



CAH News Update January 2010

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Welcome to New Staff Members

Curt Zimmerman joined ICAHN as the director of business services and development, filling the position vacated in December 2009 by Chuck Bohlmann's move to Ohio. Curt has experience in agri-business, has an accounting degree and insurance license. He is a native of Mendota and has served for eight years on the board of directors of Mendota Community Hospital. Curt has had direct exposure to the value ICAHN brings to the critical access hospital. He, his wife Laurie and their three boys live in Mendota. Curt will commute to the Princeton office and can be reached at 815-875-2999 and by e-mail at czimmerman@icahn.org.

Jeff Perschall joined ICAHN as a contractor for IT services. Jeff has extensive experience with network infrastructure and design, server virtualization, and special knowledge of vendors VMware, Microsoft, Novell, and Hewlett Packard. He has a diverse background that includes troubleshooting, networking, and project methodology. He works with Todd Cooper and Todd Hart and can be reached through either Todd Hart, thart@icahn.org or Todd Cooper, tcooper@icahn.org.

ICAHN Receives Two New Grants to Assist Members

Grant to Develop Stroke Victim Service Network

ICAHN is the recipient of a \$25,000 grant from the Iowa Foundation for Medical Care Charitable Initiative. ICAHN will coordinate the efforts of multiple organizations to develop regional plans for a continuum of care from the community hospital to a certified Primary Stroke Center for acute stroke victims. A coalition of stroke care experts will be convened to develop resources for education and leadership.

The funding was requested subsequent to the Illinois General Assembly's enactment in 2009 of HB2244/PA96-0514, the Primary Stroke Center legislation. The act amended the Emergency Medical Services Act to require creation of the inter-system/inter-region advisory committees responsible for the development of protocols for triage, treatment, and transport of possible acute stroke victims. The act created two hospital certification levels to be used to identify hospitals that can receive acute stroke victims. Primary Stroke Centers are nationally recognized and certified by the American Heart Association. A new category,

Emergent Stroke Ready Hospitals, will meet state-defined criteria to receive, evaluate, and treat or transfer acute stroke patients.

ICAHN will use the funds to accomplish the following activities:

- create a coalition with staff of the Illinois Department of Public Health Division of EMS and the American Stroke Association to develop regional plans for the care of stroke victims
- develop and present education programs to prepare hospital and EMS staff to meet the new stroke readiness criteria
- provide hospital staff with training, tools, and resources needed to meet new requirements to be designated as emergent stroke ready hospitals, as created in the new public act
- increase rural hospital staffs' knowledge and awareness about stroke symptoms, treatment options, and risk factor control to prepare them to offer community-wide education services
- develop a standardized quality improvement and assessment instrument that can be used for quality reporting to the Illinois Department of Public Health

A program coordinator has been engaged to implement ICAHN's activities - Peggy Jones, the former director for state health alliances with the American Heart Association. More information about this new program will be distributed to you soon. If you have immediate questions, Peggy can be reached at pjones@icahn.org.

Grant to Upgrade Video Conferencing Equipment

The Verizon Foundation awarded ICAHN nearly \$74,000 to help several critical access hospitals upgrade their original Polycom ViewStations to the new Polycom HDX 7000 series and to help support development and presentation of continuing education programs using video conferencing technology. Grant funds were sufficient to purchase five new units; hospitals selected are served by Verizon and indicated in the HIT survey completed last summer their current use of or future plans to use their video systems for telemedicine applications, in addition to the more frequent use in education and administrative sessions.

Recipient hospitals include:

- Crawford Memorial Hospital
- John and Mary E. Kirby Hospital
- Marshall Browning Hospital
- Rochelle Community Hospital
- St. Joseph Memorial Hospital

Of special interest is St. Joseph Memorial Hospital in Murphysboro that previously has not had video conferencing capabilities.

The new units feature improved audio; support high definition functionality; can transmit two input sources; and run the most current security protocols and have the latest encryption software. These features are important for education programs and administrative meetings but are especially critical for medical applications.

Grant funds also will be used to support several education sessions that will be developed and presented using the grant funds mentioned above – the grant to assist hospitals become *emergent stroke ready hospitals*. The Western Illinois AHEC is developing education programs to help nurses and other licensed health care professionals meet the new continuing education guidelines and the Verizon Foundation grant will help expand those offerings for the critical access hospital community.

Proposed Rules Released for EHR Incentive Payments

The U. S. Department of Health and Human released on December 30, 2009 proposed rules that describe how hospitals and eligible health care professionals can access the Medicare and Medicaid EHR incentive payments through meaningful use of EHR and other health IT systems, and a second release that describes the standards and certification criteria for the EHR systems. These activities were authorized in the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act. The proposed rules for the Medicare and Medicaid EHR incentive payments can be viewed in the Jan. 13, 2010 edition of the Federal Register and a copy has been posted on the ICAHN Web site under Downloads.

The director of the Office of the National Coordinator of Health IT, Dr. David Blumenthal, describes health information technology as the “circulatory system of modern medicine” and USDHHS’ definition of meaningful use as an attempt to further five health care goals:

- improving quality, safety, and efficiency of care while reducing disparities
- engaging patients and families in their care
- promoting public and population health
- improving care coordination
- promoting the privacy and security of EHRs
-

Blumenthal further commented:

“It is impossible to imagine a high-performing U.S. health system that does not take full advantage of the computing technology that has transformed virtually every other aspect of human endeavor.”

(“Launching HITECH”, 10.1056/NEJMp0912825, Dec. 30, 2009)

Public Comment Period

The proposed rules provide a 60-day public comment period, ending March 15, 2010. ICAHN will collate comments from its members and will collaborate with other rural advocacy organizations nationwide to offer unified comments to the USDHHS. There are multiple provisions within the proposed rules that will negatively impact critical access hospitals and we want to be certain USDHHS, the Office of the National Coordinator for Health IT, and members of congress hear our concerns and, hopefully, modify the proposed rules.

The proposed rules for the Medicare and Medicaid incentive payments contain relatively little detail about the payment process for critical access hospitals. (NOTE: Critical access hospitals are not eligible for Medicaid incentives, as the proposed rules are written, thus future references to the incentive program will refer only to Medicare provisions.) Pages 1916 to 1919 in the preamble section and pages 1997 and 1998 in the proposed rules present language specific to critical access hospitals. As written, more process questions arise than are answered by the proposed rules. Identified questions will be included in our comments to USDHHS.

Meaningful Use Criteria and Quality of Care Indicators

The proposed rules list the 23 meaningful use criteria for hospitals and the lengthy list of quality measures that must be reported. Table 2 on pages 1867 through 1870 lists the meaningful use criteria and their measures. Table 20, pages 1896 through 1899, lists the proposed clinical quality measures to be reported by eligible hospitals participating in the incentive program. The number of quality indicators to be reported in the first incentive

payment year already is under debate with a downward adjustment the hoped for outcome. The initially proposed list is viewed as potentially too robust and the resulting data volume may be beyond the ability of CMS to manage. However, comments on recent nationally-sponsored Webinars indicated that any quality measures deleted from the initial payment year(s) will eventually be reinstated in subsequent payment years.

Incremental Achievement of Meaningful Use

A three-stage approach to meaningful use has been developed in response to early stakeholder comments. (See pages 1852 and forward.) The criteria presented in Table 2 referenced above are the Stage 1 requirements. CMS indicates that the criteria for Stage 2 will be proposed by the end of 2011 and Stage 3 criteria will be proposed by the end of 2013. The characteristics of each of the three stages can be summarized as follows:

Stage 1 – focuses on electronically capturing health information in a coded format; tracking key clinical conditions; using clinical decision support; reporting clinical quality measures and public health information

Stage 2 – using EHR/health IT for continuous quality improvement at the point of care; information exchange in structured format; CPOE and lab results sharing; both inpatient and outpatient hospital settings likely will be affected

Stage 3 – promoting improvements in quality, safety, efficiency; decision support for national high priority conditions; patient access to self management tools; access to comprehensive patient data and improvements to population health

CMS estimates that payments made by the end of the decade through the Medicare and Medicaid EHR incentive programs will total between \$14 billion to \$27 billion. These amounts include an estimated savings resulting from downward payment adjustments for hospitals and eligible professionals who do not become meaningful users of between \$2.3 billion and \$5.1 billion.

Congressional Interest in Health IT/EHR Implementation Problems

The short time frame for electronic health record implementation created by ARRA highlights the potential for errors, workflow disruptions, general usability issues, interoperability concerns, and outright errors associated with these sophisticated and complex software systems. Under the best of implementation timelines, complications can be frequent, but the rush associated with the ARRA timeline has the potential to make such complications commonplace.

The ability of hospitals and providers to share and learn from one another's experiences may be restricted by vendor contracts that prohibit or at least severely limit users' ability to share with one another product defects or usability issues they identify through installation and use. Sen. Chuck Grassley (R-IA), the ranking member of the Senate Finance Committee sent letters Jan. 19, 2010 to 31 hospitals nationwide (none in Illinois) asking for their input in response to 11 questions about the process and experiences of these facilities in HIT/EHR implementation and how they address identified software issues.

The senator's goal is to highlight concerns providers have about the aggressive implementation timelines established by ARRA incentives and to focus attention on the responsibilities of vendors to be more responsive to users' issues. He seeks to ensure all

users are made aware of identified issues, preventing the duplication of unnecessary errors. Replies to the survey have been requested by Feb. 16, 2010.

An Economical Solution to Hospital-wide WiFi

Unexpected benefits accompanied the replacement of the telemetry equipment last spring at John and Mary E. Kirby Hospital in Monticello. Rocky Winterbottom, Network Administrator/Engineer, coordinated the review and on-site demonstrations from the various telemetry vendors, and Welch-Allyn was the selected vendor. Welch-Allyn telemetry uses Aruba Network's access points and the telemetry runs only on the 802.11A side of the wireless standards.

Because of prior discussions related to offering Internet access to patients, their families and visitors at Kirby Hospital, Winterbottom discussed with Welch-Allyn the possibility of using the 802.11 B through G portion of the frequency range of the access points for other wireless applications in the hospital. Welch-Allyn representatives discussed the possibilities with Aruba Networks, especially inquiring about any possible interference with the telemetry monitoring.

Aruba Networks developed firmware to insure that any applications using the 802.11B through G spectrum would not interfere with the 802.11A side of the access points. Welch-Allyn representatives installed all equipment within a several-day time period, then worked with Rocky to create two Wi-Fi umbrellas, one for the public's use and one for internal hospital applications.

According to Rocky, "The system works great and is very reliable. The hospital has its new telemetry and for a fraction of the cost we were able to use the same access points to provide the public free Wi-Fi, and the hospital now has a wireless login for its EHR."

Welch-Allyn sponsored a national Webinar last summer that featured the Kirby Hospital approach. Rocky has received a great deal of positive feedback from staff of other hospitals who appreciate the economic value of combining services in this manner, plus the Kirby Hospital users have been very pleased with the free Wi-Fi. Additional information can be requested from Rocky at rwinterbottom@kirbyhospital.org.

CME Webcast: "Improving the Care of People with Mental Illness in Rural Areas"

An interactive Webcast/teleconference is scheduled for Friday, Feb. 5, 2010 from 12:00 noon to 1:00PM ET. Content is to "...address barriers to care faced by rural populations and provide awareness to practicing clinicians of opportunities for collaboration and improvement of access and patient outcomes, which are fostered by emerging technology."

The session is coordinated by CME Outfitters (www.cmeoutfitters.com) and cosponsored by Howard University College of Medicine, Office of Continuing Medical Education. The moderator and the faculty are from the University of Mississippi Medical Center and University of Arkansas for Medical Sciences, respectively.

There is no charge for participation or CE credits but registration is required. (www.neurosciencecme.com/pr435)

This approach to CE is of interest however ICAHN staff have no prior knowledge of this group – CME Outfitters. If any ICAHN-member staff participate in the Feb. 5th program, we would like to hear a report that we can share with all our colleagues. Please contact either Mary Ring or Pat Schou with your feedback after the session.

CARS Had Busy Fall Recruitment Season

The Critical Access Recruitment Services had a busy recruitment season throughout Fall 2009. Examples of multiple marketing activities included residency program visits by CARS director Carrie Galbraith, CARS program display exhibited at multiple continuing medical education events, participation in recruitment fairs, direct mailings, and online advertising. The marketing program was successful in sourcing many qualified candidates for consideration by participating ICAHN member hospitals: CARS member hospitals conducted 16 interviews, many with family medicine residents who will complete their residency training in early summer 2010.

Competition for family medicine residents has been intense, especially for those residents whose background is rural and native to Illinois. Many residents receive multiple employment offers, allowing them to negotiate for higher than average salaries. Because the number of employment opportunities far exceed the number of physician graduates, the potential is great for a graduate to find a position that offers all they seek. Thus, a likely key to successful recruitment and eventual retention of the highly-sought family physician is willingness and ability of the recruiting hospital to negotiate employment conditions.

For recruitment information or to participate in CARS contact Carrie Galbraith, Director of Recruitment Services, at 217-739-2255 or by e-mail at cgalbraith@icahn.org.

Toolkit for CAH Community Benefit Reporting

A new toolkit is available that provides guidance to the staffs of critical access hospitals on the collection and reporting of community benefit data. The document will assist CAHs comply with federal and/or state community benefit reporting requirements.

The toolkit was prepared by the Flex Monitoring Team, a consortium of the Rural Health Research Centers at the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine with funding from the federal Office of Rural Health Policy.

View the toolkit at:

<http://flexmonitoring.org/documents/Community-Benefit-Reporting-Toolkit.pdf>

CAH Regulatory Corner – PATIENT TRANSFER

Patient transfers are one of the major patient care activities of a critical access hospital and there are several references to the transfer process in the CAH Interpretive Guidelines and Conditions of Participation. First, CAHs must be part of a rural network (C-0191) where the CAH has an agreement with at least one resource hospital that furnishes acute care hospital services. The agreement must document a communication system with the resource

hospital that includes electronic sharing of patient data, and telemetry and medical records (C-0192 and C-0193). There must be procedures for the emergency and non-emergency transportation between the hospitals (C-0194). The agreement also must document that the resource hospital will offer credentialing and quality improvement services to the CAH as needed (C-0195).

These service expectations are best met through a *transfer agreement*. The goal of this condition is to ensure that CAHs have arrangements in place to accommodate a higher level of care or additional services not provided at the CAH. It is important that CAH transfer agreements are up-to-date and address these basic requirements of the Conditions for Participation. You should evaluate regularly the receiving hospitals' services to assess whether your patients receive quality services and the transfer process is seamless. CAH's transfer policies and procedures should reflect current health care practices.

CAH guideline C-0267 requires that CAHs have policies and procedures that address patients' referrals to needed services that cannot be furnished at the CAH and assures that adequate patient health records are transferred when patients are referred to external facilities or health care providers. CAHs also are required to follow EMTALA guidelines for emergency medical treatment and stabilization, which often involves the transfer of patients.

Prepared by Pat Schou

Illinois Health Care Worker Background Check Update

The Illinois Department of Public Health distributed a progress update Jan. 28, 2010 on the implementation of the background check procedures for certain unlicensed health care workers. The updates have been posted to document "Downloads" on the ICAHN Web site at www.ICAHN.org. A full description of the Illinois Health Care Worker Background Check program and registry can be accessed at www.idph.state.il.us/nar/home.htm.

Federal Data Bank to Help Hospitals with Background Checks

The U.S. Department of Health and Human Services, Health Resources and Services Administration published the final rule for the *National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners: Reporting on Adverse and Negative Actions* in the Federal Register Jan. 28, 2010. (The simplest access to the rule is to query Google for 45 CFR Part 60.) Provisions of the rule take effect March 1, 2010.

Hospitals already have access to information about physicians and dentists reported to the National Practitioner Data Base by state and federal oversight agencies and health plans. The expanded data contained in the Healthcare Integrity Protection Data Bank, previously available only to health plans, providers themselves, and to state and federal oversight agencies, now will be added to the National Practitioner Data Base. In addition to physicians and dentists, information will be available for all medical professionals including nurses, technicians, chiropractors, and podiatrists.

Information will be reported by state licensing and certification boards, malpractice payers, hospitals, peer review organizations, accreditation organizations, and professional societies that conduct peer review.

Information describing access to the expanded data base should be made available prior to the March 1 initiation timetable.

Interesting Funding Methods Pursued by CAHs

Hopedale Medical Complex and Mendota Community Hospital both have major construction projects planned. Two case studies were provided by Lancaster Pollard that describe the hospitals' approaches to funding solutions and are included at the end of this newsletter.

Web Site for Medical Volunteers for Haiti

From the AHANewsNow: Jan. 26, 2010

"The U.S. Department of Health and Human Services has launched a Web site for medical workers who wish to volunteer their services to the earthquake relief effort in Haiti. To be considered for deployment as HHS volunteers, the Web site asks medical professionals to e-mail their request to Haiti.volunteer@hhs.gov, including their name, clinical area, specialty skills, degrees and language capabilities (particularly how fluent they are in Haitian Creole or French). HHS will also share the information with the U.S. Agency for International Development and non-governmental organizations seeking medical volunteers, who may contact them if an opportunity matching their skills and credentials becomes available. Volunteers who have registered at the Center for International Disaster Information Web site should also send a request to HHS to maximize their chances of being deployed."

HFMA Newsletter Access

The Healthcare Financial Management Association publishes a newsletter, *The Business of Caring*, that addresses best business practices and is directed to clinical leaders. The newsletter is published in collaboration with the Association of Nurse Executives. Access the newsletter at:

www.hfma.org/publications/business_caring_newsletter/

New Video Available on Delivering Effective Care to Hearing Impaired and Limited English Proficient Persons

The Joint Commission in collaboration with the U.S. Department of Health and Human Services Office of Civil Rights recently released a video demonstrating the importance of providing culturally competent health care to meet the needs of diverse populations. Improving provider communication is critical to delivering effective care for individuals with limited language proficiency and those who are deaf or have hearing impairments.

The video identifies effective and alternative communication strategies and highlights the importance of relevant civil rights legislation, federal and accreditation standards pertaining to language access, in addition to the rights of patients.

The video can be viewed at the following Web site:

http://www.jointcommission.org/PatientSafety/HLC/video_improving_pt_provider_comm.htm

2009 Poverty Guidelines Remain in Effect

The U. S. Department of Health and Human Services advises that the 2009 federal poverty guidelines will remain in effect until at least March 1, 2010. New poverty guidelines are to be published but exact date is uncertain.

ICAHN Web Site Adds Job Openings Postings

ICAHN has added a new feature – postings of jobs openings of all categories at critical access hospitals. Hospitals interested in posting a position are to contact Matt Comerford at the ICAHN office (815-875-2999 or mcomerford@icahn.org). Please provide a short paragraph describing the available position as well as a link to your hospital's Web site. Look at the ICAHN Web site at www.icahn.org.

ICAHN Staff:

Curt Zimmerman, Director of Business Services; Matt Comerford, Operations Coordinator; Todd Cooper, IT Coordinator; Don Evans, Education Coordinator; Holly Hammerich, Office Assistant; Todd Hart, Director of IT Services; Carrie Galbraith, Physician Recruitment Services; Jeff Perschall, IT Consultant; Mary Ring, PHIN Grant Project Director; Pat Schou, Executive Director; Bill Spittler, Special Projects Consultant

Case Study: Mendota Community Hospital

Hospital Type:
Critical Access Hospital

Location:
Mendota, Ill.

Project Objective:
Replacement Hospital

Financing Amount:
\$34.2 million

Source of Funding:
Taxable notes insured by
the FHA Section 242
mortgage insurance
program

Background and Challenges

Mendota Community Hospital is a 25-bed facility located 80 miles southwest of Chicago. Regular renovations and additions to the 1951 building had finally been outpaced by modern needs as staff dealt with an inefficient design, building constraints that caused operating cost increases because of department fragmentation, and the concern about attracting physicians to a hospital whose strong operating performance was becoming overshadowed by its age.

As an unrated Critical Access Hospital seeking new construction financing in a dismal credit market, Mendota faced challenges in accessing capital despite strong financial ratios that compared to those of stand-alone facilities rated BBB or BBB+. Lancaster Pollard, because it was qualified to pursue both traditional and non-traditional financing and could pursue multiple options at once, was hired to provide debt financing for the replacement hospital and a new medical office building.

Financial Solution

Lancaster Pollard evaluated and simultaneously pursued FHA/HUD mortgage insurance, bank letters of credit, USDA financing and bank-qualified private placement options. Banks were loath to provide new construction financing, however, and the USDA option would not have provided a guarantee during Mendota's nearly two-year construction financing period. FHA Section 242 financing was selected for the new facility and an adjacent medical office building.

Lancaster Pollard recommended that Mendota preserve its liquidity by issuing taxable notes rather than tax-exempt bonds. The taxable option saved Mendota several million dollars that would otherwise have had to fund negative arbitrage or be put in escrow, cutting the hospital's liquidity by 40%. Interest rates were comparable to tax-exempt financing rates.

Outcome

The new hospital and MOB will be built near a major expressway just 2.5 miles from the original facility. HUD Section 242 financing provides Mendota 27 years to pay down its debt. Lancaster Pollard competitively bid out the purchase of the notes, intentionally structuring the sale to include a local bank in the purchase at Mendota's request. The hospital achieved a low AAA-equivalent fixed interest rate and it closed on permanent financing in a market where many hospitals were forced to delay or abandon proposed capital projects.

Financing Progress

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Case Study: Hopedale Medical Complex

Hospital Type:

Critical Access Hospital

Location:

Hopedale, IL

Project Objective:

Refinance

Financing Amount:

\$5.5 million

Source of Funding:

Tax-exempt variable-rate bonds enhanced by a local bank letter of credit and backed by a Federal Home Loan Bank letter of credit.

Background and Challenges

Hopedale Medical Complex is a 25-bed Critical Access Hospital just outside Peoria, Ill. With a major construction and expansion project on the horizon, hospital leadership was not looking to change its existing debt structure until it needed to. But when a miscommunication occurred between the hospital's letter of credit bank and its trustee, Hopedale's variable-rate bonds were converted to bank bonds. The bank refused to restructure or renew the letter of credit, and Hopedale was forced to refinance the \$4.5 million in outstanding debt.

With a \$20 million expansion project approximately one year away and the need for approximately \$1 million in capital to fund pre-project costs, Hopedale needed a solution that could be implemented quickly, and that would also provide the flexibility to exit the structure penalty-free after a short 15-month period.

Financial Solution

Two options arose. A local bank stepped up and offered to provide a direct loan. Lancaster Pollard, which was already working with Hopedale to remarket its variable-rate debt, suggested a second option: Issue bonds enhanced by a letter of credit from the same local bank, and support the issuance with a Federal Home Loan Bank letter of credit to access the Chicago FHLB's AA+ credit rating.

Lancaster Pollard's analysis indicated that the cost of issuance associated with the FHLB option would cost approximately \$50,000 more than the direct loan, but that its lower interest rate would make it the less expensive option just five months into the term, saving the hospital a total of \$105,000 over 15 months. Further, the FHLB option provides a more permanent financing option in the event the major capital project fell through; the bank loan would have to be refinanced at the end of its short term, with no guarantee that the hospital would be able to secure permanent financing.

Outcome

Hopedale issued variable-rate tax-exempt bonds, and the hospital's FHLB letter of credit transaction closed in 75 days. There is no prepayment penalty, and the all-in interest rate resets weekly at about 2 percent. Hopedale is one of the nation's first hospitals to use this FHLB letter of credit structure, which became available to hospitals in 2008 and expires after 2010.

Financing Progress
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