

*A Critical Access Hospital
Case Study*

**IDAHO
FLEX
PROGRAM**

EVALUATION '09

ONEIDA COUNTY HOSPITAL, MALAD CITY, IDAHO



July 2009



I D A H O
 F L E X
 P R O G R A M

Oneida County Hospital

Malad City, Idaho

EVALUATION '09

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? A case study highlighting Oneida County Hospital, Malad City, Idaho, was conducted as part of Idaho's Medicare Rural Hospital Flexibility (Flex) Program and its program evaluation activities to examine and report on these questions.

CASE STUDY OBJECTIVES AND METHODS

The Oneida County Hospital case study was completed to identify community, hospital, and other health care related changes and outcomes that have occurred due to Oneida County Hospital's conversion to CAH status and its involvement in the Flex Program. It was also completed to identify needs and issues for program planning purposes. To accomplish this, the following occurred:

- Local health services and community background information was collected from April – June 2009 on Malad City and Oneida County, Idaho.
- Interviews of hospital staff, hospital board members, and local emergency medical services (EMS) personnel were conducted in Malad City in May 2009.
- A survey of health care providers (physicians and physician assistants) working in Oneida County Hospital was conducted in May 2009. The survey response rate was 83 percent.
- A community focus group was conducted in Malad City in May 2009. There were seven participants.

83%
response rate!

Twenty-three individuals from the hospital service area participated in the case study.

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 study and prepared this report.

MALAD CITY, IDAHO AND THE SURROUNDING AREA

Malad City is located in south-eastern Idaho near the Utah and Wyoming borders. It is the county seat of Oneida County and is nestled on the east side of the Malad Valley. Oneida County has an area of 1,202 square miles that consists of alternating valleys and ridges of mountains or hills and where sagebrush and grassland cover most of the terrain. The Curlew National Grassland lies within Oneida County. This grassland is administered by the United States Department of Agriculture (USDA), Forest Service, and managed to promote and demonstrate grassland agriculture and sustained-yield management of forage, fish and wildlife, water, and recreation resources.¹ Oneida County is named after Oneida Lake, New York, the area from which most of the early settlers had emigrated. The largest employers in Oneida County are the County, Oneida County Hospital, Hess Pumice Products, Inc., Idaho Milling and Grain, and Ireland Bank.²

In 2008, the estimated population of Oneida County was 4,130 with most people living in Malad City. The county's population has increased little over the past ten years (.1% based on US Census estimates). Malad City boast of having more people of Welsh decent per capita than anywhere outside of Wales.³ Malad City lies along Interstate 15, 109 miles north of Salt Lake City, Utah and 59 miles south of Pocatello, Idaho, where the nearest tertiary hospital is located. The nearest hospital (also a CAH) is located in Tremonton, Utah, 38 miles south while the nearest hospital in Idaho is located in Preston (also a CAH), 51 miles northeast of Malad City.



1. USDA, Forest Service, retrieved June 22, 2009. <http://www.fs.fed.us/r4/caribou-targhee/about/curlew/index.shtml>

2. Idaho Department of Labor, Oneida County Workforce Trends, June 2009. Retrieved June 24, 2009. <http://labor.idaho.gov/lmi/pubs/OneidaProfile.pdf>

3. Wikipedia.com. Retrieved June 22, 2009. http://en.wikipedia.org/wiki/Welsh_people



MALAD CITY *cont...*

When asked, “What makes Malad City a healthy place to live?”, case study participants characterized the community as having: good community support, clean air and water, a family-friendly and values-centered environment, low stress lifestyle, little crime, easy access to outdoor recreational activities, access to health services such as the hospital, “good” doctors, a large population that produces its own food, children that are sports oriented, and high quality schools with programs that support healthy living. When asked, “What makes Malad City an unhealthy place to live?”, case study participants reported: air pollution from Salt Lake City during winter months, “higher” level of poverty, lack of/limited health insurance which results in people delaying/not receiving needed care, poor diets/nutrition, limited access to mental health services (in particular services for juveniles), transfer times to a larger hospital, high unemployment, lack of community health education, substance abuse including prescription drug abuse, lack of access to some specialty services, and limited access to health and fitness related activities. Three case study participants reported there are no unhealthy aspects to Malad City. Community members also discussed the impact of their community being located off the interstate (motor vehicle accidents and illegal drug sales/use) and their increasing concern about prescription drug abuse by both juveniles and adults.

“I’d rather look at cows than cars.”

— Case Study Participant

“It’s a good compromise living in this city [Malad City].”

— Case Study Participant



Oneida County Hospital, an 11-bed CAH, converted to CAH status July 1, 1999, making it the 3rd hospital to convert in Idaho and the 57th to convert in the U.S.⁴ The hospital offers emergency care, general surgery, diagnostic imaging (x-ray, ultrasound, CT, MRI, mammograms, nuclear medicine), physical therapy, home health and personal care services, home delivered meals, visiting specialty provider clinics, and a variety of other outpatient services. Attached to the hospital is a 41-bed long-term care facility. The hospital also owns two Rural Health Clinics. The hospital administrator has been working in the hospital for 12 years, the Quality Improvement Coordinator 15 years, the Chief Financial Officer 16 years, and the Acute Care Director of Nursing 34 years. There are 135 staff (84 full-time equivalent employees) working at the hospital as well as 2 full-time physicians and 2 full-time and 2 part-time physician assistants. Physicians and physician assistants have been working in the community an average of 7 years.

Oneida County Hospital's service area is approximately 1,200 square miles and includes the communities of Malad City, Saint John, Pleasant View, Samaria, Holbrook, Stone, and Downey. The service area can be characterized as being older, less racially diverse, lower income but less likely to live in poverty, and more likely to have a high school diploma but less likely to have a college degree when compared to the state.⁵ The hospital's July 2008 to February 2009 average daily census for inpatients was 1.2 acute and 1.9 swing bed patients per day and the hospital had approximately 1,200 emergency room visits and 10,000 outpatient visits during that same time period.

Ambulance services for the area are provided by Oneida County Emergency Medical Services (EMS), a county-owned non-profit organization. The ambulance squad's service area is all of Oneida County. It provides advanced life support services through 30 staff, including: 11 EMT-Basic, 12 EMT-Advanced, and 7 First Responders.⁶ Twenty-five of the squad members are considered "very active". It has no paid staff. The ambulance service responded to 349 calls in 2008, including 261 runs and 88 transfers. Call volume has fluctuated over the past five years ranging from a low of 164 runs and 52 transfers in 2005 to a high of 299 runs and 113 transfers in 2007.⁷

Oneida County Hospital's MISSION STATEMENT:



“Oneida County Hospital and Long Term Care Facility, owned by the people of Oneida County, provides quality health care within our community.”

4. As of April 2009 there are 26 CAHs in Idaho and 1302 in the U.S. Source: Flex Program Monitoring Team, www.flexmonitoring.org.

5. U.S. Census Bureau, State and County QuickFacts, retrieved June 10, 2009. <http://quickfacts.census.gov/qfd/states/16/16071.html>

6. EMT indicates Emergency Medical Technician.

7. As reported by Oneida County EMS.

impact

OF THE FLEX PROGRAM

“We’ve come a long way and much of the credit goes to our CAH status.”

— Case Study Participant

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; 4) Integrate EMS into the continuum of health care services; and 5) Improve the quality of rural health care. Oneida County Hospital was selected for an impact analysis using a case study approach in order to examine program outcomes and the impact that the Flex Program has had on local communities. Data 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. 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: **#1** Convert Hospitals to CAH Status

Status: ACCOMPLISHED

Indicators of Outcomes Achieved:

- Oneida County Hospital converted July 1, 1999, making it the third hospital to convert to CAH status in the state and the 57th to convert in the U.S.
- It took the hospital approximately 8 months to explore the CAH conversion option, complete a financial feasibility study, work with Flex Program supported staff at the Idaho Hospital Association and the Office of Rural Health and Primary Care to prepare for and complete the CAH application process, and to be surveyed and licensed as a CAH.
- Hospital staff report that regular communication and information about CAH status and the Flex Program supported and simplified the conversion process.
- Hospital staff report they had access to the knowledge and experience of other CAHs to support their conversion process

“I don’t know if our hospital would still be here without CAH status.”

— Case Study Participant

- All health care providers surveyed report they are aware the hospital is a CAH.
- Most community members that participated in the community discussion group report they are aware the hospital is a CAH.
- All community members that participated in the community discussion group express support for the hospital and the attached long-term care facility.
- Health care providers working in the hospital report their referral patterns have not changed due to CAH conversion; however, they have changed due to other regional factors.

“We used Flex Program support a lot [during the CAH conversion process]. We had staff at all of the trainings and information sessions and I think we were better prepared because of it.”

— Case Study Participant

- Comments/information by case study participants related to the CAH conversion include:
 - *“Conversion to CAH has increased our opportunities and opened doors.”*
 - *“Our community as a whole struggles. We’ve [hospital] hung on by a thread many, many times, that without the extra reimbursement [CAH], we wouldn’t be here.”*
 - *“CAH conversion was relatively painless. We received a lot of support.”*
 - *“It [initial operation as a CAH] was a little difficult at first because the systems (payment) were not in place.”*

“We would fight to keep our hospital.” — Case Study Participant

goal: #2 Support CAHs in Maintaining and Improving Access to Health Care Services

Status: OUTCOMES ACHIEVED/ON-GOING NEEDS



Indicators of Outcomes Achieved:

- The hospital’s attached long-term care facility has been updated/renovated.
- County financial support for the hospital ended five years ago. This change was made because of the county’s limited resources and the hospital’s more stabilized financial status.
- The hospital has an updated strategic plan and recently completed a community health needs assessment.
- Hospital inpatient and outpatient volumes have increased (e.g., from an average daily census of 1.3 acute patients in 2006 to 3.0 in 2009).

- The hospital's profit and operating margins have improved and the hospital is more consistently profitable. For example, since converting to CAH status they report one loss in the past 10 years. Whereas prior to that they had a loss at least every other year.
- The hospital has been able to increase wages which has decreased staff turnover.
- The hospital is increasingly supporting staff development and promotes from within. For example, two staff starting as certified nursing assistants and then licensed practical nurses and are now starting a registered nursing program.
- The hospital added a public relations staff position, social worker, and has been able to recruit additional health care providers (physicians and physician assistants).
- The hospital eliminated obstetric (OB) services which has decreased malpractice issues, decreased physician malpractice insurance costs, and allowed the hospital to convert its OB area into an operating room.
- The hospital added/updated its services, including: tele-psychiatry, speech therapy, occupational therapy, discharge planning, social work services, radiology, mobile nuclear medicine, general surgery, ophthalmology, orthopedics, podiatry, and gynecology.
- The hospital has updated/added equipment including: digital radiology, lab, C-arm, computer tomography (CT) scanner, endoscopy, and telemedicine.
- The hospital has added two rural health clinics.
- The hospital added tele-training opportunities for hospital staff.
- Patients are accessing a total of 5-6 tele-psychiatry sessions per week through the hospital.
- The hospital has a new computer server and is working to implement CPSI as its electronic medical record. Hospital staff expect to be "totally electronic" in approximately two years.
- The hospital is in the process of implementing RPM (Rural Practice Management) for benchmarking purposes.
- The hospital has started employing its own physicians.
- Attendance at the hospital health fair is increasing. The last health fair attracted approximately 500 community members and provided approximately 340 lab tests.

"IHA (Idaho Hospital Association) has done a great job for us (CAHs) in Idaho."

— Case Study Participant

"We've been able to hire some great new staff that are more motivated and make it a good environment to work in."

— Case Study Participant



- The hospital increasingly supports the local schools by providing medical education training for teachers, CPR and first aid training for bus drivers, and physicals for athletic program participants.
- Health care providers report they are involved in local health promotion and disease prevention activities through participation in the local health fair and other disease specific initiatives (e.g., diabetes).
- Case study participants report the greatest accomplishments of the hospital in the past five years as: remaining viable, attracting new health care providers, expanding and updating services, improving internal communications, obtaining state and national recognition for improving quality of care, and establishing two rural health clinics.
- Community members express significant support for the newly established local transportation system.
- Comments/information by case study participants related to maintaining/sustaining access to health care services include:

“If we [hospital] cannot provide it [health care services] we will help find someone who can.”

— Case Study Participant

“The hospital has done an excellent job bringing specialists in.”

— Case Study Participant

- *“Enhanced reimbursement has both assisted us in keeping our doors open but also allowed us to make some needed improvements.”*
- *“The Flex Program has supported us in so many ways. Our staff is better trained and we are better informed because of the support we have received.”*
- *“Physician recruitment will always be difficult for our hospital but I think CAH status gives us an advantage.”*
- *“We used to have one year that was a good year [financially], then one was a bad year, then good, then bad. We’ve been able to flatten those swings a bit which allows us to be more strategic.”*



Indicators of On-going Needs/Issues:

- The hospital's financial performance has improved since CAH conversion; however, the hospital continues to struggle financially. This is evidenced by a profit margin that has never been above 2%.
- Case study participants report a need for an ear, nose and throat (ENT) specialist and an additional physician and the hospital is recruiting these providers.
- The hospital has not conducted employee satisfaction surveys since 2007; surveys are planned as part of implementing RPM.
- Hospital staff report the Flex Program should re-focus on the needs of CAHs rather than on other health service providers.
- The hospital needs financial assistance to purchase a new call system, re-surface the work area at the nurses' station, conduct a Charge Master review (last one was conducted 4-5 years ago), and complete a community needs assessment.
- Over the past 10 years, the hospital has seen a decline in its long-term care facility census from an average of 32 residents per day to 25 residents per day.
- Hospital staff reports a need for additional staff training, in particular: electronic charting, trauma care training for all emergency department staff, and scrub technician training.
- The hospital needs to replace its anesthesia machine.
- The hospital is trying to secure land from the city in order to replace its current physical plant.
- The hospital is experiencing an increase in non-payers as well as those who are paying less.
- Hospital staff report a need to reevaluate the patients being referred elsewhere for care as some patient are possibly being referred elsewhere when their health care needs could be best met using Oneida County Hospital/local services.
- Hospital staff expressed an interest in exploring enhanced emergency care through telemedicine use. This could be accomplished through joint meetings and discussions with St. Alphonsus Regional Medical Center and St. Luke's Health System, Boise, Idaho and Portneuf Medical Center, Pocatello, Idaho.
- The hospital is preparing for the Recovery Audit Contractor (RAC) Program.
- Case study participants believe that community members are not aware of all of the health care services available locally.
- Health care providers report the greatest issues facing the hospital's patient population as: lack of a healthy life-style which is contributing to cardiovascular and other diseases, mental health issues, lack of patient education, and lack of insurance/underinsurance. They most frequently report lack of patient education as a concern.
- Case study participants report a need for hospital board member training.
- Case study participants report a need for local assisted living services.



*“I still don't know
all of the services
that are available
[through the hospital
and clinics].”*

— Case Study
Participant

- Community members report that HIPAA (Health Insurance Portability and Accountability Act) is a barrier to resolving local prescription drug abuse issues.
- While most community members report a need to replace the hospital's physical plant, others believe the current buildings meet community need.
- Community members report a need to offer free primary care services on a limited basis (e.g., one day a week) and/or to offer the services available as part of the community health fair on a more frequent basis.
- Comments by case study participants related to maintaining/sustaining access to health care services include:
 - *"It is always a challenge to stay updated [equipment]. Some folks [health care providers] don't want to come to rural if you are outdated."*
 - *"It took 1.5 years to recruit a full-time physician assistant. If one of our physicians would leave, it would be difficult."*
 - *"I know that we provide better care and we have the data to prove it. I just don't know how to get that message to the community."*

goal: #3 Develop Rural Health Networks

Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

Indicators of Outcomes Achieved:

- The hospital is a member of The Hospital Cooperative.
- Hospital staff reports they receive a lot of training through The Hospital Cooperative.
- Hospital staff reports the annual CAH/Flex Program meeting as beneficial. More specifically, they report it as an opportunity to network, learn from their peers, and learn about the experiences of other CAHs.
- Hospital staff reports the Peer Review Network has benefitted the hospital. More specifically, peer review didn't always occur in the past as it was "too expensive".



Indicators of On-going Needs/Issues:

- Hospital staff report opportunities exist to develop network-based strategies to better meet the needs of stroke patients.
- Hospital staff report a need to support CAH collaboratives modeled after those conducted by the state's Quality Improvement Organization (QIO).
- Hospital staff reports an interest in encouraging all Idaho CAHs to participate in RPM.
- Health care providers report a need to improve hospital relations with other hospitals and providers "outside the valley".
- Comments by case study participants related to network development include:
 - *"The Peer Review Network has finally started working in the past 6 months. Prior to that there was poor tracking, communication, and a lack of enforcing participation rules. Also, none of us were really paying attention to peer review until the surveyors started raising it as an issue."*
 - *"We had charts [peer review network] that we never got back."*
 - *"It would be good if we could get all of the CAHs in Idaho to use RPM."*

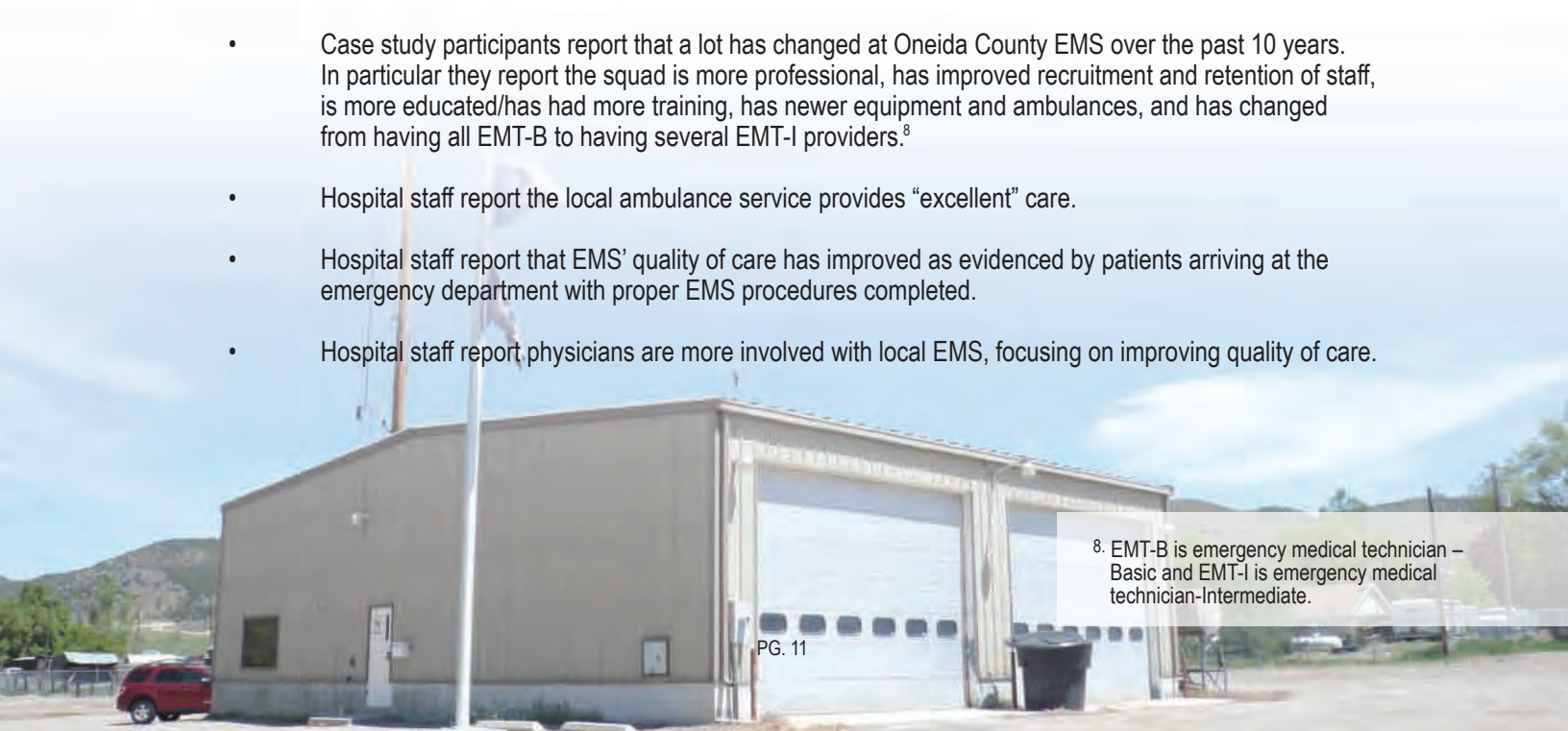
goal: Integrate EMS into the Continuum #4 of Rural Health Care Services

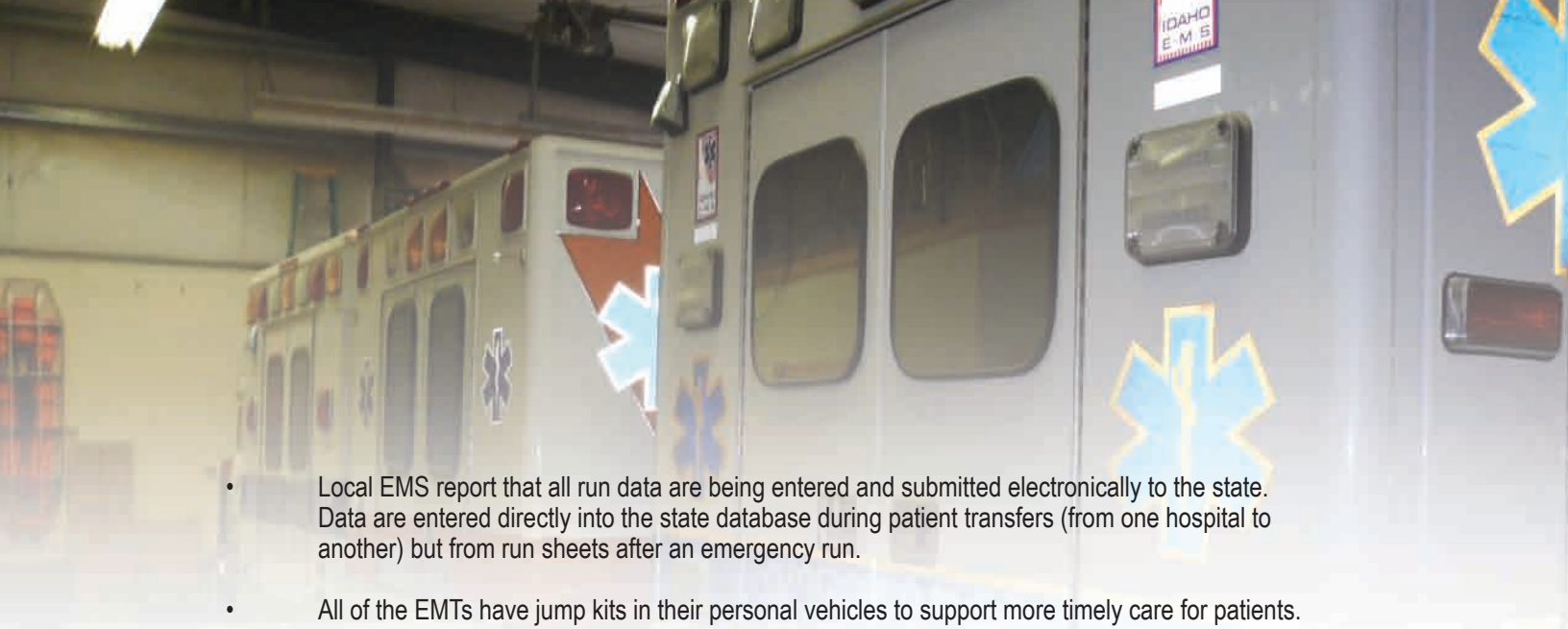
Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

Indicators of Outcomes Achieved:

- Case study participants report that a lot has changed at Oneida County EMS over the past 10 years. In particular they report the squad is more professional, has improved recruitment and retention of staff, is more educated/has had more training, has newer equipment and ambulances, and has changed from having all EMT-B to having several EMT-I providers.⁸
- Hospital staff report the local ambulance service provides "excellent" care.
- Hospital staff report that EMS' quality of care has improved as evidenced by patients arriving at the emergency department with proper EMS procedures completed.
- Hospital staff report physicians are more involved with local EMS, focusing on improving quality of care.

⁸. EMT-B is emergency medical technician – Basic and EMT-I is emergency medical technician-Intermediate.





- Local EMS report that all run data are being entered and submitted electronically to the state. Data are entered directly into the state database during patient transfers (from one hospital to another) but from run sheets after an emergency run.
- All of the EMTs have jump kits in their personal vehicles to support more timely care for patients. Several examples were identified where an EMT was able to begin assisting a patient, in a more timely fashion, because of the EMTs' location, and their immediate access to a jump kit.
- A local EMS assessment was completed by the Flex Program October 18, 2000, and a follow-up assessment October 22, 2002, to identify community EMS needs that should be addressed and areas where process was made. Case study participants report the assessments provided a "guide to action".
- The following local activities were completed in response to EMS assessment recommendations:

- *A new recruitment strategy was adopted. Currently 13 community members are on the "interested applicant list" for when an EMT course is made available.*
- *Ambulance fees were changed to be in line with national standards.*
- *EMS applied for and received grants to update equipment and ambulances through grant funding.*
- *Oneida County Hospital is now providing CPR and first aid classes for all of the school district's bus drivers.*
- *The EMS medical director has reviewed the squad's BLS and ALS protocols.⁹*
- *The EMS medical director attended the Flex Program funded statewide EMS medical director training.*
- *The EMS medical director developed and is implementing a squad training plan based on community need and changes to EMS providers' scope of practice.*
- *Flex Program funds were used to purchase two defibrillators with data cards.*

"The Flex Meetings are where I learned about EMS needs. Prior to that, we [hospital staff] didn't really think about it."

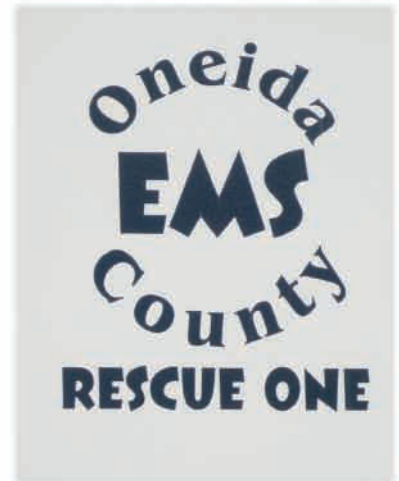
— Case Study Participant

"EMS staff are more than welcome to work in our ER [emergency room]. Three [EMTs] work for the hospital [in surgery] and then volunteer for the squad."

— Case Study Participant

⁹. BLS indicates Basic Life Support and ALS indicates Advanced Life Support.

- The following local activities are in-process/being completed in response to EMS assessment recommendations:
 - *The squad had an EMS coordinator; however, that position was eliminated. They are reviewing the merits of re-creating the position again.*
 - *An informal procedure was established where all patients are brought to Oneida County Hospital (with limited exceptions, as identified by the EMS medical director).*
 - *Plans to continue annual multi-agency disaster drills are underway. Currently they occur on a less-than-annual basis.*
 - *The EMS medical director reviews all advanced procedure EMS reports and a limited number of BLS reports; however, no standard for BLS report review is in place.*
- Comments/information by case study participants related to EMS:
 - *“EMS staff are very dedicated. They offer a very, very valuable service.”*
 - *“EMS is quick and seem to do things right.”*



Indicators of On-going Needs/Issues:

- Hospital staff report concern about depending on an ambulance service that is 100 percent volunteer.
- Health care providers report there are local EMS issues that need to be resolved; however they are working to do this. In particular, they report there is a need to better define roles, improve how hospital and EMS staff work together as a team, and to better define emergency services' relationship with the local women's crisis center and the sheriff's department.
- EMS staff report they have had no squad members attend the EMS Management training courses because of the volunteers' availability.
- EMS staff report they have not established an EMS advisory committee because of lack of time and community interest.
- An increasing percentage of patients have no insurance coverage.
- Local EMS has no method or plans in place to obtain patient satisfaction information and or patient outcomes information from referral hospitals. This may be an opportunity for EMS and Oneida County Hospital to partner.
- An additional repeater is needed on the north side of the county to further decrease the black holes in EMS' service area. A cell tower is available to accommodate the repeater.
- Local EMS is seeking funds to purchase pulse oximeters for each EMT's jump kit.

“EMS has come a long way. The community has more confidence in both the hospital and EMS.”

— Case Study Participant



- A local EMS assessment was completed by the Flex Program to identify community EMS needs that should be addressed. The following local activities have not been completed or have realized limited progress as recommended in the assessment:
 - *Emergency medical dispatch training and certification has not been supported for local dispatchers.*
 - *No formal program has been established for community-wide patient data sharing and analysis; however, as the hospital, clinics, and long-term care unit implement an EMR, opportunities to coordinate may emerge in the future.*
 - *No formal quality improvement/performance improvement training has been made/obtained by the squad.*
- Comments/information by case study participants related to EMS needs/issues include:
 - *“EMS is driven by the current leadership; if the leader is active, so are they [the squad].”*

goal: #5 Improve the Quality of Rural Health Care

Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

Indicators of Outcomes Achieved:

- Health care providers and hospital staff report the hospital has quality improvement initiatives in place to improve quality of care.
- Hospital staff report quality of care in the hospital has improved. They attribute the improvements to hospital staff and leadership focusing on quality and standards of care, CAH conversion, and participation in quality and patient safety initiatives sponsored by the Flex Program and supported by Qualis Health (the state’s Quality Improvement Organization) and the Idaho Hospital Association.
- Hospital staff report their participation in Qualis Health’s Quality Collaborative educated them on root cause analysis and finding ways to improve quality of care, provided tools and resources to educate staff and measure quality, and created an opportunity for CAHs to share ideas and make improvements.
- Hospital staff report hospital quality improvement has also resulted in improving the quality of care provided in the long-term care facility.
- The hospital and attached long-term care facility have been awarded state and national quality improvement awards: BlueCross BlueShield 2008 Hospital Quality Award, Award of Achievement and a 5 Star Rating by the Centers for Medicare and Medicaid Services in the long-term care facility.

“I think our involvement in CAH quality improvement initiatives has impacted care on the long-term care side too. As the hospital improved processes, long-term care has followed and is improving care too.”

— Case Study Participant

- Hospital staff report quality of care is improving as indicated by the following measures:
 - *Pneumonia vaccination rate was 46.5% in 2007 and has been at or near 100% since 2008.*
 - *Emergency department unscheduled returns within 72 hours have been at or below 2% for the past year.*
 - *Patients are experiencing shorter lengths of stay.*
 - *The hospital has had no hospital acquired infections for the past five quarters.*
 - *Acute myocardial infarction patients are being transferred with all of their chart information 96.8% of the time. This didn't use to be a common practice at the hospital.*
 - *All patients are being telephoned prior to surgery to remind them of their surgery date and time and pre-operative information. This has resulted in a decrease in patient no-shows and an increase in patients prepared for their surgery.*

“.. When I first moved here, there wasn't a chance I was going to go to that hospital but there have been significant changes over there in the last 5-6 years.”

— Case Study Participant

- The hospital has quality improvement measures in place for all departments, such as: timely notification of acute care patient discharges to social services, operating room patient satisfaction survey, elimination of abbreviations in patient charting, and patients receipt of timely and complete meals.
- Hospital staff report that they used to notify the hospital social worker 65% of the time when patients were admitted and needed a social worker. During the most recent quarter, notification is occurring 90% of the time.
- Hospital staff participates in quality leadership training provided through The Hospital Cooperative.
- The hospital is beginning to implement RPM as its performance improvement benchmarking tool.
- The hospital has selected an electronic medical record (EMR) for implementation.
- All but one health care provider surveyed reports knowledge of quality improvement initiatives in place at the hospital.
- Community members report there are open communications between the hospital and community. Therefore, they believe when issues are presented, they are resolved.
- Comments/information by case study participants related to improving quality of care include:
 - *“The general direction and vision at the hospital is to improve patient care and this is a top priority.”*
 - *“The quality of practitioners is good. People respect them.”*

Indicators of On-going Needs/Issues:

- Case study participants report there is a community need for drug awareness education, in particular related to prescription drugs.
- Hospital staff report the hospital was reporting to Hospital Compare but stopped due to complications and the Centers for Medicare and Medicaid Services (CMS) making frequent changes to the software and requirements for the data exchange. Reporting is planned to resume after implementation of RPM.
- The hospital no longer receives smoking cessation packets from Qualis Health. The packets were a key component to the hospital's smoking cessation program. This support ended as part of the 9th Scope of Work.
- The hospital has not been surveyed in over three years.
- Hospital staff reports a need for additional training, tools, and resources to address stroke care.
- The hospital has been unsuccessful in recruiting an ENT specialist and an additional physician.
- Hospital staff reports a need for ACLS, ATLS, and/or PALS training.¹⁰
- Hospital staff reports an on-going need for better coordination of quality and patient safety initiatives at the federal level with consideration for the EMRs that are being used in hospitals.
- Health care providers report their overall opinion of the hospital as "very good", "good", or "average".
- Comments/information by case study participants related to quality improvement needs include:
 - *"We need an EMR. The facilities that don't get started are going to be left behind and will have difficulties with patient safety, quality improvement, and physician recruitment."*
 - *"It has taken since October last year just to get the financing paperwork completed for our EMR. We didn't think it would take that much time."*



conclusions:

This case study highlights many of the local level successes and challenges of Oneida County Hospital and the Idaho Flex Program. It is clear that the hospital converted to CAH status, expanded access to health services, enhanced services, upgraded equipment, and is implementing initiatives to improve hospital operations and quality. In addition, local EMS has made significant changes to improve its operations and quality of care. It is also evident that the hospital, local EMS, and the community continue to require support in order to further advance the goals of the Flex Program and to better meet the needs of its aging population. Other needs to be addressed relate to physical plant changes, staff training, hospital marketing/community knowledge of the services available at the hospital and clinic, declining utilization of the long-term care facility, physician recruitment, and the overall long-term viability of the hospital.

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



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