

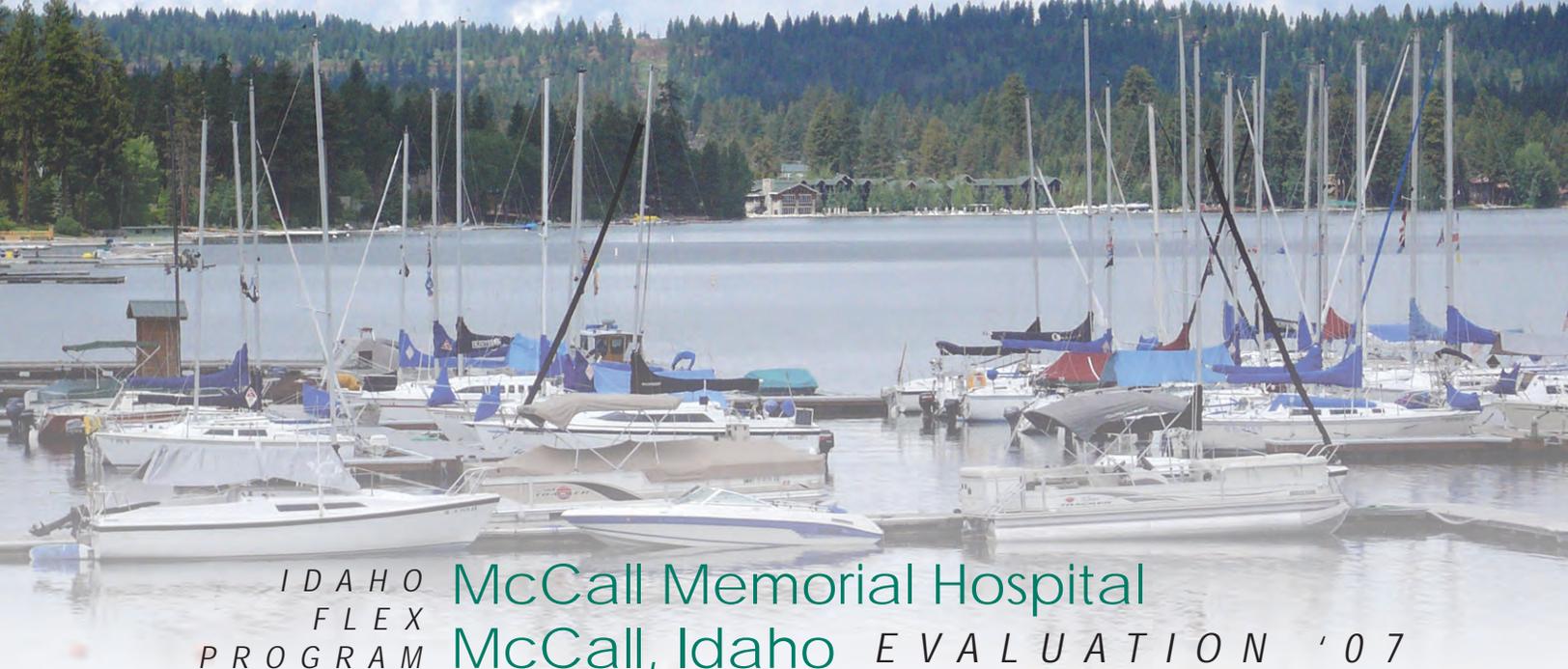
*A CRITICAL ACCESS HOSPITAL  
CASE STUDY*

IDAHO FLEX PROGRAM

# EVALUATION '07

McCALL MEMORIAL HOSPITAL, McCALL, IDAHO





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

## McCall Memorial Hospital

McCall, Idaho EVALUATION '07

*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 McCall Memorial Hospital, McCall, Idaho, was conducted as part of Idaho's Medicare Rural Hospital Flexibility (Flex) Program and its program evaluation activities to examine these questions.*

### CASE STUDY OBJECTIVES AND METHODS

The McCall Memorial Hospital case study was completed to identify community, hospital, and other health care related changes and outcomes that have occurred due to McCall Memorial Hospital's conversion to Critical Access Hospital (CAH) status and its involvement in the Flex Program, as well as 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 May – July 2007 on McCall, Idaho.
- Interviews of hospital staff, hospital board members, and local emergency medical services (EMS) personnel were conducted in McCall, Idaho, in June 2007.
- A survey of health care providers (physicians, physician assistants, nurse practitioners, nurse anesthetists, and clinical social workers/counselors) working in McCall Memorial Hospital was conducted in June 2007. The survey response rate was 83 percent.
- A community focus group was conducted in McCall, Idaho, in June 2007.

83%  
response rate

Thirty-one individuals from the hospital service area were included in the case study process. They were asked questions related to: the hospital's conversion to CAH status, changes that have occurred at the hospital over the past 10 years, quality of care, networking activities that have occurred, changes to EMS services, and community needs and issues.

The Idaho Department of Health and Welfare, Office of Rural Health and Primary Care, administers the Flex Program in Idaho and sponsored the case study. Rural Health Solutions, St. Paul, Minnesota, conducted the case study and prepared this report.

## McCALL, IDAHO AND THE SURROUNDING AREA

McCall is located in west-central Idaho, and is situated on the southern shore of Payette Lake in Valley County. Valley County has an area of 3,678 square miles that consists of mountain, lake, forest, swamp, and valley terrain. Traditionally a logging community, McCall is now part of a four-season, outdoor, recreation area that is known as a vacation destination and as having the largest skateboarding park in Idaho. The largest employers in McCall are Payette National Forest, McCall-Donnelly Schools, and White Tail Club and Resort.

In 2006, the estimated population of McCall was 2,567; this is a 23.2 percent increase in population compared to 2000 (2,084). McCall lies along Highway 55 about 96 miles south of Grangeville, Idaho, (where the nearest hospital to the north is located) and 107 miles north of Boise, Idaho, where the nearest tertiary hospital is located. Cascade Medical Center, located in Cascade, Idaho, and also a CAH, is the nearest hospital (about 29 miles south) to McCall Memorial Hospital.

### McCall

population in 2000 = 2,084

population in 2006 = 2,567

*"This is an ideal place to live and I absolutely love it."*

— Case Study Participant

When asked, "What makes McCall a healthy place to live?", case study participants characterized the community as having: easy access to recreation activities and nature, "people that value what nature brings", a perception that physical activity is a part of daily living, clean air and water, strong community relationships, little crime, access to alternative medicine and preventative care, an educated population, and a slower pace. When asked, "What makes McCall an unhealthy place to live?", case study participants reported: limited access to cultural activities, long winters that can result in depression and isolation, inability to attract employees, lack of child care services, limited fresh produce, financial pressures for working families, high and rising cost of living, lack of advanced education opportunities, increasing poverty, lack of affordable housing, high percentage of underinsured and uninsured, cost of healthcare services, and no after-hours/urgent care health services. Several case study participants also reported that as the community grows, they fear there will be/is a declining sense of community.



## McCALL MEMORIAL HOSPITAL

McCall Memorial Hospital, a 15-bed CAH, converted to CAH status October 1, 2000, making it the 11th hospital to convert in the state and the 264th to convert in the U.S.<sup>1</sup> The hospital is a district, governmental subdivision and offers emergency care, general surgery, obstetrics, orthopedic surgery, home care and hospice, and a variety of outpatient services. The hospital is affiliated with 7 clinic offices and owns one clinic, an integrative medicine clinic. The hospital administrator has been working in the hospital for 26 years, the Chief Financial Officer 5 years, and the Chief Nursing Officer/ Quality Improvement Coordinator 20 years. There are 32 physicians (12 full-time and 20 visiting/consulting), 2 physician assistants/nurse practitioners, and 90 full-time equivalent employees working at the hospital.

McCall Memorial Hospital's service area is approximately a 75 mile radius and includes the communities of McCall, New Meadows, Council, Riggins, Lake Fork, Donnelly, and Cascade. This service area population of approximately 8,000 full-time residents (which can swell to over 50,000 due to tourism and local events), can be characterized as being wealthier, older, less racially diverse, and more likely to have a high school diploma and college degree when compared to the state average. The hospital's 2006 average daily census for inpatients was 3 patients per day and the hospital had approximately 5,000 emergency room visits and 20,000 outpatient visits that same year.



### McCall Memorial Hospital's VISION STATEMENT:

*"A community-sponsored service providing quality primary health care and promoting wellness."*

*"McCall Memorial Hospital is an excellent hospital and the administrative staff work overtime to take care of patients, citizens, and employees. It is an honor to work here."*

— Case Study Participant

Ambulance services for the area are provided by 6 EMS agencies: McCall Fire and EMS, Donnelly Fire and EMS, Meadows Valley Ambulance Service, Riggins Ambulance Service, Council Valley EMS, and Cascade Fire and EMS. McCall Fire and EMS has the most interaction with the hospital and it provides intermediate life support services through 26 trained emergency medical technicians (14 Advanced-EMTs and 12 Basic-EMTs, this includes the 6 full-time fire fighters that are cross-trained as EMTs) as well as 1 First Responder. The ambulance service has 3 full-time paid staff and the remaining staff are volunteers. The ambulance service responded to 803 calls in 2006. Run volume has fluctuated over the past five years with a high of 937 runs in 2005.<sup>2</sup>

<sup>1</sup>. As of May 9, 2007 there are 26 CAHs in Idaho and 1283 in the U.S. Source: Office of Rural Health Policy, Health Resources and Services Administration.

<sup>2</sup>. As reported by McCall Fire and EMS.

# impact

## OF THE FLEX PROGRAM

*“Converting to CAH status was an excellent decision.”*

— Case Study Participant

The national 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. McCall Memorial 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 reported that without the Flex Program, each accomplishment would have been difficult, delayed, and/or not pursued.

Goal: Convert Hospitals to CAH Status  
Status: Accomplished

### *Indicators of Outcomes Achieved:*

- McCall Memorial Hospital converted to CAH status October 1, 2000.
- 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 report that CAH conversion allowed the hospital access to partnerships, programs, technical assistance and other support through the Flex Program.
- All health care providers that reported their support for CAH conversion indicated that they “strongly supported” the hospital’s conversion to CAH status.
- Comments/information by case study participants related to the CAH conversion process include:
  - *“We visited other CAHs to see if this program made sense for us and it did.”*
  - *“Conversion was seamless for us and we received all the support we needed.”*

*“Their assistance [Idaho Hospital Association and Office of Rural Health and Primary Care] was invaluable as a resource for information.”*

— Case Study Participant

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

## Status: Outcomes Achieved/On-going Needs Exist

### Indicators of Outcomes Achieved:

- The hospital eliminated no services due to CAH conversion.
- All health care providers reported that their referral patterns have not changed since the hospital converted to CAH status.
- The hospital added: a sleep lab, colonoscopy services, mobile MRI services, an integrative medicine clinic, a volunteer chaplains program, pastoral care, staff education and programming opportunities, physicians, and staff in various departments such as laboratory and radiology.
- The hospital upgraded its CT (computed tomographic) scanner to a 32-slice scanner, expanded radiology services, expanded services into satellite clinics, and matured its performance improvement and quality improvement programs.
- The hospital is engaged in the Flex Program supported Databank which allows the hospital to compare its performance related data to other hospitals (including other small rural hospitals).
- The hospital's financial performance has fluctuated since CAH conversion but it budgets for a 0 to 2 percent gross margin and had gross margins of 0 to 5 percent over the past seven years.
  - Hospital staff report that staff salaries have increased since the hospital converted to CAH status.
  - Hospital staff report they are developing a balanced scorecard for financial, quality, and human resources indicators.
  - CareLearning.com, a program initially sponsored by the Flex Program, is used by hospital staff for training (e.g., EMTALA). This has decreased training costs, improved compliance with training requirements, and improved staff satisfaction with training options.
  - 92 percent of health care providers report they are engaged in community health promotion/disease prevention activities. Community education/presentations and health screenings were the most commonly identified activities.
  - The hospital has used Flex Program grant funding for patient satisfaction surveys, strategic planning activities, sleep lab equipment, and community planning.
- All health care providers report their overall opinion of the hospital and the care provided as "very good" (80 percent) or "good" (20 percent).

*"Everything about Flex has been a catalyst to participate in other things."*

— Case Study Participant



- Health care providers report the greatest accomplishments of the hospital over the past five years as: recruitment of excellent staff and physicians, new equipment and the integrative medicine clinic, improved patient satisfaction, improved EMS care, and increased access to clinic and specialty clinics.
- Comments/information by case study participants related to maintaining/sustaining access to health care services include:
  - *“If we were reimbursed on a DRG basis, I doubt that we would have been able to pursue any of our new services.”*
  - *“APCs would have been a killer for us because of our outpatient volume.”*
  - *“It [CAH status] has enabled us to do some things, but you never take your eye off the bottom line.”*
  - *“We have a very strategic board that has a good relationship with one another. We have a reserve [financial] policy to handle the dips. Is it because of CAH? No, but it contributed to it.”*
  - *“We used to constantly have to look at whether we could afford to do certain tests for people. It was hard to offer something if we knew we were always going to lose money.”*
  - *“Flex Program activities have been useful because we can see what is going on, share best practices, and do peer stuff.”*

#### *Indicators of On-going Needs/Issues:*

- The hospital is considering pursuing nursing Magnet Hospital status and Joint Commission accreditation.
- Four health care providers report they did not know the hospital is a CAH.
- The hospital is working to address succession planning needs related to 33 staff, some in key leadership positions.
- Health care providers report that cost of health care, lack of/inadequate health insurance, obesity, diabetes, heart disease, and access to specialists and surgical services are the greatest health care issues facing the community.



- Hospital staff report a need for additional pre-diabetes and diabetes community education.
- Case study participants report a need for increased access to tele-health services.
- Case study participants report that hospital and clinic services have outgrown the spaces currently available to provide those services.
- The hospital is exploring a hospitalist program as part of its quality improvement and recruitment strategies.
- Hospital staff report a potential need for additional peer review opportunities.
- Health care providers report the greatest issues facing the hospital as: health care costs; uninsurance and underinsurance; increasing population; physician, specialist, and surgeon recruitment; changing community demographics; electronic medical record; rising housing costs; and dual diagnosis/mental health issues.
- The hospital is recruiting a registered nurse, registered respiratory therapist, medical technologist, business office director, coders, and physicians.
- Case study participants report a community need for an orthopedic surgeon, gynecologist, additional physicians, 7 days a week urgent care options, and improved access to pharmacy services.
- Case study participants report concern about limited to no access to nursing home and assisted living services.
- Case study participants report access to affordable housing as one of the greatest issue facing the community.
- Comments by case study participants related to maintaining/sustaining access to health care services needs and issues include:

- *“We’re scheduling 6 weeks out at the clinic. That is a long wait time for many patients.”*
- *“Our staff go down to the valley because they can’t get in [at the clinic].”*
- *“Most of my employees don’t have health insurance.”*
- *“Housing is the largest problem we have because rent is comparable to that of Hawaii.”*
- *“No one can afford any preventative care.”*
- *“Dental access is difficult.”*



*"We feel fortunate that we have such a great hospital but it's unfortunate that people can't afford to use it."*

— Case Study Participant

- *"Nutrition is a huge issue; everyone wants quick, fat foods."*
- *"We're looking at succession planning, age of staff, how to attract people into the area, and we need to find the right people who want a different lifestyle, different approach, lots of patient care."*
- *"We wish we could change more on a national scale because that is what often times keeps us from moving ahead."*
- *"We need to get the clinic on-board electronically."*
- *"Not only have we outgrown our space, which is creating privacy and other issues, but we need to change our processes in order to improve care and efficiency."*
- *"Our older physicians are retiring. The new physicians are used to having everything at their finger tips and they're not going to have the older physicians around to mentor them."*
- *"We're trying to create an on-line tool so patients can access their lab results on-line."*
- *"We need in-state OB fellowship options for C-section training for family physicians."*

**Goal:** Develop Rural Health Networks  
**Status:** Outcomes Achieved/On-going Needs Exist

**Indicators of Outcomes Achieved:**

- Hospital staff report improved relations and increased networking with St. Luke's and St. Alphonsus Regional Medical Center in Boise, Idaho.
- Hospital staff report using the Southwest Idaho Community Health Network to address health information technology connectivity infrastructure issues using a regional approach.
- Hospital staff report increased networking with other small rural hospitals, particularly in the areas of staff education and performance improvement.
- Comments/information by case study participants related to network development include:

*"There is so much more collaboration now that we don't have to keep recreating the wheel."*

— Case Study Participant

- *"We network a lot with other CAHs."*
- *"The networking opportunities are there. For example, the Southwest Idaho Community Health Network. CFOs, business office staff, health information technology managers, we all network with one another through the larger network."*
- *"I know all my counterparts within St. Luke's. The opportunities are there to be in touch with one another."*
- *"The more that is common between us [Southwest Idaho Community Health Network members], the easier it [health information technology] will be to manage it centrally."*
- *"Networking has existed in the State for a long time but we've had additional opportunities because of Flex."*

*Indicators of On-going Needs/Issues:*

- Hospital staff report that they are trying to create a “green” hospital that is environmentally friendly and healthier for patients and staff. This work is being done in coordination with other CAHs in Idaho.
- Hospital staff report that they are working to address regional health information technology connectivity and data sharing issues.

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

Status: Outcomes Achieved/On-going Needs Exist

*Indicators of Outcomes Achieved:*

- Case study participants report that the local EMS assessment completed as part of the Flex Program was a catalyst for change. The changes are reflected in: regional EMS using a more system-wide approach for EMS planning; improved EMS educational opportunities; increased applications for and receipt of grant funding; additional requests for hospital support, supplies, and equipment.
- Activities (such as joint training) are in process to improve EMS-hospital relations.
- A joint fire and EMS station was built in 2004.



- A local EMS assessment was completed by the Flex Program to identify community EMS needs that should be addressed. The following local activities were completed in response to assessment recommendations:

- A first responder course was conducted on-line and made available in the high school.

- Students have been able to experience local EMS by participating in the ride-along program.

- A multi-agency EMS information and training exchange occurs to improve access to local training and share information/best practices. Agencies also meet in-person on a quarterly basis.

- Staff leadership training is being pursued.

- A Valley County ambulance replacement program has been established. Vehicles are now replaced every 3 – 5 years.

- Air medical and EMS agency rendezvous protocols were written and implemented.

- A local EMS needs assessment is being completed to determine the County's need to assess a .002% tax to meet local EMS needs.

- Local EMS have applied for and received a limited number of grants. One grant purchased new mannequins to use for training.

- Local physicians have participated in the EMS medical direction training.

- A formal quality improvement program has been established that includes informal benchmarking, trouble-shooting, run-report reviews, and run report discussions/training.

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

- "I think the quality of EMS care has improved and continues to improve."

- "They [EMS] take better care of patients."

- "We're fortunate because we have an open-door policy [between the hospital and EMS]."

- "I think we've come to realize that EMS is the first point of care for many patients."



*"That workshop [EMS recruitment and retention workshop] was awesome. It's hard for us to get down into the valley so when they brought it here, it was great."*

— Case Study Participant



*Indicators of On-going Needs/Issues:*

- Hospital staff report that communication blackout areas still exist in the most remote areas.
- Hospital staff report that the smaller squads in Riggins and New Meadows have the greatest challenges because of their limited call volume and their need to provide services in the local canyons.
- EMS staff report that recruitment of volunteer EMTs is an issue, primarily because of the “changing face” of volunteers and most people cannot be on-call during the day.
- EMS and hospital staff report that over the past two years, there has been frequent (four times) turnover in the State regional EMS consultant. This has significantly limited EMS’ access to the technical assistance needed to carry out the recommendations of the local EMS assessment.

*“We need to be prepared to provide a broad array of services [EMS] in many environments.”*

— Case Study Participant

- Although EMT courses have been offered in the local schools, little recruitment success has been achieved as the students most interested in the program leave the community to attend post-secondary school programs.
- EMS staff report staff retention issues in the Valley County dispatch center.
- 50 percent of health care providers report there are EMS issues that are impacting local health care services, including: the number of trained volunteers, staff training for the most remote ambulance services, impeded radio/communication services.
- 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:

- *EMS staff are exploring on-line, interactive, Emergency Vehicle Operator Course (EVOC) training options that include a follow-up driving course to meet the squad’s EVOC training needs.*
- *The County has not supported the establishment of a Valley County EMS Committee.*
- *Although some local destination determination and diversion protocols are in place, protocols are not in place for all EMS agencies serving the County.*
- *The County does not have county-wide enhanced-911 in place.*
- *EMS staff report the need for a medical director contract template.*
- *Inter-facility transports continue to be a challenge. This is due to the six hour minimum time commitment needed to make transports to Boise, the uncomfortable ride for patients (winding, mountainous roads), limited staff available to do transfers, and annual weather conditions that affect the roads and EMS’ ability to fly (approximately 45 days per year).*

- Comments/information by case study participants related to EMS needs/issues include:
  - *“We have pockets with tremendous challenges, particularly those squads with low volume.”*
  - *“If grant funding was available, we would use it to upgrade our pediatric training equipment and materials and establish on-going leadership training opportunities.”*

**Goal: Improve the Quality of Rural Health Care**  
**Status: Outcomes Achieved/On-going Needs Exist**

*Indicators of Outcomes Achieved:*

- Physicians and hospital staff report the hospital has quality improvement initiatives in place to improve quality of care.
- The hospital has established a performance/quality improvement committee that includes administrative, medical, board, and other hospital staff. Every month, 2-3 departments report on outcomes related to the performance/quality audits they are conducting.
- The hospital implemented a quality improvement program involving patient identification bands. They have obtained 100 percent compliance with operating room and inpatients being banded.
- A national patient safety expert was obtained to identify patient safety issues. This resulted in changes to the hospital’s oxygen, needles, and medication reconciliation systems.
- Information technology staff implemented an electronic call board which allows anyone with access to a computer access to the call-board. This change has increased patient and physician satisfaction.
- Hospital staff report their involvement in the Flex Program supported quality improvement collaborative as “beneficial.”
- The hospital is using Computer Programs and Systems, Inc. (CPSI) as its main electronic health record product with other supplemental products.
- Hospital environmental services have been upgraded through the purchase of a new mop and cleaning system. The new system is more ergonomic, more efficient, lighter weight, and faster while maintaining/improving quality.
- Hospital staff report they are talking openly and honestly with patients that have complaints about their care.



- Hospital staff report they have developed the knowledge and ability to conduct root cause analysis in their “problem areas”.
- Comments/information by case study participants related to improving quality of care include:



- *“More and more we are opening up about our problems and issues.”*
- *“If we do need to make budget cuts, we don’t look to staff education to do it.”*
- *“Our performance improvement and quality improvement programs have matured a lot in the past few years.”*
- *“I hope quality is continually improving. I think we have better diagnostics, improved protocols, and better awareness of standards of care.”*
- *“We have a terrific bunch of people providing a quality service in a facility that the community takes pride in.”*

#### *Indicators of On-going Needs/Issues:*

- Hospital staff report that clinical benchmarks are still “problematic” and they are trying to develop them.
- Hospital staff report an on-going need to improve timeliness of an antibiotic when patients are admitted to the emergency room.
- 69 percent of health care providers report that they believe that the hospital’s quality improvement initiatives are improving quality of care, 23 percent report they don’t know whether they are improving quality of care, and 8 percent report they are not improving quality of care.
- Comments/information by case study participants related to quality improvement needs include:
  - *“We’re trying to identify meaningful numerators and denominators.”*

# conclusions:

*This case study highlights many of the local level successes and challenges of McCall Memorial Hospital and the Idaho Flex Program. It is clear that the hospital has converted to CAH status, expanded access to services, implemented initiatives to improve hospital performance and quality, and is working to meet community needs. 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 changing needs of the growing community. In particular, those needs center on: access to health care services (primary and specialty care, as well as financial access), recruiting and retaining staff, quality and performance improvement, health promotion, EMS training, and information technology.*

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](tel:2083340669) or via e-mail at [ruralhealth@dhw.idaho.gov](mailto:ruralhealth@dhw.idaho.gov).

You can find the Office of Rural Health and Primary Care on the Web at

<http://www.healthandwelfare.idaho.gov/site/3459/default.aspx>



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