Idaho Flex Program EVALUATION '09

A Summary of Findings from Seven CAH Case Studies

October 2009

Is the Medicare Rural Hospital Flexibility (Flex) Program and small rural hospitals' conversion to Critical Access Hospital (CAH) status improving the quality of care and the performance of small rural hospitals, enhancing local emergency medical services, and fostering network development? Seven case studies conducted from March 2006 to July 2009 were completed as part of Idaho's Medicare Rural Hospital Flexibility (Flex) Program and its program evaluation activities to examine and report on these questions. A summary of these findings is included in this report.

A. CASE STUDY OBJECTIVES AND METHODS

Case studies were completed to identify community, hospital, and other health care related changes and outcomes that have occurred due to each hospital's conversion to CAH status and its involvement in the Flex Program. The case studies were also completed to identify needs and issues for Flex Program planning purposes. Data for each case study were obtained from the Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, State EMS Bureau, and the national Flex Monitoring Team, as well as case study participants. Case study participants were asked questions related to each of the Flex Program goals, focusing on outcomes, accomplishments, needs, and on-going issues. Considering all seven of the case studies conducted, the following occurred:

- Local health services and community background information was collected on each CAH and its service area.
- A total of 61 interviews of hospital staff, hospital board members, and local emergency medical services (EMS) personnel were conducted.
- Surveys of 65 health care providers (physicians, nurse practitioners, specialists, certified registered nurse anesthetists) working in each of the CAHs were completed and included as part of the findings.
- Community focus groups were held in each CAH community and included a total of 43 participants.

A total of 169 individuals participated in the seven case studies. All seven case studies were used to complete this report.

The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, administers the Flex Program in Idaho and was the sponsor of the case study. Rural Health Solutions, Woodbury, Minnesota, conducted the case studies and prepared this report.

B. FLEX PROGRAM

The Medicare Rural Hospital Flexibility Program (Flex Program) was established through the Balanced Budget Act of 1997. It is a national program that includes 45 states, including Idaho. In essence, the Flex Program is comprised of two components – grants to assist states in implementing state specific program activities and an operating program that provides cost-based Medicare reimbursement to hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration, federal Office of Rural Health Policy, administers the grant program, while the operating component of the program is administered by the Centers for Medicare and Medicaid Services (CMS), also located within DHHS.

Six Flex Program priority areas have been established for states implementing the program, they are[1]:

- Creating and implementing a state Rural Health Plan
- Designating and supporting CAHs
- Fostering and developing rural health networks
- Enhancing and integrating Emergency Medical Services (EMS)
- Improving the quality of health care
- Evaluating Flex Program activities and related outcomes

C. CAH COMMUNITIES

Seven CAH communities participated in the case studies, including: Malad City (2009), Salmon (2009), Bonners Ferry (2008), McCall (2007), Preston (2007), Kellogg (2006), and Montpelier (2006). Considering all of the case study communities, their average population was 8,955 and the average distance to the nearest hospital was 40.7 miles at the time each case study was completed.

Community Characteristics

Each community where the case studies were conducted had unique and shared characteristics. Below is a brief description of each community.

Malad City, located in southeastern, Idaho, reportedly has the most people of Welsh decent per capita than anywhere outside of Wales. It is home to the Curlew National Grassland which is managed to promote and demonstrate grassland agriculture. Malad City community members report good community support for local activities, a family-friendly environment, access to health services, and quality schools, as well as challenges associated with air pollution, poverty, limited access to mental health services, and high unemployment.

Salmon, located in central, Idaho, has mountains, forests, the Salmon River, and access to many outdoor recreational activities. In addition, Salmon is located along the Lewis and Clark trail and is considered the birthplace of Sacajawea. Its community members report that Salmon has strong community engagement, a friendly population, limited access to fast food, access to quality health services and challenges associated with substance abuse, isolation and depression, and lack of access to some specialty services.

[1] States participating in the Flex Program are required to address all program areas except fostering and developing rural health networks.

Bonners Ferry, located in northern, Idaho, has been identified by tourists as Idaho's "friendliest city." The area consists of mountain, lake, forest, and agricultural terrain where seventy-five percent of the land is state or federally owned. Bonners Ferry community members report good community support for local activities and needs, access to health services, four distinct seasons and challenges associated with poor water quality, hazardous occupations, and lack of public transit.

Preston is located in southeastern, Idaho, and is considered the first settlement in Idaho. Though historically it has been an agricultural area, it has increasingly become a destination for fishing, hunting, snowmobiling, camping, and hiking. Preston's community members report the community has active children's social groups, a friendly population, and a population that is self-sufficient, as well as challenges associated with a lack of physicians, high cancer rates, and many people who smoke.

McCall, located in central, Idaho, is known as a vacation destination and boasts the largest skateboarding park in Idaho. McCall saw an increase in its population from 2000 to 2006 of 23.2 percent. McCall community members report the area as having a healthy lifestyle, access to alternative and preventative care, an educated population, while it faces challenges associated with poverty, many people who smoke, and a lack of health insurance in the community.

Montpelier, one of the first sites for a case study, is located in southeastern, Idaho. It is a ranching area with four season recreational activities including snowmobiling, fishing, hiking, and water sports. Farmers and ranchers raise barley, wheat, beef cattle and dairy products. Community members in Montpelier report the community has good doctors, an educated population, and few accidents, while it faces challenges associated with limited fresh produce, a high and rising cost of living, and difficulty attracting employees.

Kellogg is located in northwestern, Idaho, and is transforming into a ski and recreation resort area. It claims to have the longest ski lift in the world. Kellogg community members report their community as having a beautiful environment, people who know each other like family, and access to quality health care, while they face challenges associated with obesity, alcohol abuse, and a lack of advanced education opportunities.

D. CAHS

Seven CAHs were the focus of the case studies. All of the hospitals reported they provide acute inpatient, outpatient, emergency, swing-bed, laboratory, diagnostic, and physical therapy, as well as other services while a few reported they provide obstetric, surgery, long-term care, home health, and hospice services. In addition, kidney dialysis, oncology, alternative medicine, and service coordination with a federally qualified health center (FQHC) are available through one of the seven CAHs. As indicated in Table 1 below, other CAH characteristics vary, such as service volumes and the number of full-time equivalent (FTE) staff working in each hospital.

Table 1: CAH and EMS Characteristics

	Malad City	Salmon	Bonners Ferry	Preston	McCall	Montpelier	Kellogg
Case Study Date	2009	2009	2008	2007	2007	2006	2006
CAH Conversion Date	07/01/99	12/14/99	04/08/99	08/01/03	10/01/00	02/05/01	12/12/00
Beds	11	18	20	20	15	21	25
Number of FTEs	84	133	70	141	90	174^	85
Average Tenure of Management Staff (years)	19.25	6.5	16.5	17.5	17	19.3	9.8
ADC Inpatients Acute/Swing	1.2/1.9	4.4	2/4	3.6/1	3	N/A	N/A
Outpatient Visits	10,000	20,000	17,231	N/A	20,000	N/A	N/A
Long-term Care	41 beds	No	36 beds	45 beds	No	15 beds	No
Obstetrics	No	Yes	No	No	Yes	No	No
ER Visits (annual)	1,200	3,000	3,244	N/A	5,000	N/A	N/A
EMS Service Area (Square miles)	1,200	4,570	1,277	668	3,678	1,050	700
EMS Volunteers*	25	70	25	52	25**	47	17
EMS Run Volume	349	559	457	450	803**	368	1,312
Closest Hospital (miles)	38	93	32 ***	27	29 ***	30***	36***
Closest Tertiary Center (miles)	59	140	78	27	107	87	39
County Population	4,130	7,808	10,872	12,158	8,925	5,901	12,890

* *Indicates this includes active staff but does not include first responders, ** Indicates this includes the primary EMS agency serving the county, *** Indicates the hospital is a CAH, ^ Indicates number of employees, not FTEs, N/A indicates the data were not collected during the case study.*

E. IMPACT OF THE FLEX PROGRAM

The Medicare Rural Hospital Flexibility Program was created as part of the federal Balanced Budget Act of 1997. Its goals are to: 1) Convert small rural hospitals to CAH status; 2) Support CAHs in maintaining and improving access to rural health care services; 3) Develop rural health networks to increase health care efficiency and effectiveness and to advance the other Flex Program goals; 4) Integrate EMS into the continuum of health care services; and 5) Improve the quality of rural health care. Below is a status report for each goal, including: goal status, indicators for success, and indicators of on-going needs and issues. Although many of the indicators cannot be directly and/or purely attributed to the activities of the Idaho Flex Program, case study participants report that without the Flex Program, each accomplishment would have been difficult, delayed, and/or not pursued.

Goal: Convert Hospitals to CAH Status

CAH conversion related indicators of outcomes achieved as well as on-going needs and challenges were identified during each case study. Below is a summary of these findings when considering all of the CAH case study communities.

Overview of Outcomes/Achievements:

- All of the hospitals converted to CAH status.
- Each hospital took less than 18 months to complete the CAH conversion process.
- Five of seven hospitals reported physicians supported the hospital's conversion to CAH status.
- Four of seven hospitals reported health care workers are aware the hospital is a CAH.

Unique Needs/Challenges:

- One hospital reported increased financial issues during its conversion to CAH status. This was due to inadequate reimbursement systems to accommodate its new hospital status.

Goal: Support CAH's in Maintaining and Improving Access to Healthcare Services

CAH support and changes in health care access indicators of outcomes achieved were identified during each case study. Below is a summary of these findings when considering all of the CAH case study communities.

Overview of Outcomes/Achievements:

- All of the CAHs reported they have added or updated equipment and hospital services.
- Six of seven CAHs reported they have improved financial performance.
- Five of seven CAHs reported they participate in local health promotion or disease prevention activities.
- Four of seven CAHs reported patient volumes have increased.
- Four of seven CAHs reported they have created additional positions/increased the number of employees working at the hospital.
- Three of seven CAHs reported they have increased wages and decreased staff turnover.
- Three of seven hospitals reported no services have been eliminated since CAH conversion.
- Two of seven CAHs reported they have replaced their old hospital buildings with "state-of-the-art" facilities.

Overview of On-going Needs/Challenges:

- Five of seven CAHs reported having difficulty recruiting physicians.
- Five of seven CAHs reported having difficulty meeting the needs of uninsured and underinsured patients.
- Five of seven CAHs reported a need for new or larger spaces to meet the needs of their patient population.
- Four of seven CAHs reported a need for health promotion/disease prevention education for their communities.
- Four of seven CAHs reported a need for additional health services to best meet the needs of their communities.
- Three of seven CAHs reported a need to improve staff retention.
- Three of seven CAHs reported an increased need for staff training and development.
- Three of seven CAHs reported they are struggling financially.
- Three of seven community focus groups participating in the case studies reported their community has limited to no access to mental health services.

Goal: Develop Rural Health Networks

Rural health network development related indicators of outcomes achieved as well as on-going needs and challenges were identified during each case study. Below is a summary of these findings when considering all of the CAH case study communities.

Overview of Outcomes/Achievements:

- Five of seven CAHs reported increased networking with other hospitals.
- Five of seven CAHs reported improved training and staff education through networking.

Overview of On-going Needs/Challenges:

No common networking issues were identified across all case study communities.

Goal: Integrate EMS into the Continuum of Rural Health Care Services

EMS integration related indicators of outcomes achieved as well as on-going needs and challenges were identified during each case study. Below is a summary of these findings when considering all of the CAH case study communities.

Overview of Outcomes/Achievements:

- All EMS agencies located in the CAH communities reported increased education and training for local EMS staff.
- Six of seven EMS agencies serving CAH communities reported purchasing new equipment and updating their equipment.
- Five of seven case studies reported improved recruitment and retention of EMS staff.
- Three of seven EMS agencies serving CAH communities reported physicians have increased their involvement with local EMS.
- Three of seven case studies reported improved relations between the hospital and EMS.

Overview of On-going Needs/Challenges:

- All case studies reported a need to improve EMS staff training.
- Five of seven case studies reported a need to improve the hospital-EMS relationship.
- Five of seven EMS agencies have not established an EMS advisory committee.
- Five of seven EMS agencies reported they need new or additional equipment and supplies.
- Three of seven EMS agencies reported a need for EMS related patient satisfaction information.
- Three of seven case studies reported recruitment and retention of EMS staff is difficult.

Goal: Improve the Quality of Rural Health Care

Quality improvement related indicators of outcomes achieved as well as on-going needs and challenges were identified during each case study. Below is a summary of these findings when considering all of the CAH case study communities.

Overview of Outcomes/Achievements:

- All CAHs reported quality initiatives are in place and the quality of care provided in the hospital is improving.
- Four of seven CAHs reported improvements in staff training.
- Three of seven CAHs reported they have added and upgraded services which have improved quality of care.
- Three of seven CAHs reported they are using an electronic health record.
- Three of seven CAHs reported improved maintenance of their hospitals' physical plants.
- Three of seven CAHs have received quality improvement awards (state and national).

Overview of On-going Needs/Challenges:

- Five of seven CAHs reported a need for additional training and tools.
- Four of seven CAHs reported all physicians are not using the hospitals' and or hospital-owned clinics' electronic health records.

F. CONCLUSIONS

These case studies highlight the many successes and challenges of CAHs, local EMS, and the communities they serve. It is clear that all of the hospitals converted to CAH status, expanded access to health services, enhanced services, upgraded equipment, provided additional staff training, and have initiatives in place to improve the quality of patient care. In addition, local EMS agencies have made changes to update equipment, implement EMS staff recruitment and retention strategies, and in many cases improve EMS' overall operations. Although much has been accomplished, challenges continue to exist, such as: physician recruitment and retention, lack of fully-implemented electronic health records, ongoing financial issues in some CAHs, on-going staff training needs, and no/limited EMS-hospital integration, while local EMS agencies and CAHs continue to be interested in improving their relations and coordination of care. Within this context it is also evident that the CAHs, local EMS agencies, and rural communities continue to require support in order to further advance the goals of the Flex Program.

ADDITIONAL INFORMATION:

If you have questions about the Idaho Flex Program or the Office of Rural Health and Primary Care, please contact Mary Sheridan, Director, at **208/334-0669** or via e-mail at ***ruralhealth@dhw.idaho.gov***. You can find the Office of Rural Health and Primary Care on the Web at ***www.ruralhealth.dhw.idaho.gov***.

This report was created by Rural Health Solutions, Woodbury, Minnesota - www.rhsnow.com, funded by the Idaho Department of Health, Office of Rural Health and Primary Care, through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy.