MAY 2020

MOMENTUM

WHAT'S INSIDE

#RURALSTRONG

ICAHN
Illinois Critical Access Hospital Network

RESPONSE TO **COVID-19**

RURAL HOSPITALS LEAD AND SUCCEED TOGETHER

In early March, COVID-19 began to impact rural communities and hospitals, and ICAHN members quickly put their emergency plans in place, formed incident command centers, and held daily briefings to ensure readiness to safely care for the influx of patients or, as it's more fondly called, the surge.

On March 11, the World Health Organization (WHO) declared the Coronavirus a pandemic and the skies opened with information and regulation changes overload. The President issued the first safety guidelines for healthcare and Americans on March 16, and hospitals began to cancel elective surgeries and procedures. The official "shelter in place" federal directive came on March 30 for the next 15 days.

Testing and daily federal and state briefings became the new norm, with new rule changes and focus on social distancing, protective patient equipment (PPE), and even ventilators. Centers for Medicare and Medicaid Services (CMS) put forth a 40-page listing of medical provider waivers and a template for the hospital without walls.

States quickly put in emergency plans and issued executive orders by mid-March, with Illinois declaring its official "stay at home" orders on March 20. The Illinois Department of Public Health (IDPH) issued strong guidance for Illinois hospitals and medical providers to stop elective surgeries and procedures on March 17. IDPH announced on March 13 that its three labs were ready to receive COVID-10 nasopharyngeal samples. LAB Corp and Quest also were ready for testing.

The question remained: *"How quickly would the lab turn-around time be?"*

ICAHN, along with the Illinois Hospital Association and other national groups, provided assistance in deciphering the many pages of state and federal regulations. ICAHN initiated bi-weekly calls starting on March 13 for hospital CEOs and staff to share their challenges and ideas to fit this new environment. The discussions have been amazing, and at times, there have been more than 40 ICAHN CEOs on the conference calls. Rural hospitals realized they are in this together and had a louder voice on issues that impact rural directly.

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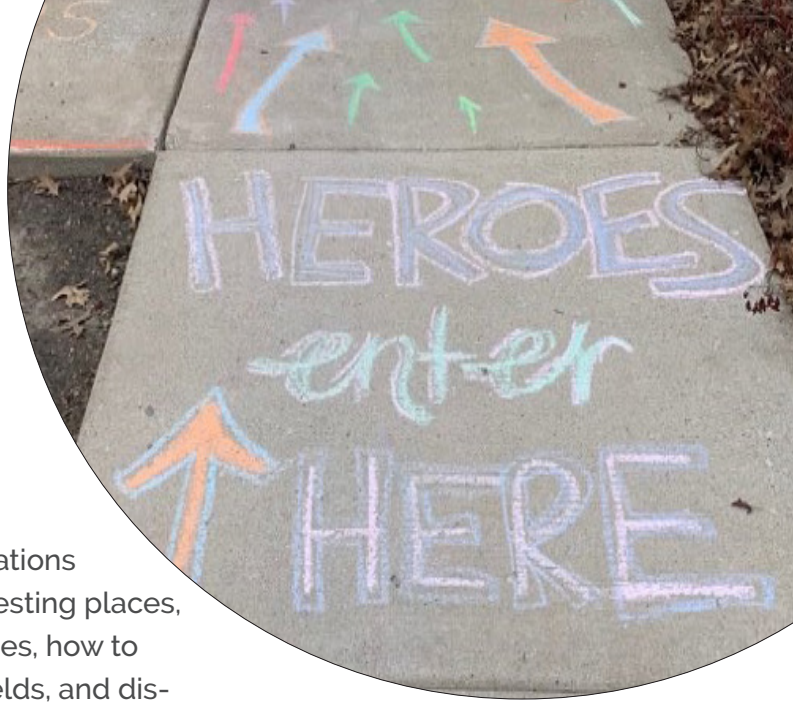
ALL IN THIS TOGETHER

Healthcare workers taking precautions against the spread

The 'New Normal' becomes topic of discussion



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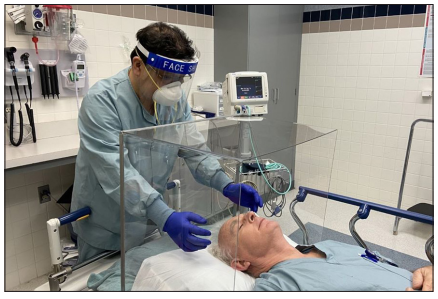
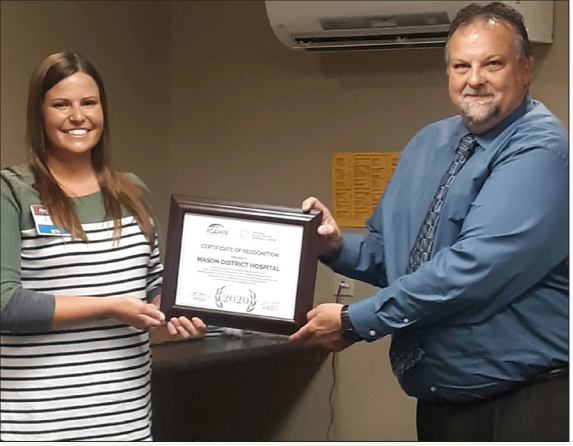
Topics discussed included the Families First Coronavirus Response Act, CMS "Hospitals without Walls" waivers, triage location, reassignment of non-essential staff, stopping and restarting elective procedures and surgery, testing turnaround times, PPE, telehealth, lab draws in the homes, financial concerns, federal funding programs, drug shortages, informed consents and liability concerns, caring for COVID patients, screening local industry hot spots, prisons, and supporting nursing homes, reporting cases and PPE to both IDPH and FEMA, child care availability for essential workers, public relations, fear, and returning to normal operations, and budget planning.

CEOs also shared public relations videos, new lab testing places, screening practices, how to make masks, shields, and disposable gowns, spreadsheets for tracking funding options, testing kits, and more. Hospitals established new communication lines and learned how to use Zoom and telehealth software programs to communicate with staff and patients. Clearly, our healthcare world has changed. We can expect telehealth to be part of patient care and we need to learn when and how to better employ it. We can expect more virtual meetings and staff working remotely, with an increased reliance on technology. We will need to rethink our business line and rebuild our public image as an enhanced and safe place for care. We will need to figure out how to bring back those patients for therapies and prevention services. We will need to work with local businesses to support their employees and identify new partners, such as box stores for testing and sharing of healthcare information. Rural providers have an opportunity to take our experiences and create a special community of care, knowing how to touch lives through both personal outreach and the new wave of technology outreach. The sky is the limit. Rural hospitals can lead, beat the virus, and build a better tomorrow together.

» Member hospitals engage creativity of staff, community





SOCIAL DISTANCED, BUT CELEBRATING TOGETHER

Amy Ewalt, RN, BSN, Care Coordinator/Care Manager, Mason District Hospital, and Doug Kosier, CEO, accept the National Rural Health Resource Center and ICAHN's award for excellence and achievement in care coordination. Via a Zoom announcement with IDPH and ICAHN, Kosier said, "We're honored to have received this national recognition for our care coordination efforts. We've put a lot of work into implementing a chronic care management program to offer to our patients, The CCM program has helped to drive the adoption of preventive care initiatives, and the changes put in place have vastly improved the overall quality scores for our clinics." An example of this included an improvement in the depression screening quality score for one MDH clinic from 2.86% in 2018 to 67.39% in 2019. The Rural Hospital Medicare Flexibility (Flex) Program provided funds to implement care coordination at Mason District Hospital.

ONE OF ONLY FOUR HOSPITALS RECOGNIZED ACROSS THE NATION

MASON DISTRICT HONORED FOR EXCELLENCE IN CARE COORDINATION

The National Rural Health Resource Center and the Illinois Critical Access Hospital Network recently announced Mason District Hospital is one of only four critical access hospitals across the United States to receive this care coordination recognition.

"The achievement in care coordination initiatives by Mason District Hospital is impressive," stated Sally Buck, Chief Executive Officer at The Center in Duluth, MN. "It reflects the innovation required to address unique population health needs in rural communities. Providing services locally benefits the patient, the overall community, and enhances critical access hospital performance outcomes."

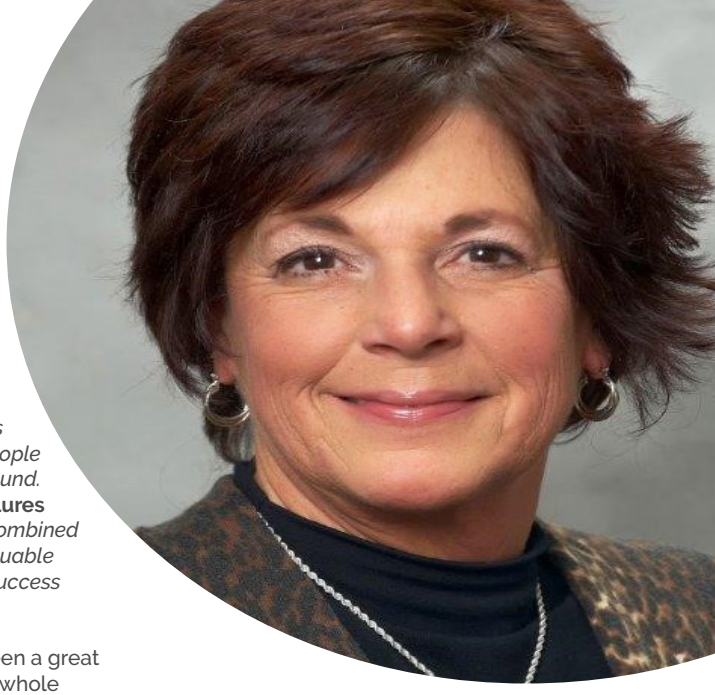
In 2018, Amy Ewalt, RN, BSN began developing the CCM program, with guidance from ICAHN's 12-week development course. Now that it has grown, providers are beginning to see the difference in the care of their enrolled patients. One of them recently said he is "thrilled with his patients in the program and is more up-to-date with their care than he has ever been," in reference to specialist referral tracking.

Mason District Hospital first promoted Medicare Wellness Visits in 2018 and then introduced full care coordination to all its providers practicing in their three rural health clinics in 2019.

As the providers realized the benefits of care coordination, the number of patients participating in the program grew from three at the end of 2018 to over 132 patients at the start of 2020.

Due to this team approach, they have successfully lowered the HbA1c levels in many of their patients. The care coordinator monitors a patient's current providers as well as keeps track of their upcoming appointments. She also ensures that MDH's primary care providers are providing appropriate follow-up, preventing duplication of services, and are knowledgeable about MDH's services provided and their benefits.

QUALITY CONNECTION CORNER



NANCY ALLEN, ICAHN Senior Operations Specialist

ICAHN Peer Network Groups and Listservs provide networking and problem-solving opportunities, bringing hospital peers together to interact and share information as a group or individually through calls and email communication. Nursing has several peer groups of which I facilitate. They include the CNEs, Emergency Department Managers, Medical/Surgical Managers, and the Operating Room Managers.

As a former CNE, I found the time well spent and an excellent avenue to glean knowledge from my peers. Peer-to-peer groups share resources, collective knowledge, and a listening ear. We have all heard the phrase "why reinvent the wheel." Peer groups are widely used for this very reason. I found the following regarding peer groups:

SEVEN BENEFITS OF BELONGING TO A PEER GROUP:

1. **Manage company's growth and development**
   You may encounter a stage in your business's development/career where you don't know how to get to the next level. Your experienced peers can help you handle each stage of your company's growth/challenges using their experience and combined wisdom.
2. **Don't Miss Anything**
   During discussions with your peer group, others can point out an area that you may have missed. They can help stop you from making a fatal business decision or give a suggestion to improve communication with staff.
3. **Accountability**
   It's easier to reach your goals if you have a group of like-minded people holding you accountable, asking if you took the next step.
4. **Personal Support**
   Every business goes through some dark days. It could be that there is a financial problem, you need to lay off part of your staff, or you're going through a tough personal time. Your peer group can listen and encourage you.
5. **Rich in resources.**
   Your peer group will have a collective amount of years—some will have decades of experience, while another peer might have just a few years. These folks' collective knowledge will provide you with resources and insight to help make good decisions.
6. **Listen to ideas**
   Do you have a revolutionary idea? Do you want to offer a new service? You'll feel more motivated to pursue your goals and dreams with a group of people cheering you on in the background.
7. **Learn from successes and failures**
   Along with the many years of combined work experience, you'll gain valuable insight by hearing your peers' success and failure stories.

The peer groups have always been a great resource, but that has gone to a whole new level in the past couple of months with COVID-19. The discussions have been robust with great sharing of knowledge, experiences, new policies and procedures, and how to reopen services and convince the public that it is safe to come back in our doors. In the last two months, some of the topics discussed have been:

- *Process of screening all employees and patients*
- *Flow into the facility*
- *Use of external sites for screening and testing*
- *Use of tents outside the ED for respiratory patients*
- *Cross training of staff to cover screening*
- *Closing of the OR for elective procedures*
- *Securing enough PPE*
- *Child care for our staff*
- *Process when intubating patients – lessons learned from those who have*
- *Reopening of the OR*
- *N-95 mask reprocessing*
- *PAPRs in the OR*

Please continue to take advantage of this great membership service. If you aren't currently a member of a peer group and would like to be added, just e-mail me at nallen@icahn.org, and we will add you to the group. I look forward to working with all of you.

PEER NETWORK GROUP	WHEN	HOW	ICAHN LEADER
Business Office/HIM	Q3 (To Be Announced)	(To Be Announced)	Jackie King
Informatics	June 9 at 11:00am	Zoom Link	Jackie King
Quality	1st Friday at 1:00pm	Zoom Link	Angie Charlet
Infection Control	Last Friday at 1:00pm	Zoom Link	Angie Charlet
Compliance	2nd Tuesday at 9:30am	Zoom Link	Angie Charlet
Pharmacy	1st Friday at 11:30am	Conference Call	Laura Fischer
Imaging	3rd Thursday at 10:00am	Conference Call	Laura Fischer
Laboratory	4th Wednesday at 11:00am	Conference Call	Laura Fischer
Plant Managers	3rd Wednesday at 10:00am	Conference Call	Laura Fischer
Material Managers	4th Wednesday at 10:00am	Conference Call	Laura Fischer
Rehabilitation	4th Thursday at 10:00am	Conference Call	Laura Fischer
Wellness	3rd Wednesday at 11:00am	Conference Call	Laura Fischer
Chief Nurse Executives	1st Tuesday at 12:00pm	Conference Call	Nancy Allen
Medical/Surgical	2nd Tuesday at 9:30am	Conference Call	Nancy Allen
Operating Room	2nd Tuesday at 2:00pm	Conference Call	Nancy Allen
Case Managers	(To Be Announced)	Conference Call	Nancy Allen
Emergency Department Managers	1st Tuesday at 9:00am	Conference Call	Nancy Allen

QUALITY CONNECTION CORNER *CONTINUED*

Quality/Infection Control Reporting:

While CMS and the Federal Office of Rural Health Policy have allowed all of our quality reporting to be optional, I would like to encourage everyone to submit when at all possible. Our ICAHN office has taken the stance to NOT collect on EDTC through 2Q2020…so no reporting until October for 3Q data. I realize several have asked about this indicator and if you do have data and wish to submit, please send to either Angie or Laura at the ICAHN office to submit to our friends at the FORHP. Remember the EDTC data elements and questions have changed! Please visit: https://www.ruralcenter.org/resource-library/edtc-measure-data-reporting-resources to obtain the new collection tool, watch the training video, and measure elements.

Needing Assistance:

I am seeking some best practices and strategies to add to this site. The first four quality/infection control folks to send me something will receive a $400 stipend to build our robust website and provide the educational resources. This can be in any area of the MBQIP portal and measures. I prefer the areas in NHSN Annual Facility Surveys/ Antibiotic Stewardship and the Outpatient Measures. Send info to acharlet@icahn.org.

Swing Bed Project:

We had 21 CAHs sign up for the swing bed patient engagement pilot! This pilot will be the start of Illinois being in the forefront to engage in patient satisfaction for our swing bed patients and identify easier methods and quality of care outcomes. The project will begin late summer. Our very own, Kerry Dunning, will be the lead subject matter expert.

New Ancillary Portal for Benchmarking:

Dan Walker and Laura Fischer have been diligently working with our friends at AdCo to develop the new portal for submitting data for benchmarking. Many of you in lab and radiology have already been part of this program…we are just taking it up a notch! While we have not settled on our name yet, we have a few ideas…watch for our new link, name, and we may do a logo challenge as well.

Flex Grant News:

COVID! COVID! COVID! That seems to be all anyone has been able to think about for the past three months. Those of us in the grant department of ICAHN understand how all-consuming it has been and that the last thing on your mind has been working on your grant projects.

Many of you may have had plans to bring experts on-site; however, due to travel restrictions are unable to do so. Furthermore, hospitals had projects that depended upon collaboration with local school districts. School districts dismissed this Spring and will not resume until next fall – delaying the completion of those projects.

We understand the challenges you are facing. The Final Award Report Forms will be sent out mid-June and due at the end of July. A question has been added that specifically addresses any changes made to the award timeline. Consequently, when completing the report, explain the impact of COVID-19, detail your plans, and give an estimation of the timeline needed to finish the project. The funds for the project should be spent or obligated via a contract or purchase order by the due date for the final report.

For those hospitals that need to extend their timeline to complete their project deliverables, Laura will be working with you to document the completion of your project. If you are unable to spend/obligate our funds, feel you need to revise your project, or have any other concerns, please email lfischer@icahn.org, and we can work through the issues.

ICAHN EMPLOYEE SPOTLIGHT

NAME: Lori Frick

TITLE: Administrative Assistant

BACKGROUND/EDUCATION: I attended Illinois Valley Community and Kishwaukee Community Colleges and have mainly worked in medical offices, performing various tasks such as medical assisting, insurance verification, billing, and other clerical duties as needed.

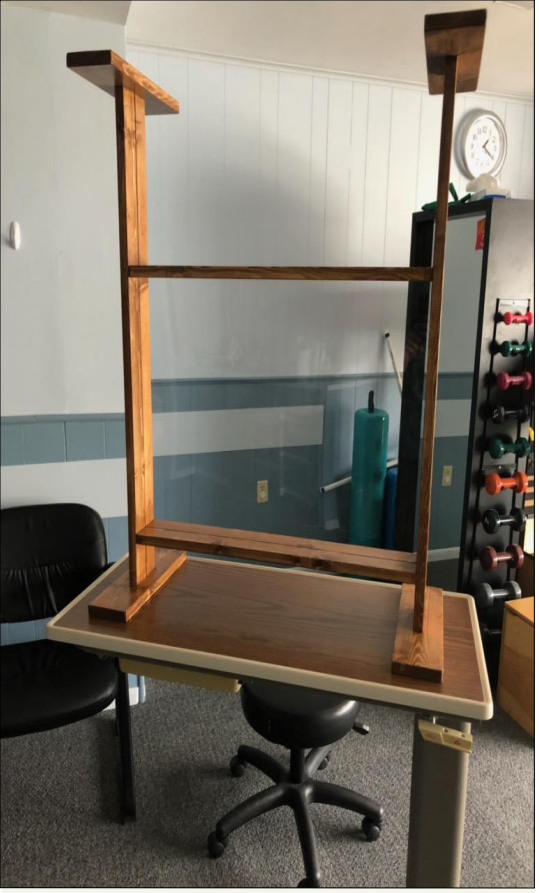
JOB RESPONSIBILITIES: As an administrative assistant, I am responsible for answering incoming calls, maintaining and updating the Listserv, writing the minutes for the Regulatory and Legislative Board, scheduling annual CEO calls, and typing CEO questionnaire summaries. I am also responsible for meeting planning, arranging preferred meeting sites, catering, menus, contracts, speaker coordination, and event and registration spreadsheets, plus upkeep on all hospital employee listings – keeping current by department. This has also been the year for learning all the nuances of Zoom, Conference Call hosting, and completing various mailings as needed for staff.

THOUGHTS ABOUT WORKING FOR ICAHN: Everyone has been so welcoming and helpful! We have such a beautiful new building in which to work every day, and I love working back in Princeton again. I never realized what a wonderful asset ICAHN is to our small, rural hospitals. Pat is so knowledgeable in her field, and if it were not for her, none of us would be able to be here making a difference for our rural communities.

PERSONAL INFORMATION: I love plants and flowers, so gardening and being in my flower gardens are passions in my spare time. I also crochet and enjoy making afghans during the colder months … girls' trips with my girlfriends and, most of all, adventures with Sam, daughter Meg, and Jackson, our 12-year-old Shih Tzu/Maltese.

Flex EMS Update: *Active Shooter and Threat Training*

The Flex Program continues to focus on active shooter/threat training and awareness. This is going to be a multi-year project and involves critical access hospitals in addition to community partners, such as EMS, law enforcement, and fire services. The project began by listening in on the first impressions and lessons learned from the Mercy Health shooting. During the upcoming months, ICAHN will be sharing webinars from subject matter experts from fire/EMS/law enforcement about how to evaluate your preparedness plan and how to build collaborations with your community partners.



‘SEEING’ SPEECH THERAPY AT CULBERTSON

The maintenance department at Culbertson Memorial Hospital created this plexiglass safety barrier, similar to those displayed at registration desks and grocery store check-outs, for the hospital speech therapy department and its youngest patients.

This particular, ingenious model is flexible and sturdy enough to be used on the floor with children, or flipped over (into a table top orientation) for use with adults.

This apparatus can now be used for effective and safe speech treatments, without the use of masks.

ICAHN AND ILCHF EXTENDING CHILD CARE GRANT THROUGH JULY 31

With essential hospital staff facing childcare challenges due to schools and daycares closing, the Illinois Children’s Healthcare Foundation (ILCHF) recently awarded ICAHN a $500,000 grant to help its rural hospital membership.

Twenty-seven ICAHN member hospitals are utilizing grant funding provided by the Essential Hospital Staff Child Care Support (EHSCCS) Initiative. Essential workers, in all departments of their respective hospitals, submit receipts for day care and are reimbursed up to $30 for one child, $50 a day for two children, $70 a day for three children, and $90 a day for four children.

“We’ve seen wonderful participation in this program, and we are hoping for even more as we are now officially extending the program through July 31,” said Stephanie DeMay, EHSCCS Grant Coordinator. “ICAHN member hospitals that may not yet have started the program are welcome to do so and can still retroactively receive reimbursements from April 6 through July 31.”

For families over four, additional compensation will be considered on a case-by-case basis. For more information, contact sdemay@icahn.org or call Stephanie at 815.719.6200.

Telehealth is the wave of the future

Because of this public health emergency, rural hospitals are seeing an accelerated adoption of telemedicine services for treating their patients.

COVID-19 pandemic causes unprecedented, sweeping changes to reimbursement system

These are unique times indeed. With the onset of the COVID-19 pandemic, our country has seen the most unprecedented and sweeping changes to our healthcare reimbursement system in history. These changes have taken place in such a rapid-fire manner that everyone who works in healthcare, including coding and billing professionals are becoming frazzled while trying to keep up.

One silver lining of this Public Health Emergency (PHE) has been the accelerated adoption of telemedicine services for treating patients. We have opened up access to care, and the temporary ability to receive reimbursement for that care, in a manner and speed that would never have developed without the dire need for social distancing to slow the spread of the virus.

Telehealth vs. Telemedicine...is there a difference? Telehealth refers to a broad range of technologies and services to provide patient care and improve the healthcare delivery system as a whole. Telehealth is different from telemedicine because it refers to a broader scope of remote healthcare services than telemedicine.

Technology requirements
During the PHE, telemedicine technology requirements can include any non-public facing application (e.g. not social media) or software available to patients such as a telephone, computer, iPad, or cellular phone. The OCR (Office for Civil Rights) at the Department of Health and Human Services (HHS) stated on March 17, 2020 that it will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered healthcare providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

Some examples of allowable telemedicine technology during the PHE include: FaceTime, Zoom, and Skype. HIPAA compliant examples include, but are not limited to: Zoom for Healthcare, Doxy.me, Skype for Business, Updox, VSee, GoToMeeting, Amazon Chime, or Google G Suite Hangouts Meet. Examples of unacceptable telemedicine applications which are public facing include Tik Tok, Facebook Live, and Twitch.

Originating site
Although it may sound counter-intuitive, the originating site for telemedicine is the location of

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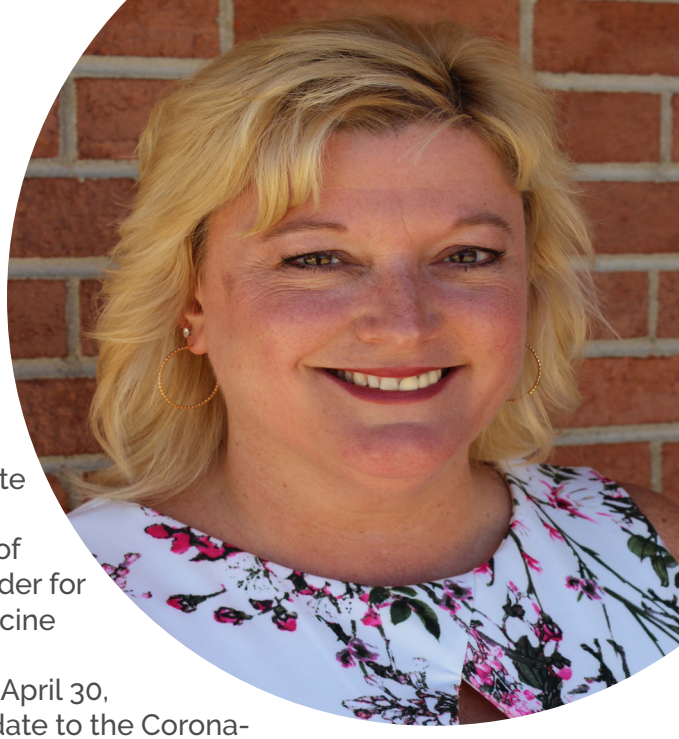
UPDATES ON TELEHEALTH AND BILLING SERVICES UNDER THE COVID-19 WAIVERS



Visit https://icahn.org/members/updates-on-telehealth-coding-and-billing-services-under-the-covid-19-waivers/for the full story

FROM PAGE 8

the patient. During the PHE, this can include the patient's home both by CMS as well as most commercial payers. The most recent set of changes included in the CMS-5531-IFC (interim final rule with comment period) released April 30, 2020, declares that hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home.

This can be accomplished by requesting an extraordinary circumstances' relocation exception that will designate the patient's home as a provider based department (PBD) of the hospital. Per CMS -55341-IFC Section II.E-.F. : *To the extent that a hospital may relocate to an off-campus PBD that otherwise is the patient's home, only one relocation request during the COVID-19 PHE is necessary.*

In other words, the hospital would not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient's home; a single submission per location is sufficient. Hospitals must send this email to their CMS Regional Office within 120 days of beginning to furnish and bill for services at the relocated on- or off-campus PBD.

We note that, during the COVID-19 PHE, a patient's home would be considered a PBD of the hospital when the patient is registered as a hospital outpatient (as discussed in section II.F. of this CMS-5531-IFC 43 IFC) and is receiving covered OPD services from the hospital.

Billing the originating site fee
Use HCPCS code Q3014 for originating site fee to Medicare and Medicaid.

Distant site:
The distant site is the location of the provider for telemedicine services.
With the April 30, 2020 update to the Corona-virus Aid, Relief, and Economic Security Act (CARES Act), CMS has expanded the types of healthcare professionals that are eligible to bill Medicare for their professional services. This now adds in healthcare professionals who were previously ineligible to furnish and bill for Medicare telehealth services, and includes physical therapists, occupational therapists, speech language pathologists and others, to receive payment for Medicare telehealth services.

These providers, in addition to physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals must all be acting within their scope of practice under state law. This brings CMS more in line with most Medicaid and commercial plans who were allowing these practitioners to provide services via telehealth earlier in the PHE.

For the remainder of this article, copy and visit the link provided in green on this page or contact Jackie King, MSHI, CPC, RH-CBS, Director of Clinical Informatics/HIM Consultant, ICAHN, at jking@icahn.org for more information.

This document was current as of May 13, 2020. There is no official end date to PHE and associate waivers at this time. The ongoing COVID-19 crisis may indeed cause CMS to enact further waivers to protect our patient and healthcare providers.

VENDOR EDUCATION PROVIDED BY:

Community INFUSION SOLUTIONS

Dealing with a dramatic loss of revenue

How hospitals can develop sustainable service revenue streams during and after the pandemic

The Problem

Because of the COVID-19 crisis, hospitals across the country are dealing with a dramatic loss in revenue. A May 2020 benchmarking analysis completed by Crowe RCA[1] found that average patient volume declined 56% between March 1st and April 15th and that hospitals reached an estimated national net revenue decline of $1.44 billion per day. The analysis also found large percentage drops in inpatient admissions, emergency room visits, observation services, and outpatient ancillary services.

How can hospitals develop sustainable service revenue streams during and after this crisis? Even before COVID-19, ICAHN member hospitals faced the challenges of lower market shares and out-migrating cash flows related to outpatient IV infusion services. In 2019, ICAHN hospitals had only a 25% market share of outpatient IV infusion patients, and over half of those hospitals had less than a 20% market share. This resulted in $31 million in out-migrating cash flow.[2]

25% average market share for ICAHN hospitals

55% of all ICAHN hospitals with less than 20% market share

$31 million in out-migrating cash flow

The Solution

Outpatient IV infusion therapy isn't sexy, but it is crisis-proof. This essential service saw only a minimal drop in volume for the 42 CIS-supported hospitals. Why? Because these services are at the core of successfully managed healthcare for rural hospitals. Strong compliance with these therapies results in increased revenue for hospitals despite the reduction in readmittance rates because compliant patients receive outpatient lab, infusion, imaging, and other ancillary services that noncompliant patients would not receive.

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1. https://www.crowe.com/-/media/Crowe/LLP/Widen-Media-Files-Folder/h/Hospital-volumes-hit-unprecedented-lows-HC2003-044A.pdf?la=en-US&modified=20200430214218&hash=B7FA8AF457E36ED70EFDFA031D56BC224D7BE110
2. Data compiled from a 2019 Medicare outpatient IV infusion analysis conducted by CIS
3. To learn more, please read Community Infusion Solutions' White Paper at https://communityiv.com/wp-content/uploads/2020/05/Impact-of-Compliance.pdf

SUSTAINABLE REVENUE

That is where Community Infusion Solutions (CIS) comes in. CIS builds outpatient Regional Infusion Centers of Excellence that have an average patient compliance rate of 90%.[3] This means CIS-supported hospitals are generating new revenue, developing sustainable service lines, reducing noncompliance rates, ensuring consistent outcomes for referred patients, and capturing out-migrating patients and revenue; all in the midst of the COVID-19 crisis.

Benefit Analysis of a CIS Managed IV Therapy Center

		Readmission Rates			Average Length of Stay		
DRG Code	Description	Pre-CIS	CIS**	Post-CIS	Pre-CIS	CIS	Post-CIS
603	Cellulitis w/o MCC	6%	6%	18%	4.9	4.7	3.8
638	Diabetes w CC	14%	11%	29%	3.2	3.0	2.5
689	Kidney & Urinary Tract Infections w MCC	20%	8%	29%	4.5	5.1	5.2
853	Infectious & Parasitic Diseases w O.R. Procedure w MCC	14%	9%	29%	10.9	10.7	11.9
854	Infectious & Parasitic Diseases w O.R. Procedure w CC		14%	23%		5.3	6.1
870	Septicemia or Severe Sepsis w MV 96 or More Hours	29%	13%	28%	13.8	12.9	13.5
871	Septicemia or Severe Sepsis w/o MV 96 or More Hours w MCC	21%	20%	22%	5.9	6.2	6.3

*CIS**: CY 2017; Pre-CIS: CY 2014; Past CIS: CY 2018*

Community Infusion Solutions, an ICAHN partner, has been around for 13 years serving over 23,000 unique patients. Our passion is to help rural hospitals give their chronically ill patients a better chance to survive and thrive through Regional Infusion Centers of Excellence tied to predictable health outcomes. Please see reference notes on previous page if you would be interested in reading CIS' White Paper.

2020 ICAHN Expo slated for Aug. 27

Registration is now open for the 2020 ICAHN Expo from 7:30 a.m. to 3:30 p.m. on Thursday, August 27 at the Crowne Plaza & Conference Center, Springfield, IL. Registration for both exhibitors and attendees can be found at www.icahnexpo.com.

Should the conference be canceled or postponed for any reason, all previously paid fees will either be reimbursed or used for the new date. For more information, call Stephanie DeMay at 815.719.6200 or email sdemay@icahn.org.

ICAHN
Illinois Critical Access Hospital Network

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