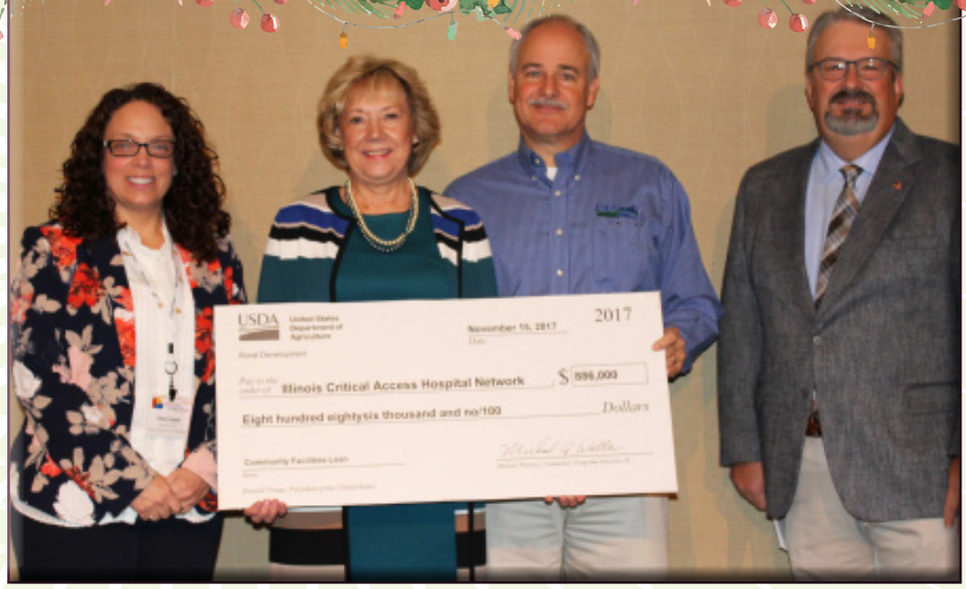
ICAHN Newsletter ■ December 2017

MOMENTUM

ICAHN breaks ground on new office building



Early Christmas present

Michael Wallace (second from right), USDA Community Programs Director, and Doug Wilson, USDA Rural Development Illinois Director, present Pat Schou (second from left), ICAHN Executive Director, and Trina Casner, ICAHN Board President, with a check representing their direct loan to the network and support of the project. Shown below is the architect's rendering of the project.

ICAHN recently broke ground on a new 6,500 square foot facility in the City of Princeton's Technology Park, less than a mile from its existing site. This work follows the announcement that ICAHN is the recipient of an $886,000 USDA Rural Development Direct Loan and the securing of Key Builders, Princeton, IL, as construction manager for the project. Several local subcontractors will be used throughout the course of this work.

"USDA Rural Development knows the importance of healthcare services and the challenges faced by rural residents in accessing those services," said Doug Wilson, USDA Rural Development State Director in Illinois. "We're honored to work with ICAHN to improve healthcare and the quality of life in rural Illinois through their support of all rural critical access hospitals with medical resources, services and education."

The first phase of excavation started on December 4 and was completed on December 16. It included removal of curbing, placement of the culvert and construction of the entrance off of Van's Way; stripping of topsoil in the building and parking lot areas; and placement and compaction of clay fill and aggregate materials to bring building and parking areas up within one foot of final grade.

As soon as weather permits (perhaps early March), final excavation will be completed so that building footings can be formed and poured, followed with the pouring of the foundation and building slab. Full building construction will begin as soon as concrete work is completed. Completion of the project is expected in July 2018.

The new ICAHN building will house 16 private offices, receptionist space, flex space for two additional people, a small conference room, file storage room, server room, kitchen, two restrooms, mechanical room, and a large training center. The training center will seat 32 in a classroom configuration and will include a state-of-the art video conferencing installation featuring large dual monitors,

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ICAHN
Illinois Critical Access Hospital Network

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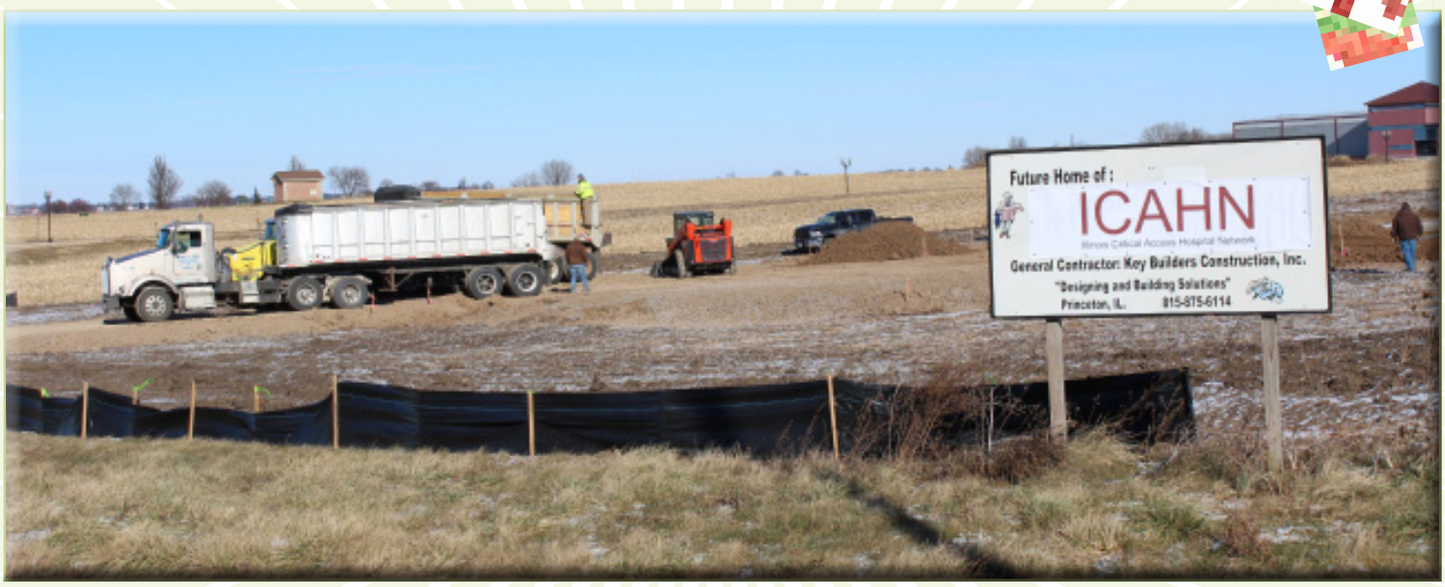

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ICAHN Groundbreaking

cameras, sound system, processor and software. The building's parking areas will accommodate up to 34 vehicles.

"This new facility will enable ICAHN to better serve its members and affiliates for years to come and will accomodate future growth in staffing as new programs and services are added to support the needs of our members," said Curt Zimmerman, Director of Business Services and Development and building project manager for ICAHN.

"The technology that will be utilized in the training center will allow ICAHN staff to connect rural healthcare leaders, visionaries, and partners with members and colleagues throughout Illinois and around the nation."

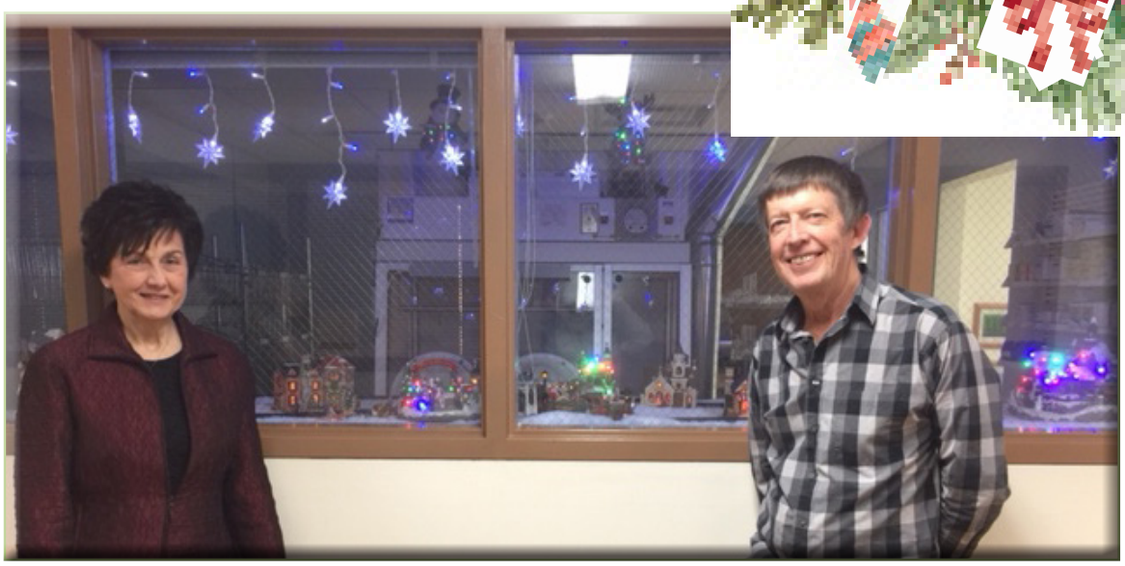
"This new facility will enable ICAHN to better serve its members and affiliates for years to come and will accomodate future growth in staffing as new programs and services are added."

– Curt Zimmerman, ICAHN Director of Business Services and Development

The decision to build follows the ICAHN Board of Directors' exploring options for expanding the existing site at 245 Backbone Road East in Princeton, moving to an existing building in Princeton or elsewhere, or building from the ground up.

Following a visit to the existing facility at the March 2017 Board meeting, the Board voted to build a new office and seek a USDA Direct Loan to finance the project. Member approval of the decision to build was obtained during the member meeting in May. The current offiice is only 2,380 square feet, but we actually need at least 4,500 square feet in office space alone," said Pat Schou, Executive Director. "We have needed additional space for several years but waited to see the impact of ACA changes and the financial position of the network before fully developing building plans. It's a process that's been in the works since 2014."

"We are excited to begin this process,"added Schou. "I truly believe with this move, ICAHN will be the footprint for rural health." The new address for ICAHN will be 1945 Van's Way, Princeton, IL.



Spreading Christmas cheer

Jim Lynch, Pharmacy Director, Washington County Hospital, spreads Christmas cheer each of the many years he's been working at the Nashville hospital by creating this beautiful lighted display. He is shown with Nancy Newby, WCH Chief Executive Officer. Despite the hustle and bustle of the season, Lynch finds time to fashion this display by himself for all hospital employees, patients and the general public to enjoy.

Critical access hospitals encouraged to become pilot sites for IL BHWELL program

The University of Illinois, in cooperation with the National Center for Rural Health Professions and the Illinois Area Health Education Center, was recently awarded a four-year, federal Health Resources and Services Administration (HRSA) grant for workforce development in integrated care in Illinois.

Integrated care or integrated behavioral health brings Masters of Social Work (MSWs) and other behavioral health clinicians onto inter-professional teams in rural health clinics, FQHCs, and critical access hospitals to address the biopsychosocial needs of patients and families.

The grant will fund IL BHWELL, which stands for the Illinois Behavioral Health Workforce Learning & Leadership scholars' program. The IL BHWELL is a clinical certificate and scholarship program at the University of Illinois for MSW students who want to learn team-based models for integrating health and mental health services in primary care settings in rural and underserved areas.

Janet M. Liechty, PhD, LCSW, BHWELL Project Director/PI, Associate Professor School of Social Work, UIC College of Medicine, Carle-IL College of Medicine, University of Illinois at Urbana-Champaign, authored the grant and her co-investigator is Michael Glasser, PhD, Director and Professor, National Center for Rural Health Professions, Illinois College of Medicine Rockford, University of Illinois. Hana Hinkle, MPH and Associate Director of the Illinois AHEC Network Program, is also partnering on the project.

BHWELL sites for the first cohort of 29 students will soon be determined, and scholarships will be awarded as soon as May of 2018.

"We are working closely with the School's Social Work Field Education Office and the National Center for Rural Health Professions to identify and develop partnerships with primary care field placement sites and to offer ongoing training and support for inter-professional teams during the two-semester field placement," said Dr. Liechty.

Scholars will learn and design strategies to promote rural population health and collaborate with community resource providers. The $10,000 scholarships will be awarded to the winning students during their final two-semester BHWELL-approved field placement as part of the MSW degree program.

"Each year, 29 BHWELL scholars will be selected to receive additional training and a $10,000 scholarship. They will earn a certificate in Integrated Behavioral Health at the completion of this program."

Critical access hospital leadership is encouraged to serve as pilot sites for this program, said Pat Schou, ICAHN Executive Director, who will also serve on the IL BHWELL's Advisory Board. "If your hospital is seeking to enhance behavioral health and social service support, it would be beneficial for you to look into this program," she added.

Innovative rural and community health clinics, rural and critical access hospitals and FQHCs that want to promote the integration of behavioral health and primary care, inter-professional training and team-based care models to achieve the Triple AIM are encouraged to participate in the IL BHWELL program.

Those interested in becoming a site or applying for the MSW program and the BHWELL scholarship can visit http://socialwork.illinois.edu/bhwell/ for more information. It is anticipated that 29 BHWELL scholars will be selected each year for the duration of the grant program.

Scholars will learn and design strategies to promote rural population health and collaborate with community resource providers. The $10,000 scholarships will be awarded to the winning students during their final two-semester BHWELL-approved field placement as part of the MSW degree program. The MSW degree can be completed on campus or in a hybrid, partially online format called iMSW that is tailored to the needs of outreach students who may live at a distance.

IL BHWELL HRSA SCHOLARS PROGRAM

"We want to attract students who are passionate about serving patients and communities in rural areas," said Dr. Liechty. "We also want to discover and build on work that is already being done in Illinois to promote integrated care.

"Critical access hospitals are important hubs of healthcare services and innovation in rural Illinois, and we know many are already implementing integrated behavioral health models," she added.

"Likewise, rural health centers are moving toward integrated care and many are located within 30-50 minutes from cities such as Urbana-Champaign, Decatur, Danville, Springfield, Peoria, etc., which is a very reasonable commute. Also, FQHCs are usually eligible BHWELL sites, and they are located throughout both urban and rural areas in Illinois, so no matter where you are located in this state, there is opportunity to participate."

To contact the BHWELL director and staff, email IL-BHWELL@illinois.edu. For more information and to join the BHWELL mailing list see http://socialwork.illinois.edu/bhwell. For more information about the benefits of integrated behavioral health and financing see the SAMHSA-HRSA Center for Integrated Health Solutions at https://www.integration.samhsa.gov/.

ILLINOIS School of Social Work | ILLINOIS AHEC network | THE NATIONAL CENTER FOR RURAL HEALTH PROFESSIONS

WIU and Memorial Hospital collaborate with ICAHN, Culbertson Hospital on Rural Health Coach program

Memorial Hospital in Carthage has collaborated with Western Illinois University to create the Rural Health Coach Program. This new program concept began with an internship partnership between Western and Memorial Hospital.

Memorial Hospital CEO Ada Bair worked with WIU health services management graduates Claire Jarrell and Evan Gronlund, who served as interns at Memorial, to design the Rural Health Coach Program. After the interns presented the program opportunity to University officials, Bair set the program into motion with WIU, ICAHN, and Sarah D. Culbertson Memorial Hospital, Rushville, to develop the program.

The organizations are now offering the 16-week *Rural Health Coach Program: From Theory to Practice*, which includes a student as the rural health coach, serving as a liaison between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. In addition to helping the at-risk population, the student increases his or her health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy.

The program was piloted with Ashley Peterson, a WIU health service management major from Macomb. Through Peterson's internship, the curriculum was fine-tuned, Bair explained.

WIU professors, led by WIU Associate Provost and Associate Vice President of Academic Affairs Nancy Parsons, helped choose students and get a pilot program started. Classes began this fall, with staff from Memorial Hospital, ICAHN, and Culbertson Memorial facilitating weekly classes at the University.

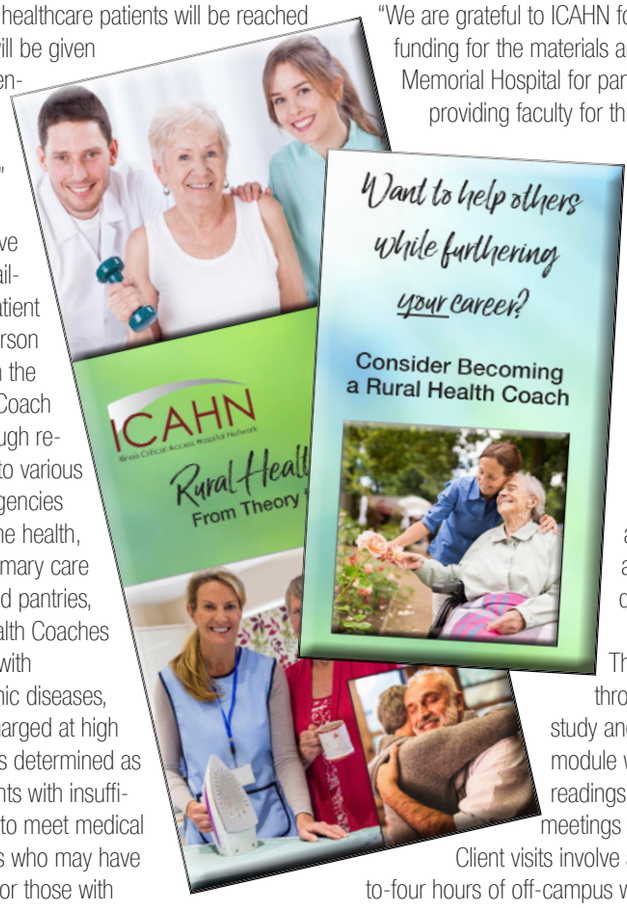
"The Rural Health Coaching initiative is a wonderful opportunity for our WIU graduate students to gain valuable and enriching experiences working with our regional community hospitals providing care for patients," Parsons said. "This University and community endeavor is a 'win-win' situation for all involved."

"Our rural health coaches are compassionate, resourceful and non-judgmental students, who also possess great social skills. Developing a rapport with our at-risk patients is important. They are also willing to learn about healthcare from the client perspective and are interested in 'hands-on' experience," said ICAHN Wellness Coordinator Mary Jane Clark. "Advancing this program means that high-risk healthcare patients will be reached sooner and will be given the comprehensive support they need more quickly."

Photo courtesy of WIU Visual Production Center

Program developers and new coaches

Shown seated (left) Thomas Barkoski (kinesiology), Kelsey O'Connor (kinesiology) and Chukwuebuka Ogwo (health sciences), new rural health coaches, and Mary Jane Clark, ICAHN Wellness Coordinator; and Lisa Downs, DNP, RN, Outpatient Clinic Supervisor, Infection Control Nurse, Sarah D. Culbertson Memorial Hospital, Rushville, Dr. Nancy Parsons, Associate Provost for Undergraduate and Graduate Studies, WIU, Lisa Lahey (communications), Courtney Coleman (health sciences) and Jennifer Garner (health sciences), new rural health coaches; Ada Bair, Memorial Hospital CEO; and Britney Trone, Clinic Nurse Manager/Patient Care Coordinator, Sarah D. Culbertson Memorial Hospital.



Comprehensive support is available to the patient through in-person meetings with the Rural Health Coach and also through referrals made to various community agencies including home health, pharmacy, primary care providers, food pantries, etc. Rural Health Coaches assist clients with multiple chronic diseases, patients discharged at high risk or families determined as high risk, clients with insufficient income to meet medical need, patients who may have frequent falls or those with frequent emergency room visits.

"We are grateful to ICAHN for obtaining grant funding for the materials and to Culbertson Memorial Hospital for participating and providing faculty for this new program," said Bair. "Our goal is to build a model that can be used throughout the state and to continue to grow the program. The Rural Health Coach program has vast potential. The goal is always to keep people healthier, and this is definitely a step in the right direction."

The course is offered through independent study and involves a training module with assigned readings and preparation for meetings with the coordinator. Client visits involve approximately two-to-four hours of off-campus work each week.

ICAHN Coding Support Services

Remote Coding Services

Staffing shortages? Vacations? Medical leaves? Our coding team is comprised of contracted ICAHN hospital members' experienced and credentialed coders who will work after hours or on weekends to help your hospital reduce expensive backlogs quickly, save space in your facility, and avoid expensive travel costs! In addition to these benefits, ICAHN's coding staff takes pride in its high level of coding accuracy and productivity and further backs up its services with a robust quality assurance program.

AHIMA, AAPC and ARHPC-credentialed, ICAHN's coders offer Remote Coding Services in the following specialties:

- Outpatient Services
- Observation Services
- Inpatient Services – Critical Access Hospital (non-DRG)
- Swing Bed
- Physical / Occupational / Speech Therapy
- Physician Evaluation and Management
- Emergency Department Professional and Facility
- Surgery
- Injection/Infusion
- Specialty Practices
- Wound Care
- Rural Health Clinic (RHC)
- Radiology
- Risk Adjustment Medical Coding – HCC

Coding Audit Services

We recognize the important role that accurate medical coding plays in ensuring compliance, maximizing revenue, correctly identifying patient risk, and providing quality data. ICAHN's auditing services are provided in a secure, remote environment to save on costly travel expenses. These services always include an executive summary, individual report card by provider/coder, along with up to an hour of one-on-one training with those staff.

- Documentation and coding review, including evaluation and management (E&M) services, procedures, and ICD-10 CM for RHC, CAH and other providers in group or solo practices
- Retrospective or prospective methods
- Annual or as needed
- New staff competencies
- Executive summary
- Provider education

HIM Consulting

ICAHN Coding Support Services will provide a comprehensive review of your HIM departmental operations and assist you in identifying any areas of risk. We will prove support and education to implement processes to ensure that your coding, billing or documentation improvement projects are completed efficiently and effectively.

- HIPAA and Release of Information Training
- HIM Department Workflow and Staffing
- Policy and Procedure Guidance

To secure these services for your hospital or to obtain more information, contact Jackie King, MSHI, CPC, CDC, ISH-CRS, Clinical Informatics Specialist, HIM Consultant, at jking@icahn.org or 815.875.2593.

Reimbursement Models of the Future

This article is provided courtesy of Ralph Llewellyn, CPA, CHFP, Partner, Director of Critical Access Hospitals, Eide Bailly, an ICAHN Organization Sponsor.

Questions are frequently raised about the future of the critical access hospital program. While there are often comments and concerns about the future of the program, there have not been concrete proposals to eliminate the program. However, there are some proposals for alternative programs that have been proposed that are worthy of discussion.

MedPAC Proposals

In January 2016, MedPAC offered two proposed operating models for the rural setting. The first model was an Emergency Department model. Under this model, there would be a 24/7 emergency department that would be provided a fixed grant for standby costs and would be reimbursed for services based on the hospital outpatient prospective payment system. Acute care services would not be allowed and swing bed services would be reimbursed based on prospective payment rates. This reimbursement model would be available for current facilities under either the Critical Access Hospital (CAH) or Prospective Payment System (PPS) programs.

Unfortunately, the proposal was vague on the size of the grant. Ultimately, it is the size of the grants that would determine the viability of this reimbursement model. There were unanswered questions as to any limitations on services, such as therapies and surgical services. The proposal was also silent on the impact this model would have on providers with Rural Health Clinics (RHCs). Currently, provider-based RHCs that are part of a CAH are reimbursed based on a cost per visit methodology without limits.

Based on current language, it would appear that an RHC owned by an emergency department would not be exempt from the cost per visit limitations. This could have a significant financial impact on rural providers and make this option unfeasible for most providers. Finally, there would need to be an update on the coverage of ambulance services to allow this methodology to work as Medicare currently only covers ambulance services that have a destination of a hospital, CAH, skilled nursing facility, beneficiary's home, and a dialysis facility for an ESRD patient who requires dialysis.

The second proposal was a Clinic with Ambulance. This would consist of a clinic with eight or 12-hour days and 24/7 ambulance capabilities. As in the case of the Emergency Department model, a fixed grant would be provided for ambulance standby capacity and uncompensated care costs. Clinic services would be reimbursed based on a PPS methodology. Federally Qualified Health Clinic (FQHC) rates were provided as an example. This proposal was also vague on the size of the grant that would determine the financial viability of this option and was also silent on the reimbursement for ancillary and ambulance services. While this model could provide access to clinic services for a portion of the day, the methodology does not address access to care after normal clinic hours. In addition, the same concerns regarding the coverage for ambulance services exist in this model.

Rural Emergency Hospital

Senator Chuck Grassley (R-IA) introduced Senate Bill 1130 on May 16, 2017. This bill would create a Rural Emergency Hospital (REH) model that would provide for 24/7 emergency room and observation services. There would be no inpatient beds, and the facility would be designated as an REH. Reimbursement under this model would be 110% of reasonable cost and would include telehealth and ambulance services. The current language would appear to address coverage of the ambulance services from the REH to a CAH or PPS facility but does not appear to provide language that would provide coverage to the REH as a destination site. The bill is also silent on how it would impact the reimbursement of RHC services for those provider-based RHCs currently part of a CAH and the allowability of emergency room availability costs provided by physicians, PAs, and NPs. At this point, no action has been taken on this bill.

Save Rural Hospitals Act

Representative Sam Graves (R-MO) introduced House Bill 2957 on June 20, 2017. Unlike the other proposals, this proposal addresses several additional issues that are not related to CAHs. This includes low volume hospital payments, rural ambulance payments, Medicaid primary care payments, rural DSH reductions, and reforming practices of the Recovery Audit Contractors. It also eliminates sequestration for rural hospitals, sole community hospitals and Medicare dependent hospitals, reverses cuts to reimbursement for bad debts for CAHs and rural hospitals, equalizes coinsurance for CAHs, and eliminates the 96-hour physician certification requirement for CAHs.

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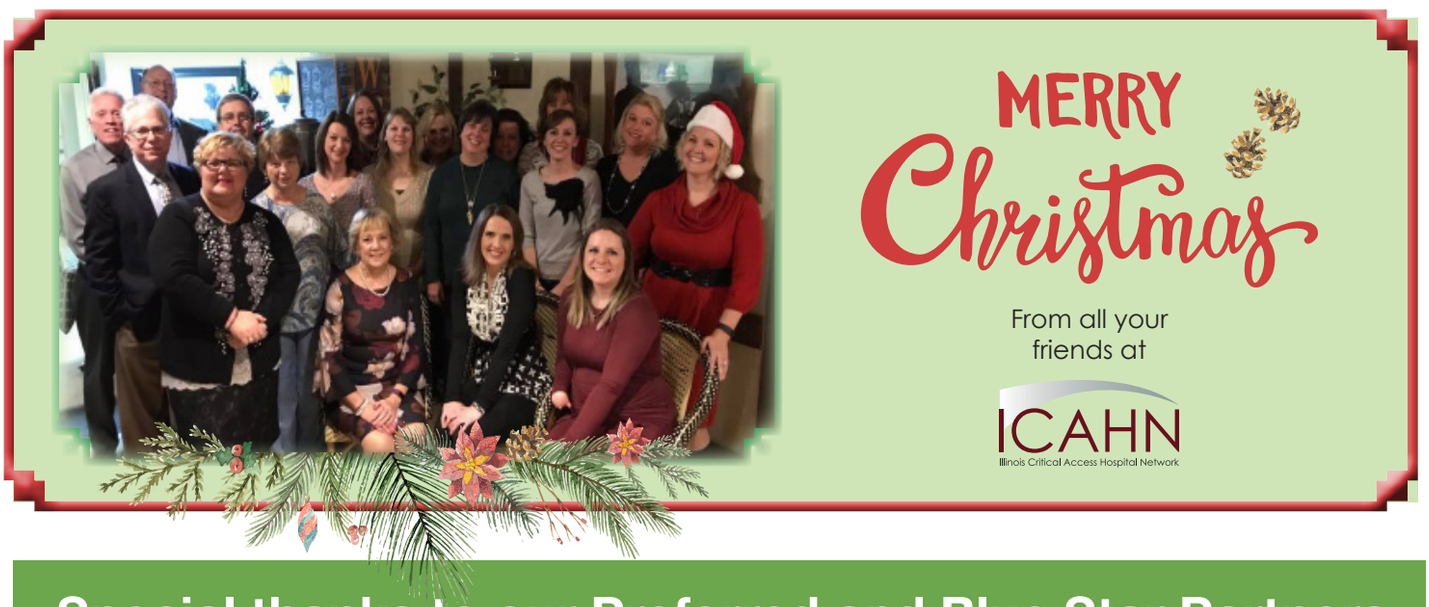
Reimbursement Models of the Future

This bill would also create a Community Outpatient Hospital (COH) program. This model would include a 24/7 emergency room and observation services. The facility would not provide care over two or more nights and would not have inpatient beds. Services would include the COH, RHC and FQHC. Payment would be based on 105% of reasonable cost and would include telehealth services. It is unclear as to whether the 105% applies to the RHC and/or FQHC. The bill does not address the allowability of emergency room availability costs provided by physicians, PAs, and NPs or the coverage of ambulance services to the COH. No action has been taken on this bill.

Call to Action

It is important to note that these proposals/bills do not include language that would eliminate the CAH program. They provide for alternative programming options for those CAHs where the CAH program no longer makes financial sense.

Overall, these models provide some common themes; the majority focus on an outpatient model with an emergency room, ambulance and telehealth. The biggest challenge with each of these proposals are the issues that have not been fully addressed. These include clinic reimbursement, ambulance coverage, grant size, any limitations on service offerings, and allowability of emergency availability costs. Without explicit clarification of these items in any legislation, there is the risk that a new reimbursement model will be created that is not financially feasible in its original form. Ultimately, additional future legislation would be required to clarify those items in order to make the program a financially feasible option for rural providers. We highly recommend providers connect with their Congressional leaders to identify these areas of concern and to promote amendments to the original proposals that would create a reimbursement model that could be financially viable to the rural provider and meet the intent of Congress.



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