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Need a Hospitalist? Call a Nurse!

by Lola Butcher (April 10, 2017)
Hospitals & Health Networks

Even physicians learn to love a program that could provide a lifeline for hospitals struggling to find doctors

Hospitalist programs, common in medium-sized and large hospitals for years, have been too costly for many smaller and rural hospitals to adopt. But a new model using nurse practitioners opens the door for small and critical access hospitals, in some cases with dramatic results for patient outcomes and patient satisfaction, as well as for physician retention rates. They could even be a key to the survival of some of America's most challenged hospitals.

Nurse practitioners run the hospitalist program at Rusk County Memorial Hospital in Ladysmith, Wis., overseen by an off-site collaborating physician. "Without the creation of our hospital medicine program, it is unlikely our hospital could have survived," says Charisse Oland, CEO of Rusk, a 25-bed bed hospital with a service area of about 18,000 people.

A few years ago, an independent medical group that had been providing much of the area's primary care started having a difficult time attracting new physicians to replace those who left. On top of that, the physicians who remained increasingly referred patients to another hospital 45 minutes away.

Rusk took several steps to address the problem, including starting its own primary care clinic. But it was the adoption of a nurse practitioner hospitalist model pioneered at two other Wisconsin critical access hospitals — Eagle River Memorial Hospital and Aspirus Medford Hospital — that sparked an impressive turnaround.

The accompanying case study digs deeper into the Rusk success story, including the three scenarios hospital leaders considered in choosing and designing the hospitalist program, how the program works and the lessons learned along the way.

Other hospitals are discovering the value of the nurse hospitalist, as well. Several small hospitals in Indiana and Ohio contract with Hospital Care Group, which uses NP hospitalists to supplement care provided by physician hospitalists. Hospital Care Group employs 25 physicians and 15 NPs who provide round-the-clock hospitalist coverage at 10 hospitals. The mix of physician and NP staffing varies from one hospital to the next, depending on each one's medical staff needs and what it can afford.

"Our primary model is to have a physician there during the daytime and a nurse practitioner covering that hospital either on-site or off-site during the night, usually from 5 p.m. until 7 a.m.," says Mark Drapala, the company's CEO.

By contrast, the NP hospitalist at Pinckneyville (Ill.) Community Hospital works weekdays, allowing him to round with primary care physicians as they check on their patients and provide continuity of care throughout the day.

“He is constantly in and out of the rooms, checking on each patient, regardless of their acuity level,” says CEO Randall Dauby. “The perceived care is better, the customer service is better, and the results are showing up on our Press Ganey scores.”

Pinckneyville’s NP hospitalist sits on the hospital’s quality council and works on process improvement initiatives that community physicians don’t always have time for.

“Our physicians are happy because they get to their offices quicker,” Dauby says. “And the improvement in 30-day readmissions has been great because the nurse practitioner is involved in the discharge case management process.

“Overall,” he says, “it’s been wonderful.” The entire article can be found here.

34 Statistics for Medicare Admissions, Costs, Margins and Charges at Hospitals

by Laura Dyrda (March 20, 2017)
Becker’s Hospital Review

Medicare's fee-for-service program paid 4,700 hospitals $178 billion in 2015 for inpatient admissions, outpatient services and non-Medicare uncompensated care costs. Here are 34 statistics on Medicare admissions, costs, margins and charges in 2015 from MedPAC's March 2017 report to Congress.

Inpatient services

1. Number of inpatient admissions: 10 million
2. Total fee-for-service payments: $112 billion
3. Payments per FFS beneficiary: $3,002
4. Inpatient costs per discharge increase from 2014 to 2015: 2.2 percent
5. Inpatient discharges per FFS Part A beneficiary percent change from 2006 to 2015: 19.5 percent decrease
6. Share of total Medicare revenue from inpatient services: 60 percent (down from 71 percent in 2010)

Outpatient services

7. Number of visits for outpatient services: 200 million
8. Total fee-for-service payments: $58 billion
9. Payments per FFS beneficiary: $1,753
10. Outpatient visits per FFS Part B beneficiary percent change from 2006 to 2015: 47.4 percent increase
11. Share of total Medicare revenue from outpatient care: 28 percent (up from 21 percent in 2010)

Uncompensated care

12. Non-Medicare uncompensated care costs: $8 billion
13. Payments per FFS beneficiary for uncompensated care: $202
14. Share of total Medicare revenue from uncompensated care: 4 percent

Hospital margins

15. All hospitals excluding critical access hospitals and Maryland hospitals: -7.1 percent (compared to -4.9 percent in 2010)
16. Urban hospitals: -7.3 percent (compared to -5.2 percent in 2010)
17. Rural hospitals excluding critical access hospitals: -4.9 percent (compared to -2.6 percent in 2010)
18. Rural hospitals including critical access hospitals: -3.2 percent (compared to -1.7 percent in 2010)
19. Nonprofit hospitals: -8.5 percent (compared to -6.3 percent in 2010)
20. For-profit hospitals: -1.3 percent (compared to -0.1 percent in 2010)

21. Major teaching hospitals (hospitals with a high resident-to-bed ratio): -5.2 percent (compared to -1 percent in 2010)
22. Other teaching hospitals: -5.8 percent (compared to -4.6 percent in 2010)
23. Nonteaching hospitals: -9.6 percent (compared to -8 percent in 2010)
24. EBITDA margin excluding critical access hospitals and Maryland hospitals: 10.6 percent (up from 10.4 percent in 2010)
25. Total all-payer margin excluding critical access hospitals: 6.8 percent (up from 6.3 percent in 2010)
26. Operating margin excluding critical access hospitals: 6.4 percent (up from 5.2 percent in 2010)

Hospital charge markups based on MedPAC's analysis of 2014 Medicare claims and cost reports. Here are the cost-to-charge ratios:

27. Routine: 1.4
28. Special care: 1.8
29. Supplies/devices: 2.8
30. Drugs: 3.6
31. Operating room: 4.8
32. Lab: 6
33. Radiology: 7.9

The full text of the report can be found here.

Jay County Hospital Convenience Care Clinic

Jay County Hospital (JCH), along with Meridian Health, is happy to announce a collaboration to offer additional healthcare services and access to the Jay County community. In February, Meridian Health in collaboration with Jay County Hospital opened **MeridianMD Convenience Care** to offer same-day treatment for minor illnesses and injuries through walk-in availability.

JCH Jay County HOSPITAL Quality Care By Those Who Care

The MeridianMD Convenience Care clinic is available evenings and weekends when patients can't wait for medical attention for less serious ailments and injuries such as:

Coughs, colds	Upper respiratory infections, bronchitis
Sore throat, strep throat	Sinus infections
Urinary tract infections	Ear infections
Ankle/wrist injuries	Rashes

The clinic is located just inside the main entrance of Jay County Hospital at 500 West Votaw Street, Portland. For more serious conditions, the JCH emergency room is still available 24 hours a day, 7 days a week.

"Jay County Hospital is committed to providing our communities with accessible, high-quality health care, and we are extremely happy to partner with Meridian Health who shares the same commitment. Being able to provide this much needed service to our community is exciting, and I am happy to be a part of this partnership," states Dave Hyatt, Jay County Hospital President.

MeridianMD Convenience Care is open Monday-Friday from 2pm-8pm and Saturday & Sunday from 8am-Noon. Jay County Hospital healthcare providers staff the clinic for convenient care by trusted providers.

CMS Issues 2018 IPPS Proposed Rule with Eye on Regulatory Simplification

by Rajiv Leventhal (April 17, 2017)
Healthcare Informatics

The rule signals the first noteworthy move from CMS Administrator Seema Verma as it relates to payment regulation

The Centers for Medicare & Medicaid Services (CMS) has issued a proposed rule that would update 2018 Medicare payment and polices when patients are admitted into hospitals. The rule also has several other components to it related to health IT and value-based purchasing, including a stipulation that would allow eligible professionals (EPs) to report to a 90-day reporting period for the meaningful use program in 2018.

Late in the afternoon on April 14, CMS posted the "Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule, and Request for Information" to the Federal Register. In all, the more than 1,800-page rule covers a variety of Medicare program updates for 2018 as well as a request for information to solicit ideas for regulatory, policy, practice and procedural changes that would ease the burden that prior policies have put on clinicians. Indeed, according to a CMS announcement, "The proposed rule aims to relieve regulatory burdens for providers; supports the patient-doctor relationship in healthcare; and promotes transparency, flexibility, and innovation in the delivery of care." The fact sheet for the rule can be read here.

Overall, in its attempt to relieve providers of administrative burdens and encouraging patient choice, CMS is proposing a one-year regulatory moratorium on the payment policy threshold for patient admissions in long-term care hospitals while the agency continues to evaluate long-term care hospital policies. CMS is also proposing to reduce clinical quality measure (CQM) reporting requirements for hospitals that have implemented electronic health records (EHRs). Some of the rule's most noteworthy components include:

- For 2017, eligible hospitals and critical access hospitals (CAHs) demonstrating meaningful use for the first time in 2017 or that have demonstrated meaningful use in any year prior to 2017, the reporting period would be two self-selected quarters of CQM data, rather than a full calendar year.
- Also for 2017, if an eligible hospital or CAH is only participating in the EHR Incentive Program, or is participating in both the EHR Incentive Program and the Hospital Inpatient Quality Reporting (IQR) program, the eligible hospital or CAH would report on at least six self-selected of the available CQMs, rather than eight, as previously constructed.
- For 2018, CMS is also proposing to modify the EHR reporting periods for new and returning participants attesting to CMS or their state Medicaid agency from the full year to a minimum of any continuous 90-day period during the calendar year.
- What's more, as mandated by the 21st Century Cures Act, CMS is proposing to add a new exception from the Medicare payment adjustments for EPs, eligible hospitals, and CAHs that demonstrate through an application process that compliance with the requirement for being a meaningful EHR user is not possible because their certified EHR technology has been decertified under ONC's Health IT Certification Program.
- Furthermore, CMS is inviting public comment on potential new quality measures for future inclusion in the Hospital IQR Program, accounting for social risk factors, and providing confidential feedback reports to hospitals with measure rates for certain measures stratified by patients' dual eligibility status.

Related to payment increases, CMS noted that it currently pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS and long-term care hospitals under the LTCH PPS. Under these two payment systems, CMS sets base payment rates prospectively for inpatient stays based on the patient's diagnosis and severity of illness.

But the new proposed changes, which would apply to approximately 3,330 acute care hospitals and approximately 420 LTCHs, would affect discharges occurring on or after October 1, 2017.

Specifically, the proposed increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful EHR users is approximately 1.6 percent.

CMS projects that the rate increase, together with other proposed changes to IPPS payment policies, will increase IPPS operating payments by approximately 1.7 percent, and that proposed changes in uncompensated care payments will increase IPPS operating payments by an additional 1.2 percent for a total increase in IPPS operating payments of 2.9 percent. Other additional payment adjustments will include continued penalties for excess readmissions, a continued 1 percent penalty for hospitals in the worst performing quartile under the Hospital Acquired Condition Reduction Program, and continued upward and downward adjustments under the Hospital Value-Based Purchasing Program. In sum, CMS projects that total Medicare spending on inpatient hospital services, including capital, will increase by about $3.1 billion in FY 2018.

Meanwhile, in addition to the payment and policy proposals, CMS is releasing a request for information to welcome feedback on positive solutions to better achieve transparency, flexibility, program simplification and innovation. Specifically, CMS is soliciting ideas for regulatory, sub-regulatory, policy, practice and procedural changes to better accomplish these goals. The agency noted that ideas could include recommendations regarding payment system re-design; elimination or streamlining of reporting; monitoring and documentation requirements; operational flexibility; and feedback mechanisms and data sharing that would enhance patient care, support the doctor-patient relationship in care delivery, and facilitate patient-centered care within inpatient stays at general acute care and long-term care hospitals.

In sum, this proposed rule is the first significant regulation related to payment reform under the Trump administration. CMS Administrator Seema Verma said in a statement that accompanied the rule, “Through this proposed rule we want to reduce burdens for hospitals so they can focus on providing high quality care for patients. Medicare is better able to support the work of dedicated hospitals and clinicians who provide the care that people need with these more flexible and simplified approaches.”

Comments for the proposed rule will be accepted for 60 days.
The entire article can be found here.

CDC Office on Smoking and Health Resource – National Tobacco Control Program (NTCP) State Fact Sheets

CDC’s Office on Smoking and Health has created a new resource, the National Tobacco Control Program (NTCP) State Fact Sheets. These fact sheets provide state-specific problem data, current CDC tobacco control funding levels for the state, the state’s public health response to tobacco use, impact of the *Tips From Former Smokers* campaign in the state, and information showing how the state tobacco prevention and control programs reduce healthcare costs.

The State Fact Sheets can be found in the link below:
https://www.cdc.gov/tobacco/about/osh/program-funding/index.htm

Once you enter the webpage, you can click on the interactive U.S. map to access the fact sheet for a particular state.

2 California Hospitals Directly Employ Physicians

by Doug Desjardins (March 27, 2017)
Health Leaders Media
This story originally appeared in California Healthfax

More critical access facilities are expected to take advantage of the state's new exemption to the ban on corporate medicine

Two critical access hospitals in California have hired physicians under a new law that exempts the smallest and most remote hospitals from the state's ban on corporate medicine.

Mayers Memorial Hospital in Fall River Mills and Healdsburg District Hospital hired physicians in January under provisions of Assembly Bill 2024, which allows certain hospitals to hire physicians under a seven-year pilot program that began in January.

"We become much stronger in our ability to attract physicians who want to work in a different environment than what larger hospitals offer," said Nancy Schmid, CEO of Healdsburg District Hospital.

At least half of the state's 34 critical access hospitals plan to take advantage of the new law, said Peggy Wheeler, vice president of Rural Health and Governance for the California Hospital Association (CHA).

"I conducted an informal poll of [critical access] hospitals about a week ago and it appears about half of them plan to hire a physician this year," said Wheeler.

"This is something critical access hospitals have been requesting for a long time and it's good to see that they're going to take advantage of [the waiver]."

AB 2024 exempts 34 critical access hospitals from the state's corporate medicine ban.

A Steady Paycheck
Small, rural hospitals often have a difficult time recruiting physicians and AB 2024 allows hospitals to offer physicians a guaranteed salary and benefits that wouldn't be available to them as independent contractors, according to Wood.

"Most young physicians would prefer to be employed by a hospital rather than go into private practice," he said.

"It is a daunting task for young physicians, who are often tens of thousands of dollars in debt, to move to a small town and try to build a practice from the ground up."

A 2015 survey conducted by research firm Merritt Hawkins found that 92% of first-year medical residents would prefer to work directly for a hospital rather than practice as an independent contractor.

The state's ban on corporate medicine was created more than century ago in response to mining companies hiring their own physicians, and concerns over whether the physicians worked in the best interests of patients or their employers.

In the past decade, several bills that would have allowed rural hospitals to directly employ physicians failed, Wheeler said. AB 2024 succeeded because it limited the waiver to critical access hospitals, rather than all 67 rural hospitals in the state.

Medicare Disadvantage
Physicians in small communities are also at a disadvantage because their patient population is comprised largely of Medicaid and Medicare patients, which provide lower reimbursement rates than commercial health plans.

"They're at a real disadvantage because so many people in rural communities are covered under government health plans, and that makes it harder for them to make a living," said Wheeler.

California is one of only five states that don't not allow hospitals to hire and employ physicians, she said.

Meningitis B Tool Kit Available for FREE

The Indiana Immunization Coalition has developed a Meningitis B tool kit for providers that is available free of charge for download or order on the Indiana Immunization Coalition website, www.vaccinateindiana.org. It can be found in the catalog after you log in. Please share this email with your colleagues.

Each year, approximately 1,000 people contract meningococcal disease in the United States. The Centers for Disease Control (CDC) has found that among those who become infected, 10 to 15 percent will die. Of

those who survive, another 20 percent will suffer from permanent disabilities, such as brain damage, loss of limbs, hearing loss and/or other serious impacts to the nervous system.

In all, there are at least 12 types, or “serogroups,” of meningococcal diseases, one of which is serogroup B. In the U.S., the B strain accounts for 50 percent of all cases in persons 17 to 23 years of age in the U.S.

The first B vaccine was FDA approved in 2014, and while not required, the CDC recommends it for anyone ages 11 to 23. The vaccine is especially important for those living in close quarters, like college dorms, where the disease can rapidly spread. In fact, since spring of 2013, meningitis B outbreaks have occurred on five major college campuses in the U.S.

Indiana State Law requires that all universities and colleges inform students of the risks associated with meningococcal disease and the benefits of vaccination. However, this required information does not specifically address the B strain of the disease.

Idaho Critical Access Hospital Gives Hope to Other Stressed Rural Healthcare Facilities

by Kaiser Health News (April 13, 2017)
Healthcare Finance

The 14-bed hospital serves all of Butte County, whose population of 2,501 is spread over territory half the size of Connecticut

Just before dusk on an evening in early March, Mimi Rosenkrance set to work on her spacious cattle ranch to vaccinate a calf. But the mother cow quickly decided that just wasn't going to happen. She charged, all 1,000 pounds of her, knocking Rosenkrance over and repeatedly stomping on her. "That cow was trying to push me to China," Rosenkrance recalls.

Dizzy and nauseated, with bruises spreading on both her legs and around her eye, Rosenkrance, 58, nearly passed out. Her son called 911 and an ambulance staffed by volunteers drove her to Lost Rivers Medical Center, a tiny, brick hospital nestled on the snowy hills above this remote town in central Idaho.

Lost Rivers has only one full-time doctor and its emergency room has just three beds -- not much bigger than a summer camp infirmary. But here's what happened to Rosenkrance in the first 90 minutes after she showed up: She got a CT scan to check for a brain injury, X-rays to look for broken bones, an IV to replenish her fluids and her ear sewn back together. The next morning, although the hospital has no pharmacist, she got a prescription for painkillers filled through a remote prescription service. It was the kind of full-service medical treatment that might be expected of a hospital in a much larger town.

Not so long ago, providing such high-level care seemed impossible at Lost Rivers. In fact, it looked as if there wouldn't be a Lost Rivers at all. The 14-bed hospital serves all of Butte County, whose population of 2,501 (down from 2,893 in 2000) is spread over a territory half the size of Connecticut. Arco, the county's largest town, has seen its population drop 16 percent since 2000, from 1,026 to 857 last year. "Bears outnumber people out here," is how hospital CEO Brad Huerta puts it.

The medical center nearly shut its doors in 2013 due in large part to the declining population of the area it serves – almost becoming another statistic, another hospital to vanish from rural America. But then the hospital got a dramatic reboot with new management, led by Huerta, who secured financing to help pay for more advanced technology, upgraded facilities and expanded services. He also brought in more rotating specialists, started using telemedicine to connect the hospital to experts elsewhere and is now planning to open a surgery center and a long-term care rehabilitation wing. If Lost Rivers had closed, the alternative would have been hospitals in Idaho Falls or Pocatello, each more than an hour away across high-altitude prairie. Instead, "I don't have to go across the desert for hardly anything," said Rosenkrance, resting at the hospital the morning after the cow attack.

Rural hospitals are facing one of the great slow-moving crises in American health care. Across the U.S., they've been closing at a rate of about one per month since 2010 – a total of 78, or about 6 percent. About 14 percent of the U.S. population lives in rural counties, a proportion that has dropped as the number of urban dwellers grows. Declining populations mean a smaller base of patients and less revenue. And the

hospitals are caught in a squeeze: Because many patients in the countryside are older and sicker, they require more intensive and often expensive care.

Faced with these dramatic economic and demographic pressures, however, some hospitals are surviving -- even thriving – by taking advantage of some of the most cutting-edge trends in health care. They are experimenting with telemedicine, using remote monitors to track patients and purchasing high-tech equipment to perform scans and other types of exams. And because many face physician shortages, they are partnering with universities and increasingly relying on nurse practitioners, paramedics and others to deliver care. In parts of rural Oregon and Washington, veterans can get counseling through a tele-mental health program. Physicians in Iowa and North Dakota have access to virtual emergency room support.

At Lost Rivers – a dramatic rural health turnaround story – Huerta's strategy was to use technology and innovation to offer the kind of high-quality medical care that would keep patients like Rosenkrance coming back. "Necessity is the mother of invention," Huerta said. "Small hospitals like mine are always going to be under the gun. You have to get really creative."

In the decades to come, America's heartland and hinterlands will continue to be home to the people who run the country's farms, forests and fisheries, and its wilder regions will continue to draw visitors who crave nature and recreation. And those people will need medical care. As a result, rural health researchers say hospitals like Lost Rivers are important test cases. They show that, despite daunting obstacles, rural America need not be left behind when it comes to health care. In fact, because they are being forced to innovate faster than their urban counterparts, they can provide a glimpse into the future of medicine.

"Being in a rural place does not preclude high-quality medicine," said Tom Ricketts, senior policy fellow at the Sheps Center for Health Services Research at the University of North Carolina, Chapel Hill. "They are under a lot of pressure, but there are rural places you can point to as places you would say, 'This is how things ought to be done.'"

Where Folks Wear 'Multiple Hats'

It's a Tuesday afternoon at Tara Parsons' flower shop. She cleans up as she waits for customers -- or for an emergency call. Parsons, a fourth-generation Arco resident, is not just the town florist; she is also the county coroner, a sheriff's dispatcher and a volunteer emergency medical technician. This afternoon, she is on ambulance duty.

"We all wear multiple hats out here," she said.

The town of Arco was founded in the 1870s as a junction for horse-drawn stagecoaches. Its quirky claim to fame is that in 1955, it became the first town in the world to be powered by nuclear energy, a credit to the Idaho National Laboratory down the road toward Idaho Falls. Every summer, to celebrate its history, the town puts on a celebration that features a rodeo and a softball tournament.

The streets are lined with shuttered and boarded-up storefronts, some with their signs still on display: the Galloping Goose, the Sawtooth Club. Residents talk nostalgically about the town's heyday, when there were banks, a bowling alley and a movie theater, back when residents drove to Idaho Falls only twice a year, to get school supplies and do Christmas shopping.

Now, most of the businesses are gone. The town still has a lumber shop, a hardware store and a few auto garages. There's also a bar, a gym and a dollar store. And around the corner there's the local diner – Pickle's Place – where people come day and night for fried pickles and biscuits and gravy.

Like so many other residents, Butte County clerk Shelly Shaffer has a personal connection to the hospital: Her mom worked there, her sister was born there, and she used to take her children there. Lost Rivers Medical Center – which also has two outpatient clinics – is one of the town's biggest employers.

"It would be devastating if we didn't have our hospital," she said.

That was the direction they were headed. When Huerta, the CEO, arrived four years ago, he found the nearly 60-year-old hospital in disarray – dilapidated facilities, fearful employees, reluctant patients and a financial mess left behind by the former CEO. The hospital's bank account held just $7,000 and morale was

at an all-time low. "We were the poster child for everything that was wrong with rural health care," he said. "It had been a slow, steady decline from neglect."

Shannon Gamett, 28, a nurse at Lost Rivers, said paydays were nerve-wracking: "We would run as fast as we could to the bank to cash [a paycheck], or it might not clear."

After borrowing money to pay his employees, Huerta campaigned to pass a $5.5 million bond for Lost Rivers. He asked locals if it was worth $5 a month – one six-pack of beer or two movie rentals – to keep the hospital running. They answered "yes" at the polls, and the hospital emerged from bankruptcy. Next, Huerta set his sights on overhauling the badly outmoded facilities. One of his top priorities was the laboratory, which he said looked like a high school science classroom from the 1950s.

He instituted a new philosophy: If it doesn't happen at a "real" hospital, it doesn't happen at Lost Rivers. That meant ending some local practices, nixing little things like letting staff members wear scrubs of any color they fancied, and big things, like allowing people to bring their horses in for X-rays. "I said, 'I have no problem doing this, but you tell me what insurance the horse has,'" he recalled. "The practice stopped immediately."

To bring in more revenue, he applied for grants and got the hospital a trauma center designation (the first level IV trauma center in Idaho) so it could get paid more for the care it was already providing. He saved money by inviting the town's residents to help renovate clinic exam rooms and by moving the medical records to a cloud-based system that didn't require more information technology employees.

Prognosis Unclear

Despite Huerta's efforts, however, the long-term success of Lost Rivers is not guaranteed. "If you don't have enough people to support a clinic or a hospital, it has no economic reason to be there," said Ricketts, the Sheps Center fellow. "It just disappears."

Arco and Butte County officials hope the local economy will get a boost from a planned expansion of Idaho National Laboratory, which conducts nuclear energy testing and research. Residents also are mounting a campaign to get the Craters of the Moon, a national monument in Butte County, designated as a national park.

"It would literally put us on the map," county clerk Shaffer said.

But even if that happens, Huerta knows he can't expect a big influx of new residents. Rural parts of the United States saw an absolute decline in population following the 2008 financial crisis, a trend that has since stabilized. But there is little or no growth. So Huerta has to concentrate on keeping the patients he has -- and giving them a reason to keep coming. And it's working: The hospital is now making a small profit and has some reserves on hand for future projects.

"If you are not offering the services, people are going to go somewhere else," Huerta said. "And as medicine advances and reimbursement is still pegged to volume, you have to find ways to keep that existing population here."

One big challenge for Lost Rivers and many other rural hospitals is that their patients tend to be older -- and thus sicker and costlier to treat. People 65 and older account for about 18 percent of the rural population, compared with 12 percent in urban areas, according to the National Rural Health Association. An older patient base can strain hospitals because Medicare, the public insurance program for the elderly, doesn't pay hospitals as well as private insurance does. Elderly patients also may need more intense care than small hospitals can provide.

Rural hospitals have a higher percentage of patients on Medicaid, the public insurance for poor people, which pays notoriously low rates to providers.

Some seniors move to Arco precisely because there is a hospital in town. But for others, what Lost Rivers offers simply isn't enough.

Residents Ray Westfall, 82, and his wife, Winona, recently put their house on the market after deciding it was time to move to Utah, closer to family and more specialized health care. Westfall has neuropathy in his legs, which causes numbness most of the time. He gets around with a walker. Winona has dementia.

"We can get some care here at the local hospital, but mostly we have to travel to Idaho Falls," he said.

Westfall is a regular at Parsons' flower shop. On a recent Tuesday, he bought a bouquet for his wife -- carnations, her favorite.

Parsons said many of the emergency calls she responds to are for older folks who've suffered strokes, fallen at home or are struggling to breathe. One 99-year-old woman she took to the hospital on this morning had fallen in her living room.

Parsons said she has known many of her patients for years, through her parents or grandparents. As they grow old and get sick, she picks them up in the ambulance and drives them to Lost Rivers.

"And before long, I'm doing their funeral flowers," she said.

Telemedicine: A New Frontier

At first the Bengal Pharmacy, on the bottom floor of Lost Rivers Medical Center, looks like any other pharmacy, with racks of over-the-counter cold medications, bandages, reading glasses and medical supplies. Shelves of prescription medications sit behind the counter. But it has no pharmacist on site; instead, technicians and students from Idaho State University in Pocatello shuffle about, filling prescriptions.

Their supervisor is a pharmacist at the university, about 80 miles away, who checks their work remotely. Patients who want to talk to him go to a small private room with a phone and video link. The pharmacy is named for the university's mascot.

For rural hospitals, telehealth can make otherwise faraway services accessible to people where they live, said Keith Mueller, director of the Center for Rural Health Policy Analysis at the University of Iowa. That can be critical, especially during the winter when snowstorms sometimes cut off access to rural towns.

"We can, in effect, bring the provider to the community without physically doing so," Mueller said. "Even in urban areas, people want more and more convenience in how we receive our services. Here we are talking more about necessity."

At Lost Rivers, patients can have telemedicine appointments with a psychiatrist. And doctors can get virtual guidance from specialists in trauma, emergency care and burns. But new technologies sometimes take getting used to. "When you lose that hometown community pharmacist, that human touch, when you turn it over to computers, that's a concept that people have difficulty with," said Martha Danz, who sits on the hospital's board.

Leon Coon, 83, said the concept is a bit foreign to him. "I just don't do that stuff," said Coon, who works loading hay. "I'm a little old-fashioned." Sipping coffee at the truck stop early on a Wednesday morning, Coon said he doesn't even text, so he's a bit wary of technology that puts him in touch with a pharmacist all the way in Pocatello. But then again, he said he doesn't rely on the medical system much at all.

"Anytime you go to the doctor, it's just like a mechanic," he said. "They're going to find something wrong. I feel good most of the time, so I just don't go."

Shane Rosenkrance, whose wife got trampled by the cow, said he remembers when there were five community drugstores in the valley. Now, he is grateful to have the one pharmacy -- even if the pharmacist isn't actually behind the counter. "To have health care, you have to have a pharmacy," he said. "And through technology, they are able to do it."

Telemedicine is hardly a panacea. The projects often depend on grants or government awards, because rural hospitals' operating margins are slim. And some of the telemedicine and remote monitoring technologies require high-speed internet, which isn't always reliable or cost-effective in rural areas.

"You can't do home monitoring everywhere," said Sally Buck, CEO of the National Rural Health Resource Center. "You can't do telehealth everywhere."

Telemedicine also may raise more questions than it answers for some patients, and even create a need for in-person follow-ups. Orie Browne, the medical director for Lost Rivers, said he tries to keep patients from having to travel. But if someone needs more advanced medical care – or a specialist that Lost Rivers doesn't have – he will refer them to another hospital. The hospital has a helicopter pad, and patients with emergencies that can't be handled at Lost Rivers can either be flown out by helicopter or transferred by ambulance.

"Ego is a dangerous thing," he said. "If there is anyone who can do a better job, I'm going to get [my patients] there."

Nevertheless, Huerta said, he hopes to expand telemedicine, including such services as oncology. Huerta recognizes that Lost Rivers doesn't have the staff or the expertise to do it all. He believes the hospital should try to do more when it can, and refer out the rest.

"We aren't trying to do brain surgery," he said. "We're not doing Level I trauma. But colonoscopies? Tele-oncology? People in rural areas get cancer too, and it's demanding driving hours back from a chemotherapy session."

Rounding Up Doctors

Browne started work at Lost Rivers one recent day in March, then drove 45 minutes to one of its outpatient clinics in Mackay, 26 miles away. One of his first patients was Elizabeth Galasso, 59, who was worried because her heart rate was racing.

"I was scared," Galasso said, speaking with a hoarse voice as she sat hunched on the exam table. "I felt my heart pounding clear down into my stomach."

An EKG showed her heart was beating normally. Browne told her it was likely a panic attack, but suggested a stress test just to make sure. He told her that her age, her smoking history and anxiety all put her at risk for heart disease.

"But I think things are going to be just fine," he said. Galasso reached over and hugged him.

Browne, who took over as Lost Rivers' medical director in 2015, said he was drawn to the outdoor activities in the area – and the variety of rural health care. He used to have a private practice in Idaho Falls and rotated into Lost Rivers for a week at a time. Now, he spends his days bouncing between the emergency room, the hospital inpatient beds and the primary care clinic. "That's good for a person who gets bored easily," he said.

Many doctors, however, don't feel the same pull. Rural hospitals and clinics have long struggled to recruit doctors. In rural areas, there are roughly 13 physicians – of any kind – per 100,000 people, compared with 31 in urban areas, according to the National Rural Health Association.

Doctors and other medical providers can be enticed by programs that repay their school loans if they work in a rural area. Some medical schools have programs designed specifically for students who plan to practice in rural or underserved communities. Another way to make treatment more accessible in rural areas is to expand the responsibilities of nurse practitioners, physician assistants and even paramedics.

Lost Rivers relies on nurse practitioners and physician assistants to provide care for patients in the clinics and the hospital. In addition to Browne, the medical center has four part-time primary care physicians, some who live hours away and come in once a week. Various specialists, including a cardiologist and an orthopedist, also rotate into the medical center's outpatient clinics about once a month. And an MRI machine gets driven to the hospital once a week.

Tim Tomlinson, a podiatrist who lives in Twin Falls and drives 100 miles to Arco once a week, spent a recent morning seeing a lineup of patients. One was a man who had to have a toe amputated after a horse stepped on his foot, another a diabetic who needed a skin graft checked on his foot.

Tomlinson said he's gotten paid late before, and he has seen the hospital nearly shut down more than once. But he keeps coming because he has developed a practice – and he thinks its important patients have access to specialty care. Lost Rivers isn't unique in its difficulties, he noted. "All those small towns are

struggling as young people move out, leaving mostly old people," he said. "That puts a drain on the hospitals."

Patients are living longer with chronic diseases now, so the demand for elderly care is only going to increase. If not the rural clinics and hospitals, Tomlinson said, "who's going to deliver it?"

Even with the decline in the nation's rural population, many people are rooted in rural America because of family or because they like the outdoors and a slower pace of life. One of them is Gene Davies, who has lived in Arco more than 60 years, runs a mechanic shop straight out of a different era. Handwritten signs sit on a wooden chair next to the door: "Gone to Dr." "Be back tomorrow." "Hope to be back Monday."

Davies said he appreciates the remoteness of the region. "I ain't got no plans to go anywhere else," he said. "I've seen enough of the other world. I don't want it."

Rosenkrance, the cattle farmer, said she's not going anywhere, either. She's been coming to the hospital since she was a child, when she ran through the halls while her father worked in the pharmacy. Now her husband teases her about having a standing reservation in the emergency room.

Just before discharging Rosenkrance, nurse Celeste Parson told her she needed to rest physically and mentally. The accident had left her with a concussion, a lacerated ear and a black eye. Then Parson issued her the most important instruction: Don't do anything that could cause another blow to the head.

"We would really like you to rest up for at least a week," Parson said. "But the doctor knows for you, two or three days is more realistic."

As she grabbed an ice pack and her purse, Rosenkrance reflected on the importance of Lost Rivers for residents across the whole valley.

"This hospital is a big deal," she said. "It's saved a lot of lives."

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