreement
- Active Management and Monitoring (functional assessments and progress toward goals)
- Use of Prescription Drug Monitoring Program
- Referral to Medication Assisted Treatment (MAT)
- Social Supports and Care Coordination
- Osteopathic Manipulation by Providers

Physical Therapy

- Acupuncture
- Dry Needling

Drug Diversion

- Chart Audits
- Staff Education
- Waste Monitoring
- Drug Testing

Integrated Behavioral Health

Emergency Department

ED Physicians will:

- Use the Alternative to Opioids (ALTO) Project (Please see back page for details)
- Obtain additional training in non-narcotic therapies
- Use the Prescription Drug Monitoring Program (PDMP) to gather data
- Provide a resource packet to patients
- Not replace lost or stolen prescription narcotics
- Not prescribe long-acting opioids

Supportive Services

- Pain Management Group
- Stress Management

Community Collaborations

- Communities That Care
- Alamosa County Prevention Coalition
- Connecting Communities That Care
- Neonatal Task Force
- SLV Veterans Coalition

Chiropractic Treatment

"SLVH is working to break our own habits of prescribing opioids, in order to help our patients break their own habits of addiction. With this goal comes hard work and dedication to both educating our providers as well as providing resources to our patients so that we can all come together as a community to fight this epidemic."

San Luis Valley HEALTH

Helping Solve the Opioid Puzzle

SanLuisValleyHealth.org

SAN LUIS VALLEY ALTERNATIVE TO OPIOIDS (ALTO) PROJECT FOR EMERGENCY DEPARTMENTS (ED)

Mission Statement:

Pain is the most common complaint in the emergency department. ED physicians are on the front line of the opioid epidemic that is crippling our community. SLV Health (SLVH) EDs have taken the initiative to start an Alternative to Opioid (ALTO) Project to curb addiction to prescribing opiates. Through this project, SLVH is educating health providers on alternatives to opioids based on the Colorado American College of Emergency Physicians (ACEP) 2017 Guidelines. This is a multi-disciplinary training which includes administration, pharmacy, IT, anesthesia, respiratory, nursing, Advanced Healthcare Providers (AHP) and physicians. Knowing full well that just decreasing prescribing habits isn't going to solve the epidemic, an informational packet has been developed for patients that provides resources for substance abuse, therapy and other pain management tools.

CURRENTLY IMPLEMENTING:

- Colorado Hospital Association (CHA) Safety Pilot Results and Colorado ACEP Guidelines
- Updating the outpatient clinics' pain agreement to make it more user friendly
- Updating pain policies in the ED
- Internal auditing to review data on prescriber habits
- Approving and stocking alternative medications in SLVH's pharmacy
- Creation of order sets to prompt providers to use ALTOs to ensure patient safety
- Educating nurses, AHPs and providers on the use of ALTOs
- Developing a packet of local substance abuse resources for patients
- Medical Directors of local EDs are working together in a coordinated effort
- Working with all levels of patient care from pre-hospital (EMS), to clinics, to inpatient, police/jail/detox, and behavioral health
- Regional symposium where all local leaders in the substance abuse epidemic were brought together to share resources and develop a comprehensive plan to bring the community's resources together

PROJECT CHAMPIONS:

- Regional Medical Center (RMC) ED Medical Director: Megan Koenig, DO, MBA, FACOEP
- RMC ED Nursing Director: Monica Hinds, BSN, RN
- Conejos County Hospital (CCH) ED Medical Director: Donna Nelson, MD
- CCH ED Nursing Director: Tandra Dunn, RN
- Pharmacy Director: Lee Hankins, R.Ph
- Communications & Marketing: Donna Wehe
- IT Champions: Alan Newby and Cindy Jackson

PLANS FOR IMPROVEMENT

- Provider/Nurse Training (online modules and in person)
- Reduction in opioids prescribed through the ED (working with IT and PDMP to improve data mining)
- Community meetings to determine gaps in resources
- Improving access to medical records between various systems