

*A Critical Access Hospital
Case Study*



**IDAHO
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PROGRAM**

EVALUATION '09

STEELE MEMORIAL MEDICAL CENTER, SALMON, IDAHO

July 2009



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PROGRAM

Steele Memorial Medical Center Salmon, Idaho

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 Steele Memorial Medical Center, Salmon, 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 Steele Memorial Medical Center case study was completed to identify community, hospital, and other health care related changes and outcomes that have occurred due to Steele Memorial Medical Center'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 – July 2009 on Salmon, Idaho.
- Interviews of hospital staff, hospital board members, and local emergency medical services (EMS) personnel were conducted in Salmon June 10 and 11, 2009.
- A survey of health care providers (physicians, nurse practitioners, specialists, certified registered nurse anesthetists) working in Steele Memorial Medical Center was conducted in June 2009. The survey response rate was 55 percent.
- A community focus group was conducted in Salmon, June 10, 2009. There were 9 participants.

Thirty 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.

SALMON, IDAHO AND THE SURROUNDING AREA

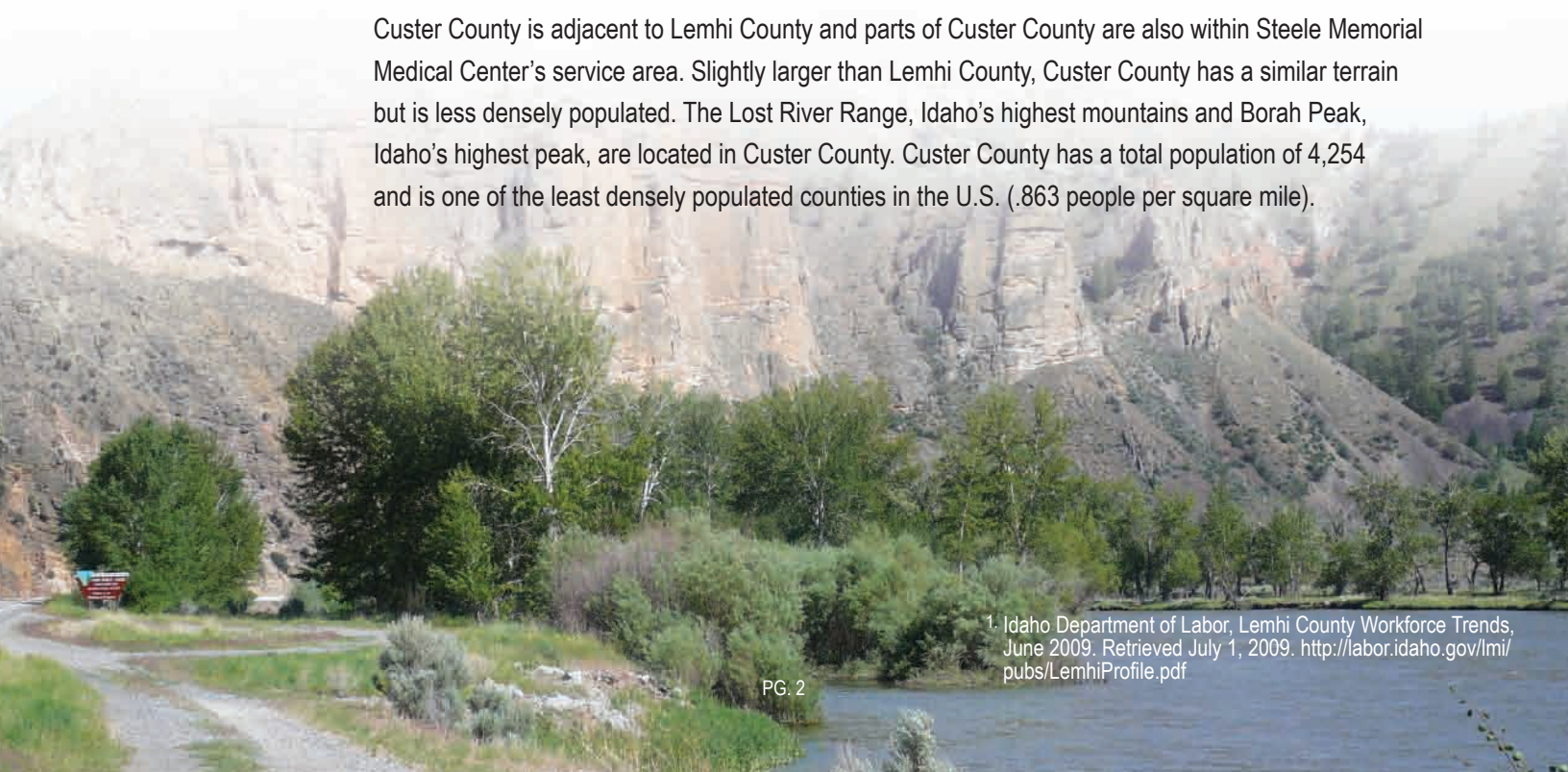
Salmon is located in central Idaho near the Montana border and is situated at the base of the Beaverhead Mountain Range. Salmon lies along U.S. Highway 93, 140 miles south of Missoula, Montana, and 165 miles north of Idaho Falls, Idaho, where the closest tertiary centers are located (both destinations are approximately 2.5 hours by automobile). The closest hospital is located in Hamilton, Montana, 93 miles north of Salmon.

Salmon is the county seat of Lemhi County. Lemhi County has an area of 4,570 square miles that consists of mountains, forests, rolling hills, grasslands, and the Salmon River, "The River of No Return". Ninety percent of the land is owned by the federal government. Once a mining, lumbering, and ranching area, Lemhi County is transitioning into an outdoor recreational oasis that offers river rafting, kayaking, downhill and cross-country skiing, snowmobiling, hiking, hunting, mountain biking, and fishing activities, as well as a growing arts community. In addition, Salmon is located along the Lewis and Clark Trail and is considered the birthplace of Sacajawea. The largest employers in Lemhi County are Salmon School District, Steele Memorial Medical Center, Lemhi County, Natural Resources Conservation Services, and Bureau of Land Management.¹ The government employs 32 percent of the county's workers while the greatest job growth has been in education, health care, and recreation.



In 2008, the estimated population of Lemhi County was 7,808 with most people living in Salmon. This is 1.71 persons per square mile. Based on U.S. Census estimates, the county's population has not increased over the past ten years.

Custer County is adjacent to Lemhi County and parts of Custer County are also within Steele Memorial Medical Center's service area. Slightly larger than Lemhi County, Custer County has a similar terrain but is less densely populated. The Lost River Range, Idaho's highest mountains and Borah Peak, Idaho's highest peak, are located in Custer County. Custer County has a total population of 4,254 and is one of the least densely populated counties in the U.S. (.863 people per square mile).



¹ Idaho Department of Labor, Lemhi County Workforce Trends, June 2009. Retrieved July 1, 2009. <http://labor.idaho.gov/lmi/pubs/LemhiProfile.pdf>



SALMON *cont...*

When asked, “What makes Salmon a healthy place to live?”, case study participants characterize the community as having: access to many outdoor recreational activities, few smokers, limited access to fast food, active children’s social groups such as 4-H, a lot of community engagement/volunteerism, local access to high quality medical care services, no pollution, good air quality, healthy lifestyle, little crime, minimal stress, and people that help one another. When asked, “What makes Salmon an unhealthy place to live?”, case study participants report: many opportunities for accidents (e.g., motor vehicle, recreational, ranching, mining), high level of chemical abuse (alcohol, prescription drugs), many people who smoke, isolation, stress because of economic conditions/poor wages and unstable family life, catastrophic forest fires, and limited access to many specialty health care services. Two case study participants stated Salmon has no unhealthy characteristics. Many case study participants report poor relations between various community organizations and the impact this has on community development (e.g., schools). Community members also discussed how the air quality in the community has improved over the last few decades. They attribute the improvements to a decline in the mining industry and fewer people burning wood to heat their homes.

“A lot of organizations [in Salmon] don’t seem to like to work together and I don’t know why that is.”

— Case Study Participant

“We’re not rural we’re frontier, really frontier.”

— Case Study Participant



STEELE MEMORIAL MEDICAL CENTER

Steele Memorial Medical Center, an 18-bed CAH, converted to CAH status December 14, 1999, making it the 5th hospital to convert in Idaho and the 109th to convert in the U.S.² The hospital offers acute care, emergency care, general surgery, OB/GYN services and surgery, diagnostic imaging (e.g., x-ray, MRI, ultrasound, CT, mammograms), cardiac rehabilitation, sleep studies, oncology services, physical therapy, visiting specialty provider clinics, and a variety of other outpatient services.

The hospital also owns a Rural Health Clinic. The Chief Executive Officer has been working in the hospital for 4 years, the Quality Improvement Manager 12 years, the Chief Financial Officer 5 years, and the Chief Nursing Officer/Chief Operating Officer 5 years. There are 152 employed staff (133 full-time equivalent employees) working at the hospital as well as 5 full-time physicians and 2 full-time nurse practitioners. Health care providers surveyed have been working in the community an average of 7.8 years.



**Steele Memorial
Medical Center**

MISSION STATEMENT:

“Compassionate Healthcare.”

The hospital's current average daily census is 4.4 patients per day (acute care and swing beds) and the hospital has approximately 250 emergency room visits per month and 26,000 hospital and 20,000 clinic outpatient visits per year. In addition, approximately 60 babies are delivered at the hospital each year.

Steele Memorial Medical Center's service area includes all of Lemhi County and parts of Custer County and more specifically the communities of Salmon, Baker, Elk Bend, Tendoy, Carmen, North Fork, Gibbonsville, Ellis, and Challis. The service area can be characterized as being significantly older, less racially diverse, lower income, more likely to live in poverty, less likely to smoke, and less likely to have a college degree when compared to those in the state.^{3,4} In addition, a large proportion of service area residents (14.4% of the population in Lemhi County and 13.9% of the population in Custer County) are veterans.^{5,6}



² As of April 2009 there are 26 CAHs in Idaho and 1302 in the U.S. Source: Flex Program Monitoring Team, www.flexmonitoring.org.

³ U.S. Census Bureau, State and County QuickFacts, retrieved June 10, 2009. <http://quickfacts.census.gov/qfd/states/16/16071.html>

⁴ Cigarette Smoking in Idaho, Idaho Department of Health and Welfare, August 2008, retrieved July 1, 2009. <http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=IzN48ykRzXg%3D&tabid=102&mid=977>

⁵ Idaho: Veteran Population by Period of Service, by County, US. Department of Veterans Affairs, retrieved July 13, 2009. http://www1.va.gov/vetdata/docs/ID_pos.pdf There are a total of 136,584 veterans in Idaho or 8.9% of the state's total population.

⁶ There are 1,129 veterans in Lemhi County and 593 in Custer County. In comparison, there are 136,584 veterans in Idaho or 8.9% of the total population.

STEELE MEMORIAL MEDICAL CENTER *cont...*

There are six emergency medical services (EMS) agencies operating in Lemhi County: Salmon (ALS), Leadore (ALS), QB Corporation (emergency responders), Gibbonsville QRU (BLS), Elk Bend QRU (BLS), and Salmon Search and Rescue (BLS).^{7,8} All of the EMS agencies are coordinated by Lemhi County Emergency Management, a county-owned non-profit. There are approximately 20 EMT-Advanced, 50 EMT-Basic, and 25 first responders serving Lemhi County.⁹ Most of the squads' members are considered "very active". The ambulance services in Lemhi County made 559 runs in 2008 and run volume has fluctuated little over the past five years.¹⁰



"A great place to work [hospital] and a wonderful place to live [Salmon]."

— Case Study Participant

"They're [EMS] a bang-up bunch. They stay trained, sharp, and they are very responsive."

— Case Study Participant



7. ALS indicates advanced life support, BLS indicates basic life support.

8. QRU indicates Quick Rescue Unit.

9. EMT indicates Emergency Medical Technician.

10. As reported by Lemhi County Emergency Management.

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; 4) Integrate EMS into the continuum of health care services; and 5) Improve the quality of rural health care. Steele Memorial Medical Center 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.

“CAH status was an essential decision for survival. I wasn’t in support of it when I first heard about it but now I believe it was the best decision.”

— Case Study Participant

goal: #1 Convert Hospitals to CAH Status

Status: ACCOMPLISHED

Indicators of Outcomes Achieved:

- Steele Memorial Medical Center converted December 14, 1999, making it the fifth hospital to convert to CAH status in the state and the 109th to convert in the U.S.
- It took the hospital approximately 12 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 reports they received a lot of CAH conversion support from the Flex Program and Idaho Hospital Association (IHA). They believe this contributed to a smooth transition to CAH status.

“If we [hospital] were to lose our CAH status, I don’t know if the hospital could stay open.”

— Case Study Participant

- Two health care providers working at the hospital report they were involved in the hospital's decision to convert to CAH status. Both providers "strongly supported" the decision to convert.
- All health care providers surveyed report they are aware the hospital is a CAH.
- Some community members that participated in the community discussion group report they are aware the hospital is a CAH.
- Health care providers working in the hospital report their referral patterns have not changed due to CAH conversion; however, one reports an increase in their patient volume has resulted in an increase in referrals.



- Comments/information by case study participants related to the CAH conversion include:
 - *"It was the billing side that was so complicated [as part of CAH conversion] and implementing the 96 hour length of stay requirement."*
 - *"Staff at the Flex Program and IHA were always available to support us."*

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

Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

Indicators of Outcomes Achieved:

- Most case study participants attribute hospital improvements in the past five years to CAH conversion, a new hospital building, and new hospital management.
- The hospital's 54 year old physical plant was replaced with a "state-of-the-art" facility.
- The hospital emergency room (ER) has changed from on-call ER staffing to being staffed 24 hours per day.
- Hospital staff report Flex Program funding has supported the hospital's efforts towards increasing and upgrading patients' access to health services through improved technology and equipment.

"We used to hear about how old and dirty our hospital was, about incompetent staff who weren't professional. All of that has changed."

— Case Study Participant

- Hospital staff report their hospital is represented at most or all Flex Program meetings, training sessions, and conferences. They have used information from Flex Program/CAH meetings towards adding and enhancing services (e.g., sleep studies, management staff meeting with each patient every day).
- The hospital has added several new services, including: oncology, tele-psychiatry, sleep studies, cardiac and pulmonary rehabilitation, orthopedic surgery, podiatry, mobile MRI, and calcium screening.
- The hospital upgraded and/or enhanced many services/equipment, such as: full-time general surgery, 24 hour ER coverage, sedation, CT, PACs, X-ray, and information technology (including adding an electronic medical record – EMR).
- Seventy-three percent of health care providers report they are involved in patient health promotion/disease prevention initiatives through their work at the hospital. Most of this work has included health screening, public speaking, and community outreach activities.
- Health care providers surveyed report the greatest accomplishments of the hospital over the past five years as: increased patient access to surgery, specialty services, telehealth, and full-time ER coverage; improved quality of health services; new physical plant and equipment; and improved image in the community.
- 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 is teaching all employees computer skills, including providing all employees access to email and Intranet.

“I’ve worked in other health care environments and I’ve seen a lot of things. The transformation I’ve seen here is amazing. We really operate as a team.”

— Case Study Participant

“We have a new hospital and it is wonderful.

Our old hospital was so dark. The pharmacy was probably the scariest part

[before the new hospital] because he [pharmacist] was only here 2 hours a day.”

— Case Study Participant

“People [hospital staff] used to race to the bank to cash their check because they were afraid it would bounce.”

— Case Study Participant

- The hospital’s financial indicators have improved significantly. For example, days cash-on-hand has changed from 6 days to 78 days, gross revenue increased from \$7 million to \$18 million, days revenue in accounts receivable dropped from 70 days to 55 days.
- Hospital board members report they participate in on-going board training (webinars, Trustee Magazine, workshops and retreats, emails and information from hospital leadership) and have started doing a board self-assessment to identify strengths and weaknesses.



- Comments/information by case study participants related to maintaining/sustaining access to health care services include:

“I have a lot of pride in this hospital.”

— Case Study Participant

“They [hospital] used to transfer everything out. Now they can fix broken bones, do surgeries, we have some specialists. And its good care.”

— Case Study Participant

- *“They [Flex Program meetings] are always worthwhile. They offer good information and I am always looking for resources, identifying opportunities, and networking.”*
- *“I’m really good at taking someone else’s idea and going with it [referring to Flex Program meeting information and sharing].”*
- *“Five years ago the perception of the hospital was horrible. It’s turning around though and everything is improving.”*
- *“Hospital finances used to be so bad that the hospital would sue patients for past debt.”*
- *“Our hospital has changed a lot. Now we have plug-ins [electrical outlets], phones, air conditioning and heat in the rooms, and the roof doesn’t leak. It’s 100% better.”*
- *“We have a very good hospital and EMS and I am always recommending that they [community members] just go and try the hospital. Anyone who received care outside the community [Salmon] would know that this hospital [Steele Memorial Medical Center] is really good and wouldn’t complain.”*

“There are amazing staff at the hospital. They have improved everything while reducing costs and using resources very efficiently.”

— Case Study Participant


- *“They’re [hospital management] always looking ahead.”*
- *“Turnaround is hard but some major changes needed to be made [at the hospital]. With the combined new board, medical staff, and leadership, we are moving in the right direction.”*



Indicators of On-going Needs/Issues:

- The hospital no longer receives regularly scheduled local tax funding due to the hospital's improved financial status; however, funding from the county was needed last year to cover hospital building loan payments.
- The hospital continues to work to address billing and coding issues; however, the biggest billing issue continues to be patients' inability to pay for services.
- Hospital staff reports no performance improvement measures in place for materials management.
- The hospital is working to increase its market share as the hospital has the capacity and service area population that indicate patient volume could be higher.
- Case study participants report the hospital needs grant funding to focus on community health promotion and disease prevention (diabetes and heart health) and making preventative services available at a low cost.
- The hospital would like to add a new medical office building, in particular to accommodate specialty services.
- Case study participants indicate an interest in exploring making dialysis services available in the community.
- Case study participants report a need to address the health care needs of local veterans.
- Case study participants report a need to expand hospice services in the community so they better reflect national standards and increase access to key hospice-based care.
- Case study participants report it is difficult for patients to do price comparisons for services received at Steele Memorial Medical Center vs. other hospitals.
- Health care providers report the greatest health care issues impacting the hospital's service area population as lack of mental health and specialty care services and lack of health insurance/under insurance/affordability of health care services.
- Health care providers report the greatest challenges facing the hospital as: finances, increasing market share, health care provider recruitment and retention, governance, lack of population, and continuing to improve the image of the hospital.
- Community members report a need for: a "patient advocate" or "patient liaison" at the hospital; a staff person that can assist with billing issues; improved hospital-patient communications; improved lab/tests turnaround times and patient notification; additional information about generic drug options when receiving a prescription; and improved access to physicians and nurse practitioners via telephone to ask questions and discuss needed follow-up.
- Case study participants report that the physical plant of the local school has a negative impact on the community's economy and the hospital's ability to recruit new physicians.



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- Community members report the greatest health care access issue in the community is the lack of a school nurse.
 - Community members report efforts are underway to develop a local mental health collaborative including having a community mental health discussion and establishing a mental health week. This may be an opportunity for the hospital.
 - Comments by case study participants related to maintaining/sustaining access to health care services include:
 - *“Health insurance costs are too high. Even [for those working] at the hospital. It is too expensive to include family members so people go without.”*
 - *“They [hospital staff/physicians] don’t call so I assume everything [lab results, tests] is ok.”*
 - *“People are prolonging going to the doctor. They just cannot afford to do it even if they are really sick or think something is wrong.”*
 - *“A new school would recruit new doctors.”*
 - *“Trying to sell a school to an older population is difficult.”*

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 training is available 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 hospital’s relationship with Quorum Health Resources (QHR) has been beneficial.

Indicators of On-going Needs/Issues:

- Hospital staff report although they are a member of The Hospital Cooperative, due to distance, they don't participate in many initiatives.
- The hospital uses video conferencing for meetings; however, the equipment is often being used to provide patient services/is not available.

“Networking is really important to our hospital as it allows us to share resources and learn from one another.”

— Case Study Participant

“We are the ones that sit way up here and it is difficult to get to Pocatello for a 3-4 hour meeting. We hosted one of the meetings [The Hospital Cooperative] and only a few people showed.”

— Case Study Participant

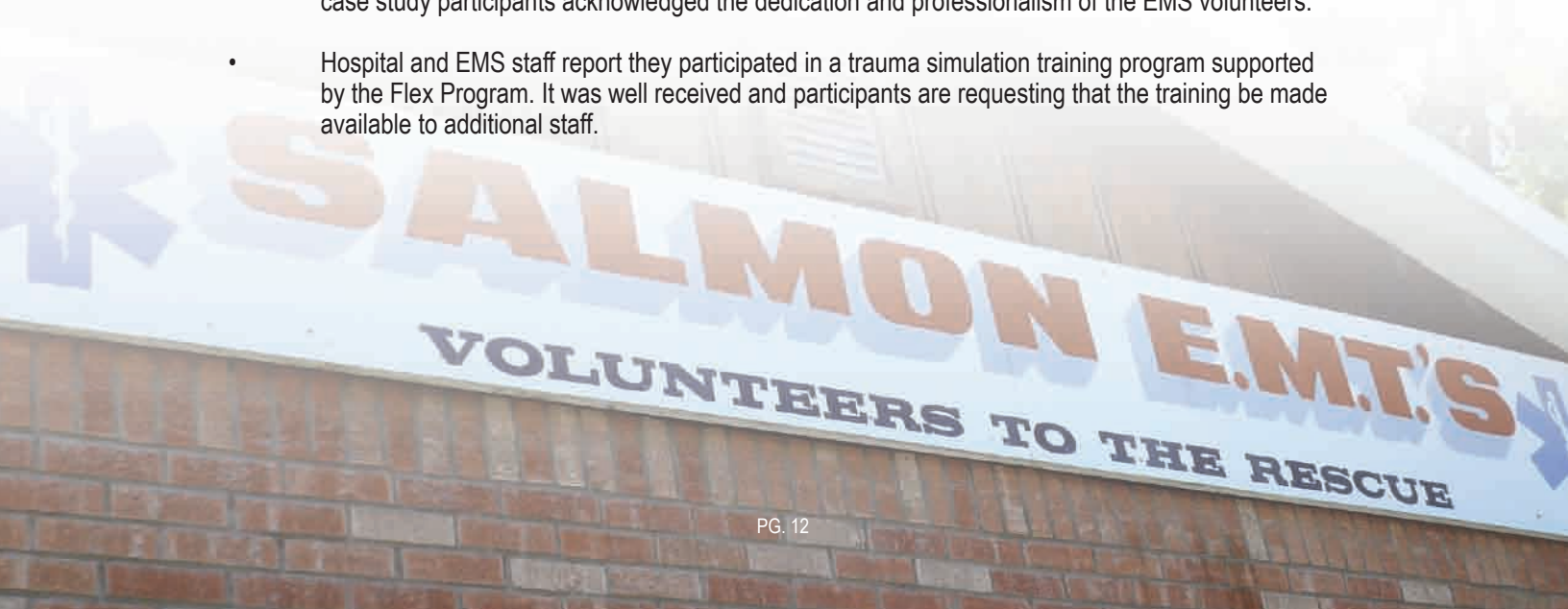
goal: Integrate EMS into the Continuum of Rural Health Care Services

#4

Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

Indicators of Outcomes Achieved:

- Case study participants report local EMS provides a valuable service and high quality care. Many case study participants acknowledged the dedication and professionalism of the EMS volunteers.
- Hospital and EMS staff report they participated in a trauma simulation training program supported by the Flex Program. It was well received and participants are requesting that the training be made available to additional staff.



- Local EMS is submitting run data electronically to the state EMS Bureau.
- The EMS medical director reviews every run report submitted by Salmon and Leadore EMS.
- An EMS assessment was completed by the Flex Program April 24, 2001, and a follow-up assessment May 1, 2003, to identify community EMS needs that should be addressed and areas where progress was made. Case study participants report the assessments provided “good information for decision-making purposes.”
- The following local activities were completed in response to EMS assessment recommendations:
 - *Created an EMS recruitment and retention program that pays for new EMT’s training and requires in return that the EMT remain with the squad 2 years.*
 - *Established a high school EMT program that was operational 3 years. Seventeen students graduated through the program, 4 became paramedics, 2 nurses; however, none were retained by the squad. Due to the lack of retention and resources needed to complete the courses, the program was eliminated.*
 - *An emergency services coordinator position was created and has been staffed as a full-time position.*
 - *The EMS services coordinator manages EMS training opportunities.*
 - *Local EMS participates in specialty training (e.g., geriatric trauma training, mobile simulation lab training for 10 EMTs).*
 - *New patient care protocols were implemented using the Idaho Physician Commission guidelines.*
 - *An EMS vehicle replacement plan was developed that plans to replace vehicles every six years. As a result, an EMS vehicle has been replaced every year for the last 3 years. New replacements will be needed again in 2 years.*
 - *EMS conducts annual table-top exercises and full-scale exercises every 2 years to prepare for disasters/emergencies.*
 - *Communication systems are approximately 98% inner-operable across county agencies.*
 - *A medical direction job description was created using the state template.*

“They [EMS] do a good job. I can’t imagine not having them.”

— Case Study Participant

“The SIMS training [trauma simulation] was really good for new staff. They got to take charge without the pressure of a critical patient.”

— Case Study Participant



- The following local activities are in-process/being completed in response to EMS assessment recommendations:

- *Local EMS is exploring alternative funding sources (primarily grants) as the county tax base is very limited/strained.*
- *Local EMS continues to pursue Emergency Medical Dispatch training for dispatch personnel. Two classes are planned; however, staff turnover continues to be an issue.*
- *EMS increased the number of local EMS instructors from 2 to 17; however, they are currently down to 5 instructors due to lack of retention.*
- *EMS is in the process of developing a medically directed quality improvement plan that includes predetermined benchmarks, performance indicators, measurement tools, and data collection.*



- Comments/information by case study participants related to EMS:

- *“Their [EMS] quality and expertise have improved which has impacted what they can do in the field. For example, they have increased their training and they understand better what they are doing.”*
- *“I’m glad they [EMS] are here.”*

“It’s disheartening when you don’t have a relationship [hospital and EMS] but we still have a partnership.”

“Who are we [EMS volunteers] going to turn it over to? There may be no one willing to volunteer. You get to the point that you feel guilty if you quit because people rely on us.”

— Case Study Participant

— Case Study Participant

Indicators of On-going Needs/Issues:

- Many case study participants report strained relations between the hospital and EMS, in particular between organizational leadership.
- Case study participants report a need for the hospital and EMS to coordinate more on emergency/disaster planning and preparedness, particularly given the roles of both organizations in the community.
- Case study participants report EMT recruitment is difficult.
- Health care providers report there are local EMS challenges. In particular, a need for: EMS-hospital integration, improved relations between the hospital and EMS, recruitment of EMS volunteers, improved radio coverage across the entire service area, on-going education, and additional access to ground transportation to decrease reliance on air transport.
- Hospital and EMS staff report EMS supplies used to be purchased for EMS by the hospital. Due to hospital finances, changes were made to align hospital accounting practices with industry standards. The changes require the hospital to track and allocate the cost of supplies on a departmental basis. EMS did not concur with the change and stopped obtaining supplies from the hospital. This change has increased the cost of EMS supplies and has had a negative impact on hospital-EMS relations.
- Although EMS volunteer retention rates are high, it is difficult to recruit new EMS volunteers.

- EMS needs 2 more repeaters to further improve county-wide communications systems.
- Case study participants report that increased state and national training requirements for volunteer EMTs has had a negative impact on EMS recruitment.
- EMS reports there is statewide confusion regarding changes being made to medical direction and the new Physician's Committee.
- 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:
 - *The EMS medical director has not obtained formal EMS medical direction training.*
 - *No formal quality improvement/assurance training has been obtained by local EMS staff.*
- Comments/information by case study participants related to EMS needs/issues include:
 - *“EMS provides really good care. I wish they [EMS] would be more receptive to working with the hospital.”*
 - *“EMS does a great job. There's just friction between hospital and EMS leadership.”*
 - *“EMS has a hard time recruiting new staff.”*

goal: #5 Improve the Quality of Rural Health Care

Status: OUTCOMES ACHIEVED/ON-GOING NEEDS

Indicators of Outcomes Achieved:

- The hospital has a formal performance improvement process that includes quality improvement components.
- The hospital has an established hospital board committee that is dedicated to quality and patient safety.
- The hospital implemented CPSI as its electronic medical record.
- The hospital was awarded the BlueCross BlueShield 2007 Hospital Quality Award, Award of Achievement.
- All health care providers surveyed report they are involved in quality improvement initiatives at the hospital.

“If I compared us to other hospitals, we'd really shine.”

— Case Study Participant

- All health care providers surveyed report the quality of patient care is improving at the hospital. This is being accomplished through a formal quality improvement program, improving hospital policies and procedures, an active peer review process, increasing the hospital's scope of services and technology, making more specialty services available through the hospital, and continuing education opportunities for providers.
- Health care providers surveyed report their overall opinion of the hospital as "very good" (64%) or "good" (36%).
- All hospital staff, board members, and health care providers included in the case study report they are aware of the hospital's quality and patient safety measures and reporting.
- Hospital staff report quality of care in the hospital has improved.



"We have a progressive small hospital. Even though it's small, there's excellent patient care."

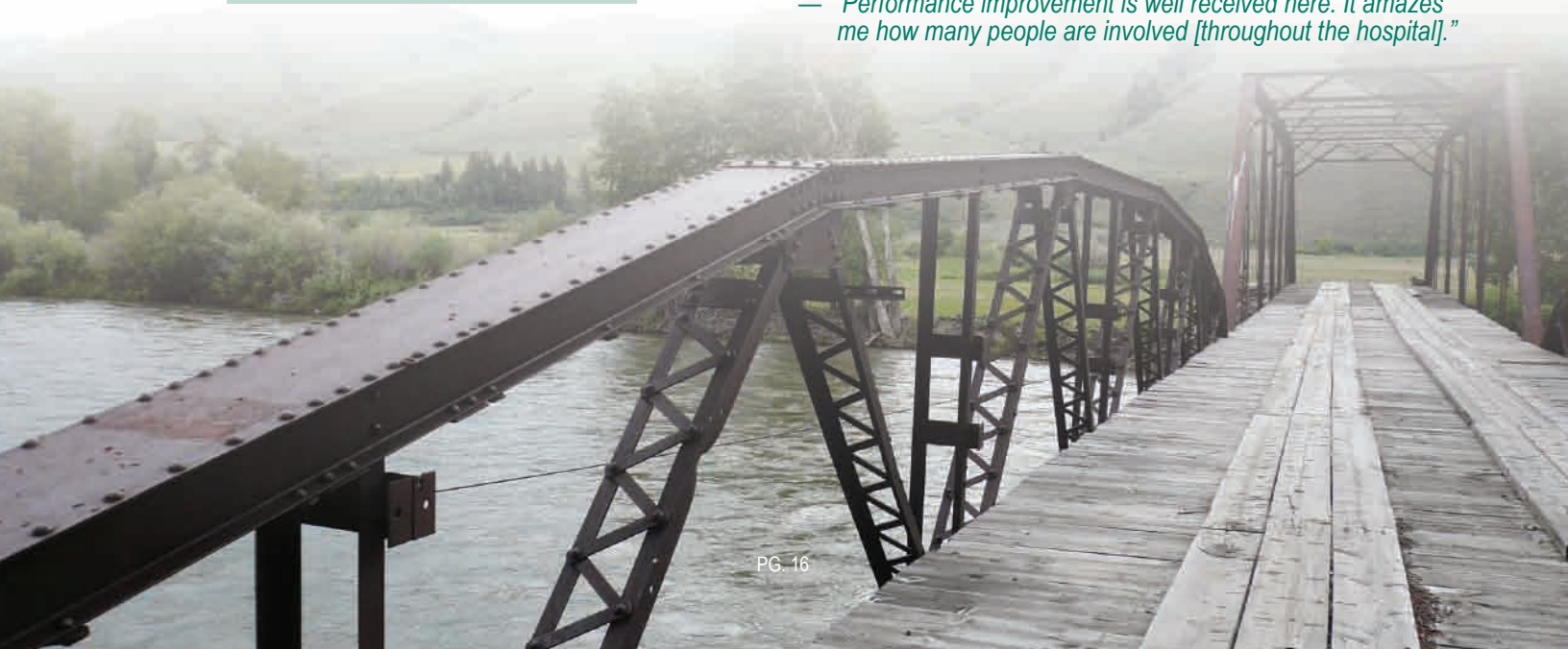
— Case Study Participant

- Hospital staff report steps have been taken to improve quality and patient safety (e.g., cleaning chemicals are no longer sprayed and bleach is no longer used because of their toxicity).
- Hospital staff report they are working to: improve medication reconciliation by getting a system in place, decrease adverse drug reactions by focusing on nausea and constipation as they are two issues that are under-reported, and improve care planning.
- The hospital is working towards health promotion and disease prevention by conducting calcium screening tests and mammograms at "reasonable" rates.
- Community members spoke very favorably of most local physicians and nurse practitioners.

"We're trying to focus on stats, not stories."

— Case Study Participant

- Comments/information by case study participants related to improving quality of care include:
 - *"We [hospital] may not be Joint Commission accredited but we still strive to meet those standards."*
 - *"I think the quality of care is improving, but there's always room for improvement."*
 - *"We have great ER [emergency room] doctors, that's their specialty because that's all they do."*
 - *"Performance improvement is well received here. It amazes me how many people are involved [throughout the hospital]."*



Indicators of On-going Needs/Issues:

- Although the hospital has implemented CPSI as its EMR, some physicians are not entering their orders electronically.
- Hospital staff suggest the need for the hospital to establish a health promotion program for employees. The program could serve as a pilot to be later implemented community-wide. The program would focus on elements of the medical home model and begin by establishing annual exams.
- Health care providers report limited education/training issues but note there may be a need for mental health related training. Providers noted that their remote location makes it difficult to access many training programs.
- Community members report the hospital's quality of care is "totally judged by rumor" versus data and patient outcomes.
- Community members report there is a need for a community-wide project that includes all businesses and focuses on the value of customer service.
- Community members report clinic wait times as "long", "excessive", and "can be an hour wait".
- Comments/information by case study participants related to quality improvement needs include:
 - *"I wish they [clinic] would just tell me ahead of time if there is going to be a long wait time."*
 - *"Customer service in the whole community is an issue."*



conclusions:

This case study highlights many of the local level successes and challenges of Steele Memorial Medical Center and the Idaho Flex Program. It is clear that the hospital converted to CAH status, built a new hospital, expanded access to health services, enhanced services, upgraded equipment, has performance and quality measures in place, and is implementing initiatives to improve hospital operations and quality. In addition, local EMS has made changes to improve its operations; however no/limited EMS-hospital integration has occurred. 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 and those who are uninsured/underinsured. Other needs to be addressed relate to hospital-EMS relations, health care provider recruitment and retention, hospital marketing/community knowledge of the services available at the hospital and clinic, access to local health care services for the large veteran population, and the 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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