

California

Critical

Access

Hospital

Network

**CCAHN Strategic Plan
2010-2011**

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To be added:

CCAHN Organizational Structure

Proposed Timeline for completion of CCAHN Organizational Development

BACKGROUND

Background

In the summer of 2008, Mendocino Coast District Hospital (MCDH) in partnership with four other California critical access hospitals (CAHs) applied for and received a Health Resources and Services Administration (HRSA) Rural Health Network Development Planning Grant. The other partner hospitals included:

- Catalina Island Medical Center, Avalon
- Frank R. Howard Memorial Hospital, Willits
- Redwood Memorial Hospital, Fortuna
- Mayers Memorial Hospital, Fall River Mills

These five hospitals applied on behalf of 28 CAHs participating in the critical access hospital network (CCAHN) formed in February 2008. This Network was created for the purpose of providing a forum for discussing critical issues affecting the viability of some of California's most remote hospitals as well as opportunities to leverage the knowledge and experience of participants to address common issues facing all CAHs in California.

The proposed project was focused on laying the foundation for establishment of a formal horizontal CAH network to be accomplished through:

- Convening meetings of network participants
- Completing a targeted needs assessment
- Conducting a comprehensive strategic planning process
- Developing a framework for a business/operations plan aimed at achieving a sustainable network
- Taking steps toward tackling common issues of network participants (in particular those related to HIT, quality and performance improvement, and work force recruitment and retention)
- Leveraging the resources of other grant programs
- Examining the experience of established and successful critical access hospital networks in other states

The need for an effective network is predicated on recognition of:

- the fact that five CAHs had reported they were again on the verge of closure
- increasing provider recruitment issues, rapidly changing technology, state seismic safety requirements, the need to improve quality of care through systems to measure and track quality
- declining MediCal reimbursement and a population that includes a high number of under and uninsured residents
- the fact that while California has very large urban areas, 80% of the state's land area is rural
- the ability of a network to help bridge geographic barriers and better meet the needs of the 2.15 million people who live in California's rural communities

The grant made it possible: to hire part time staff to coordinate a series of CCAHN meetings (face to face, teleconference, and webcam); to engage consulting assistance to develop a formal CCAHN strategic plan and to carry out other network development activities.

Initial steps in development of a formal CCAHN strategic plan included interviewing California critical access hospital CEOs (see Appendix I, CEOs Interviewed and

Appendix II, CEO Interview Comments by Category), convening an Exploratory Group (see Appendix III, Exploratory Group Names and IV, Exploratory Group Comments Summary) focused on discussion of key network formation issues, and conducting a series of meetings leading up to a formal CCAHN Strategic Planning Retreat held in Napa CA on Oct 1, 2009. Retreat attendees identified through a nominal group approach their prioritization of benefits and services they expect to receive through a CAH network (see Appendix V, Clusters or groupings of networking opportunities, services or benefits, and/or technical support)

Consistent with the Network Development Grant requirements, the Napa retreat included presentations by the executive directors of two successful out of state networks:

- Carolyn Bruce, Western Healthcare Alliance, Grand Junction CO
- Pat Schou, Illinois Critical Access Hospital Network, Princeton IL

These two speakers described what worked and did not work in their state's early network formation efforts. They also demonstrated very clearly the range of benefits possible through a truly effective CAH network. The day long discussion of the many challenges facing California rural hospitals in their efforts to achieve a formal working CAH network and culminated in a motion from the floor that a CCAHN Advisory Committee be appointed to address key issues and to report back to the membership within a 90 day period.

Members of this CCAHN Advisory Committee are Ray Hino, Woody Laughnan, Kevin Erich, Robert Schapper, Lee Barron, Chuck Bill, David Yarbrough, Katharine Anne Campbell, Richard Hathaway, Charles Harrison, and Bryan Ballard. Specific items this group was asked to address included:

- CCAHN Mission Statement
- Organizational structure and dues
- Quality improvement software decision, Kansas, Stroudwater, ICAHN
- Priorities January to March, 2010 (e.g. hiring an executive director)
- Collaboration on information technology
- Inventory of expertise/services per hospital (perhaps added to CAH master list)
- Network benefits and services:
 - Staffing standards
 - Financial performance, technical assistance
 - Education and sharing

At the November 13, 2009 Advisory Committee meeting, held in Sacramento, the Committee recommended to the CCAHN membership that CCAHN be an independent entity within CHFT and that administrative overhead (e.g. budget, accounting, payroll, etc.) be provided through CHFT.

CAH CEOs at a CCAHN General Membership Meeting scheduled for January 29, 2010 is expected to vote formally to accept the CCAHN Advisory Committee recommendation. The membership is also expected to

- adopt a proposed CCAHN Organizational Structure (see Appendix _____)
- nominate seven CAH CEOs to serve on the CCAHN permanent Advisory Board
- forward these nominations to the CHFT Board

At a February, 2010 CCAHN General Membership meeting, the CCAHN Advisory Board is expected to:

- elect a chair and vice-chair
- formally adopt a dues structure
- appoint a CCAHN Personnel Committee
- instruct this Committee to initiate a search for an executive director or an organization that is interested in and capable of providing the CCAHN executive leadership and management support

The CCAHN 2010-2011 Strategic Plan will be presented at the March 2010 Annual Rural Healthcare Symposium and CCAHN members will be invited to make comments or suggest changes which could be considered as the Plan is finalized.

The Personnel Committee is expected to make its recommendations regarding the hiring of an executive director or engagement of a network management entity at the May 2010 CCAHN Advisory Board meeting...at which time the CCAHN Board is expected to formally adopt:

- the finalized CCAHN 2010-2011 Strategic Plan
- the CCAHN FYE June 30 2010 Budget

VISION FOR THE FUTURE

Vision of the Future...What the California Critical Access Hospital Network should look like three years out (2013)

This CCAHN Vision of the Future is based on:

- Statements by CCAHN membership regarding what they expect of their network
- What successful networks in other states (e.g. Colorado, Illinois) have done to ensure that these networks are successful
- Characteristics of effective networks described in the HRSA Rural Health Network Development Grant Guidelines

In 2013, the California Critical Access Hospital Network will:

- have a strong Advisory Board solidly committed to delivering value and responding to stated needs, desires, and interests of the CCAHN membership...a Board that adheres to the principles of effective governance
- have a forward looking, progressive executive leadership team capable of pursuing opportunities for creating and expanding programs which provide tangible benefits to CCAHN members
- be comprised of member critical access hospitals who actively participate and support efforts by the entire network to address critical issues impacting rural healthcare providers in their efforts to more efficiently and effectively provide high quality care and services to patients and residents of their communities
- be self sustaining...having achieved long term financial viability through a reliable combination of member dues, federal and private foundation grants, and revenues from the operation of services provided to member hospitals and outside organizations and agencies

STRATEGIC GOALS AND OBJECTIVES

EFFECTIVE GOVERNANCE

It is the strategic goal of CCAHN to have an Advisory Board composed of members who understand, observe, and act in accordance with recognized principles of effective trusteeship, and, who

- share a strong interest in the success of the CCAHN
- understand their role and responsibilities as trustees
- seek out opinions and feedback from network members
- actively participate in Advisory Board discussions, deliberations, and decision making
- dissent where appropriate but understand the need to “close ranks” once Advisory Board decisions are made

Strategic Objective – CCAHN Advisory Board Operational Guidelines

By April 2010, the CCAHN Advisory Board should review, revise, and/or modify the proposed CCAHN Advisory Board Operational Guidelines...which supplement the Organizational Structure document for the purpose of guiding the Board's internal deliberation ensuring a smooth CCAHN Advisory Board policy development and decision making process.

Strategic Objective – Board self assessment

By June 2011, conduct a CCAHN Advisory Board evaluation/self assessment of the Board's effectiveness in moving toward the realization of CCAHN strategic goals and timely achievement of specific objectives as outlined in the 2010-2011 strategic plan.

EXECUTIVE LEADERSHIP, NETWORK STAFFING AND INFRASTRUCTURE

It is the strategic goal of CCAHN to develop and maintain a network management team and infrastructure with strong, decisive executive leadership that

- is creative, forward looking, and very capable of responding appropriately to the policies and program direction established by the CCAHN Advisory Board
- understands and appreciates the challenging complex and difficult environment in which California critical access hospital leadership must operate
- is skilled in communicating with network members and representatives of outside organizations and agencies
- is constantly on the lookout for opportunities to create new programs and services that bring value and help ensure the network's success and viability

Strategic Objective – Executive leadership and management

By:

March 2010 develop CCAHN Advisory Board recommendations for recruiting an executive director, or contracting with an entity capable of providing executive leadership and network management services. These recommendations should

- take into consideration, assistance and support available through CHFT
- include
 - an executive director job description
 - a listing of desirable candidate knowledge, skills, and abilities
 - a proposed compensation package
 - a recruitment and/or management contracting timetable

By:

April 2010 hire an executive director or contract to engage a network management firm.

Strategic Objective – Network staffing

By July 2010 develop a proposed network staffing pattern that defines the staffing needs and requirements of the CCAHN during

- the first full year of operation
- years 2 through 5 following formal establishment of the network

These staffing need estimates should take into consideration, assistance and support available through CHFT.

STRATEGIC GOAL AREA – FINANCIAL VIABILITY, SELF SUSTAINABILITY

It is the strategic goal of CCAHN to develop a network that is financially viable long term and capable of sustaining itself over time and that is supported by a healthy mix of

- revenues from the operation of CCAHN programs and services that bring value to network members as well as income from outside organizations and entities (e.g. credit and collection services, etc.)
- dues from network members as a demonstration of willingness to put “skin in the game”
- federal grant programs (e.g. HRSA Continuation Grant, SHIP monies, FLEX, etc.)
- grants and contributions from donors and/or private foundations (e.g. Robert Wood Johnson, Bill and Melinda Gates, etc.)

Strategic Objective – CCAHN dues structure

By March 2010, adopt a CCAHN dues structure designed to ensure CCAHN viability through a start up period and the initial years of CCAHN operation, which

- specifies the dollar amount of dues to be assessed to member CAHs annually
- includes a hardship provision for CAHs who cannot afford payment of the specified dues (possibly using pooled SHIP funds)

Strategic Objective – Bridge period funding, other grant sources

By June 2010, identify additional funding (e.g. USDA, Robert Wood Johnson, Gates Foundation, etc.) which could be potential sources of support between the termination of the HRSA Planning Grant and receipt of the HRSA Continuation Grant (assuming receipt of the Grant).

Strategic Objective – Rural Healthcare Network Development (RHND) Grant Program

By March 2010

- using prior year HRSA RHND Grant Application Guidelines, begin preparation of the 2010 Grant Application

By July 2010

- obtain 2010 RHND Grant Application guidance and begin preparation of the application

By September 2010

- complete and submit the RHND Grant Application

Strategic Objective – Annual budget

By May 2010 review, revise, and adopt a proposed FYE June 30 2010-2011 Annual Budget.

Strategic Objective – Revenue generating programs and services

By August 2010

- survey all California CAHs to identify those services currently purchased by members from outside sources (e.g. physician and staff recruitment, ER coverage, agency nurses, business office functions, etc.)
- determine which of these services could be provided by a CCAHN business entity or single vendor (for all interested network CAHs)

Strategic Objective – Operational/Business plan

By August 2010 adopt a 2010-2011 CCAHN Operational/Business Plan which

- confirms the CCAHN new program and service development priorities
- outlines the approach to be taken in launching each of the identified programs

PROGRAMS AND SERVICES

It is the strategic goal of CCAHN to provide a range of programs and services in response to stated needs and interests of California CAHs...programs which bring value, and are recognized and appreciated by network members as making a meaningful contribution to their hospitals ability to

- provide the highest quality care
- operate more efficiently (e.g. billing, collection, claims management, shared staffing, group purchasing, etc.)
- respond to rapid and fundamental changes in local, state, and national healthcare environments
- meet the healthcare needs in communities they serve

Strategic Objective – List serve program

By July 2010 complete development of a list serve program through which department managers and other staff can communicate as needed by email, phone, text messaging, etc. with individuals performing similar functions (lab, OT, PT, dietary services, etc.) at other California CAHs

Strategic Objective – Share groups

By September 2010, develop at least six share groups chaired by individuals who have excelled in, and have extensive relevant experience in specific categories...and schedule, where appropriate, quarterly share group meetings. Share groups could include but not be limited to

- quality improvement
- financial performance
- EMRs
- HR/staffing standards
- other

Strategic Objective – Group purchasing organization (GPO)

By October 2010

- determine whether it would be beneficial to CCAHN members to participate in a GPO
- assuming participating in a GPO makes sense,
 - determine which group purchasing organization opportunity has the greatest potential for cost savings to network members
 - enter into an agreement with the chosen GPO which enables CCAHN members to participate in a group purchasing organization

MEMBER PARTICIPATION AND SUPPORT

It is the strategic goal of CCAHN to achieve an organization characterized by active participation and support among member CAHs whose representatives

- willingly serve on CCAHN work groups (e.g. for development of a new CCAHN program, etc.)
- have a strong interest in communicating and sharing achievements, knowledge and insights in specific areas (e.g. financial management, IT, quality and performance improvement, etc.) with other member CAHs
- participate in network share groups
- are willing to speak out on issues affecting rural healthcare providers and to lend their voices to CHA's advocacy efforts

Strategic Objective – Work groups

By November 2010, appoint four work groups to address issues of concern to CAHN hospitals.

Strategic Objective – CCAHN work shops

By March 2011 schedule and hold work shops on at least two topics of key interest or concern to CAHN hospitals (e.g. maximizing cost based reimbursement, staffing/performance measures, RHC management, etc.)

Strategic Objective – CCAHN annual meeting

By October 2010 hold a CCAHN annual meeting to provide network members with an opportunity to

- assess progress in achieving an effective CAH network
- offer input for an update of the CCAHN 2010-2011 Strategic Plan

Strategic Objective – Updated 2011-2012 CCAHN Strategic Plan

By March 2011 develop and present at the 2011 Rural Healthcare Symposium, an updated 2011-2012 CCAHN Strategic Plan.

RELATIONSHIP WITH OTHER ORGANIZATIONS AND AGENCIES

It is the strategic goal of CCAHN to develop and maintain strong and effective relationships with other organizations and entities (e.g. CA State Office of Rural Health, California Health Foundation and Trust (CHFT), California Hospital Association (CHA), (California Area Health Education Centers (CA-AHEC), Health Resource and Services Administration (HRSA), networks in other states, etc.).

Strategic Objective – Agreement with CHFT

By March 2010 enter into a formal Agreement with CHFT for provision of administrative and infrastructure support (e.g. budget, accounting, payroll, human resources, etc.) to be provided in kind through CHFT.

Strategic Objective – Relationship with other CAH networks

By July 2010 enter into discussions with other critical access hospital networks Illinois Critical Access Hospital Network (ICAHN), Western Healthcare Alliance (WHA), Ohio Critical Access Hospital Network (OCAHN), etc., for the purpose of identifying either opportunities for collaboration and/or participation in programs offered or operated by these networks (e.g. GPOs, billing and collection services, physician recruitment, etc.).

APPENDIXES

Appendix I, CEOs Interviewed

Interviewees

Alan Burgess, CEO, Tehachapi Valley Healthcare District, Tehachapi
Bryan Ballard, CEO, Catalina Island Medical Center, Avalon
Charlie Harrison, CEO, Mountains Community Hospital, Lake Arrowhead
Chuck Bill, CEO, John C. Fremont Hospital, Mariposa
Claire Kuczkowski, CEO, Trinity Hospital, Weaverville
David Yarbrough, CEO, Biggs-Gridley Memorial Hospital, Gridley
Gary Boyd, CEO, Mammoth Hospital, Mammoth Lakes
Joe Rogers, CEO, Redwood Memorial Hospital, Fortuna
Jonathon Andrus, CEO, Fairchild Medical Center, Yreka
Katharine Anne Campbell, CEO, Mayers Memorial Hospital, Fall River Mills
Kenneth Platou, CEO, Mercy Medical Center, Mt. Shasta
Kevin R. Erick, CEO, Frank R. Howard Memorial Hospital, Willits
Lee Barron, CEO, Southern Inyo Healthcare District, Lone Pine
Leesa Sanchez, CNO, Colorado River Medical Center, Needles
Richard Hathaway, CEO, Plumas District Hospital, Quincy
Robert Schapper, CEO, Tahoe Forest Hospital District, Truckee
Tom Hayes, Interim CEO, Eastern Plumas District Hospital, Portola
Wanda Grove, CEO, Surprise Valley Community Hospital, Cedarville

Appendix II, CEO interview comments by category

Advocacy

Advocacy – more strength for CAHs at state and federal level – CAHs get screwed – need strength in numbers – CAHs value needs to be valued
CHA somewhat helpful – bigger hospitals get more
Legislative changes in healthcare and healthcare policies
Advocacy – but don't duplicate CHA – reinforce
ACHD and CHA could be resources –
Advocacy
Goal to work with and through CHA (in MT, lab program and social support)
Could have cooperation with district assoc as well
Need to work collaboratively with CA ORH and CHA
Political advocacy
Lobby
Instead of 1 CAH could be a group advocate together
No problem with CHA and ACHD – good coop FLEX
What do people have in common? CHA = big guys
Advocacy – legislation – issues heard
Need coordinated schedules between ACHD and CHA –couldn't make this meeting due to ACHD meeting at the same time
Benchmarking, QI
Able to draw best practices
Sharing of data
QI data sharing
Benchmarking
Patient satisfaction measurement tool
Quality
Tracking QI process in ER – problem with numbers
Combine with entire network – baseline is skewed
Recruitment, staffing, staff training
Recruiting, consulting, training (CALs very good), lobbying, purchasing
Staffing pools
Joint purchase, contracting, GPO
Purchasing GPO saved \$170k/yr
Joint RFP for medical insurance – strength in numbers
Purchasing – best price
Lab services – what is kept in the local hospital or sent to reference labs – could we send it to another CAH
Malpractice insurance
Risk management
Supplies
Joint RFP for insurance – medical insurance for staff increasing 13%
Pooling malpractice insurance
Alpha/beta risk pool CHA
Group purchasing
Billing-part of system (Adventist) so very interested in helping support CAH network – now part of Premier GPO
Adventist does Premier GPO – very useful

Group purchasing
Legal work
EMR – the biggest IT maybe one company?
GPO should be considered
Opportunity limitless – GPOs
Other component: his hosp owned by Catholic Healthcare West – how does he deal with this? Maybe CHW has a billing service – Mercy only CAH in CHW network
Manager networking, list serve, best practices
Ability to share info on different policies – CAHs different from regular acute care
Staffing, operational issues – what works, what doesn't – best practices
Best practices – even housekeeping – policies, processes, high quality
Rural health clinics and acute
Opportunity to do best practices
FTE per AOB
One person has to wear multiple hats
List serve would be good
Nevada teleconference on monthly "from home"
CAH isolation not easy to manage – if CAH is part of a system, the mother ship doesn't understand – need contact with other CAHs
List serve
New to CAH – needs peers in CAHs
So we can share
Unique challenges as CAHs
Should share issues and problem solve
What works what doesn't
Opportunity to get together
Retention and modeling price
QA measurements (JACHO)? They don't have so they don't have to do
Because some local talent, they don't realize importance of planning etc.
List serves
Communication – Webinar
Billing – she could share techniques
HIPPA
Regular meeting
Sharing best practices
Sharing nuggets of info
Strategic planning, benchmarking CAH to CAH, similar hospitals getting together
List serve
IT, EMR
One vendor for EHR
EMR – in the middle of developing but don't have \$ to complete
EMR reimbursement = \$ up front based on discharge
Technology and EMR implementation
EHR system – all will end up doing something different – need 1 model
Meaningful user
Pharmacy, lab, radiology, clinic, coding, financial, medical staff to coders to billers
EMR – IT
IT/EMR, grant writing
Most interested in EMR and link to stimulus \$
EMR – grant from Phillips Corp
Many talking about EMR – no one has solution – CAH network could keep each other

encouraged
Share information – data sharing, IT an example
IT pool
Financial, reimbursement, revenue maximization
All abide by same reimbursement principles
financial – cost report – reallocation – do things to help bottom line
Reimbursement mechanisms
Key challenges = operational and financial
Governed by same reimbursement regs but continue to discover how to interpret these regs
One or two top CAH literate CFOs available to network
Reimbursement
Reimbursement (CAHs in general)
RHC opportunity for reimbursement
Coding re RHC, clinic, SNF, FQHC
Cost reports (i.e. call pay)
Collection and billing
Problem, issue solving
Brainstorm what the issues are
Effective method to deal with issues
Physician recruitment
Recruitment – physicians – aligning needs
Staff and physician recruitment
Dues, financial sustainability
Needs to deliver services
If we are to tap funding sources, we need to do something to make us attractive to funding sources
Believes there should be funding available
If funds were available, it would position us well-network would make it attractive
Hire a person with good grant writing skills – he would be willing to pay high dollars
Cohesive – granting should give \$
Re fee for membership: will need a fee to get things going – what is payback? Doesn't want a free lunch
Structure with grant data
Tough – not for profit entity – grant applications
Must deliver value
5000 = how to do a sliding scale
ACHD and CHA do on gross revenue
Would pay low dues – not a flat fee – do something creative
Base on a sliding scale based on gross revenue or expenses or net revenue
Could support a fee – sliding scale – board would have to make decision
\$3-\$5000 would be ballpark
Yes - No on \$5000 – but could be a part of CHA dues, FLEX, Foundations, CAH
Value? What you get for what amount of \$ (CHA dues are high but OK)
Each in different financial position
Has fees and dues already – demonstrate value – then fine to pay dues
\$4999 fee OK – not over - need working together and communicating
If a beneficial organization formal would be good - \$5000 would be OK-doable – what benefits – would need to see plan
Could be doable – probably have to be the cap – no more than \$5000
Good grant writer/finder

\$5000 seems high – belongs to ACHD – must show value
Dues OK if network is good - \$5000 high what is value?
\$5000 OK – he would not have to take it to his board
AHA membership is \$5000
Support for CA network concept, importance
Very important – discuss issues together
Strong support
Wants something to work
Reinforcing commonality
Start with fact CAHs meeting vital need in community
12 - biggest difficulty with CAHS – no depts – multiple hats - Value has different definition than urban patient + service = high value
5 if functional and beneficial – don't become just another organization
Need of small rural consulting, training, lobbying, GPO – HIPPA, EMR/IT, state survey
Strong support – CA behind times
What is it going to accomplish
Very important – really small part of healthcare system
Has been trying to keep telling his colleagues that this can be done
Critically important vehicle – meet on a regular basis
To do things together we can't do individually
Ability to converse regularly with other CAHs with similar issues
CAHs meeting vital needs
Strength in numbers
Result in direct benefits will ensure support for network
Only 28 CAHs in such a big state
Keep together as safety net for CAHs
Strength in numbers
Focused as a safety net
Continue to survive
No support
Rurals not necessarily competing – helpful
8 years behind the curve
Dialoging – CAHs are smaller – address issues with like hospitals
Get group together
No opinion
Need to work together
Glad to see somebody doing this
CA late getting to the CAH game
Organization governance
Doesn't want social club
Meetings take so much time – either combine or teleconference – travel an issue
need a vision & leader to get strong network
Blend – wants to work under CHA – don't replicate or duplicate
Don't get too formally structured – advisory board to help plan seminars, etc
As a free standing he doesn't want to lose ability to make decisions
Loose structure in NV
More formal – be a member of – leadership
District hospital moves in own way even if a CAH (i.e. Palm Drive)
Wants an organized formal structure – but don't go overboard or over size
NV 12 hospitals 6 people
If funding, fairly formal

Somewhere in the middle – don't go overboard
Depends on goal of corporation
Most impressed with resort hospital network in Rocky Mountain States
If conflict with CHA – then workout internally
Formal so a Palm Drive type wouldn't go off half cocked
Less organization – attempts to form corporation may not go well
Not formal – Peggy Wheeler has served his needs
We need to explore and commit to getting it done

Appendix III, Exploratory Group

Bryan Ballard
Chuck Bill
Kenneth Platou
Robert Schapper
Pam Seale
Rochelle Spinarski
Jonathon Andrus

Appendix IV, Exploratory Group Comments Summary

Conference call 9-16-09

Pam Seale, Bryan Ballard, Peggy Wheeler, Chuck Bill, Robert Schapper, Jonathon Andrus, Michael Philps, Kathleen Philps, Rochelle Spinarski
(Kenneth Platou – out of office)

Exploratory group comments – summary

What range of services and programs are network members most interested in seeing the CCAHN provide...?

RHC-broader rural

CAH-individual needs

CHA-state issues

1. Benchmark comparative financials include CAHs having rural health clinics – should also include benchmarks for them
 - a. freestanding RHCs, demonstrate best practices re compensation & reimbursement
 - b. access resources
 - c. link operations with cost report to maximize reimbursement
2. list serve
3. BETA – peer review on reappointment of radiologist
4. staffing – program to pool efforts – hiring a recruiter or retained recruitment firm – how does this go back on to the cost report
5. QI – share data, distinct part SNFs – resources to help with these, help to apply QI issues to both sides
6. identify and broker education via Webinar into a central place for CAHs (e.g. MRSA, staffing, etc.)
7. EMR
8. GPO

Membership criteria

1. CAHs or similar like maybe a 30 bed rural
 - a. purpose oriented
 - b. could get tangled up with CHA, RHC (Peggy)
 - c. focus – CAH – not an exclusive club
2. Constituency group of an existing organization (would this work?)
 - a. Don't set up conflicts within organization
 - b. AHD and CHA almost at odds re hiring physicians...reimbursement and remoteness

Organizational structure, governance

1. simpler the better – even if just a committee
2. leave legal stuff to CHA or subordinate organization
3. less formal – better to start with
4. ask Peggy re recruitment – does CHA have mechanism – maybe work objective of a RH FLEX grant if beyond CAH eligible, etc and the FLEX \$ could go through CHA
5. do through the Foundation of CHA – maybe CAHs could get \$s
6. CHA wants to keep all folks in the boat – give critical mass for CAH and CHA

-
-
7. FLEX and SHIP grant hospitals– 41 SHIP - 16 rural with <50 beds- 25 are also CAH – some of the 16 are trying to become CAHs – these hospitals are already in the “family”
 8. must keep it CAH focused
 9. would we have to struggle to find value for <50 beds but >25
 10. board, Advisory Committee elected by members to make decisions

Financial

1. Peggy/Michele – does she have \$ to pay for next phase? ORHP continuation grants – fairly clear cut
2. Network development planning grant – if good, it is expected that we can apply for the continuation grant (implementation grant?)
3. dollars left in FLEX application (per Rochelle Spinarski) might be able to be used for implementation
4. CAHs already paying fees (per Peggy)
5. must stay close to the mission of CAHs – from CHA or CHFT
6. VALUE – what do we really want to see here? Tangible, meaningful
7. keep it simple
8. answers will depend on economic status
9. extension of RHC (Peggy)
10. most important to business organization will define value
11. they can pay a fee
12. one priority a year
13. Pool funds from Michele to help pay
14. regular go to resource
15. CAH specific
 - a. Define organization
 - b. Need
 - c. Value
16. what elements to maximize a CAH?

Network implementation

1. why did a hospital become a CAH
2. are we optimizing
3. sustainability
4. we should go through Peggy – she does a good job
5. list serve not important
6. go to place for CAH to optimize
 - a. operations
 - b. financial
 - c. political
 - d. will define membership resources, funding
 - e. financial assessment of 27 CAHS – met criteria
7. simple chart
 - a. how well CAHs are doing
 - b. how do we offer help list
 - c. successful CAHs demonstrating best practices, etc
 - d. NRHA could be resource
8. CAH cost shifting – Medicare cost for CAHs higher for patient than PPS

Appendix V, Clusters or groupings of networking opportunities, services or benefits, and/or technical support (as voted by retreat attendees Oct 1, 2009)

13 votes: Staffing (e.g. nursing pool), staff recruitment & retention, physician recruitment and credentialing, program support, contracting with outside vendors, GPO participation, etc.

12 votes: Financial & business office expertise and support, tools to maximize cost based reimbursement, billing & collection processes, etc.

10 votes: Quality, quality improvement, customer satisfaction, joint commission & regulatory compliance, SB1953 requirements...technical support, etc.

7 votes: List serve or peer group networking opportunities (CFO, CNO, and lab, dietary, housekeeping, physical plant, human resources, and IT dept mgrs, etc.)

7 votes: Other services or benefits the CCAHN could make available to network members

5 votes: IT-EMR education, training, technical support, joint projects, etc.