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SPRING 2018 ISSUE

in this issue

events calendar

See Central OH HFMA website for complete details - www.centralohiohfma.org

All-Ohio Institute
May 23-25, 2018
Columbus Marriott Northwest

New Member Reception
August 23, 2018

Fall Conference
September 21, 2018
Nationwide Hotel and Conference Center

Holiday Gala
December 7, 2018
Crown Plaza at Nationwide

president's message

Dear Members,

It's hard to believe that this is the last President's message of my chapter year with only 10 days until the end of my term. As my term is coming to an end I thought it was a time to reflect on the successes the chapter has had this year.

Our sponsorship committee revamped our sponsorship levels and benefits to make it less complex. James Monroe the committee chair hosted several webinars to explain these changes to recurring and potential sponsors and address any concerns they had with the changes. The hands-on approach was well received by our sponsors, chapter leaders, and ultimately lead to winning a Yerger award for the success of the program.

At this time last year, the chapter leaders were very worried about our membership retention goal that was given to us by national HFMA. Lauree Handlon our membership committee chair was diligent in contacting non-renewing members and letting others on the leadership team know who had not renewed to see if other members had a personal connection with that person to get a better response. This effort showed as we met what we thought would be an insurmountable goal. Further our membership rose from 450 members in May 2017 to 628 in May 2018. Through the help of the membership committee and our board, we were able to find several new members who have been instrumental to the success of our events through the chapter year.

We also had several successes in the events this year. Our spring conference was changed from its normal format to a one-day conference focused on the opioid epidemic in central Ohio. John Ziegler lead the charge on this event and along with the support of his team they found many compelling speakers that attracted a full crowd that rated the event highly on the surveys. This was the 5th year of hosting a Women in Leadership conference and it was our biggest ever. In fact, Lynette Vermillion and her team planned such an attractive event that it drew 182 attendees, which made it, by far, the largest single chapter event the Central Ohio Chapter has ever hosted. We will be holding the first ever conference with all four Ohio chapters on May 23-25, which has been a goal of our chapter for the better part of ten years. Our incoming President, Patti McFeely, has been leading the charge on this event for our chapter along with Mary Laile and several others on the Programming Committee. Providers and sponsors have been talking about this event for nearly a year and based on the registrations this will be the last in the long line of successes this year. I can't talk about the events without discussing our Social Czar, Jeffrey Carranza, who has had another great year of finding us attractive venues for our events, while still making it cost effective.

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These successes are what made our chapter 1 of 11 in the country to achieve a 100% on their Chapter Balanced Scorecard this year. I know that without the spectacular effort and drive of the individuals mentioned above we wouldn't have achieved such lofty success. I truly appreciate the contributions to the chapter!

Thank you, all, for a great year!

Matt
Matthew (Matt) S. Rakay, CPA

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Members on the Move

Lynette Vermillion, our Past President of the chapter was featured in the HFMA National Spotlight in a video on the value of HFMA to her. Also, Lynette has become accounting manager for Riverside Methodist Hospital.

Jessie Thompson, Enterprise Project Management Office Director at Ohio Health has just joined HFMA and is looking forward to attending our local events.

Wendy Timmons, who was an HFMA member back in the late 80's and 90's, has rejoined HFMA as part of Ohio Health's Enterprise Membership. Wendy is in the Reimbursement Department, having moved into this department after the birth of her son, 11 years ago.

Jim Whitman, Director, Business Development for Red Apple Capital has joined our chapter

John Rodwell, Client Executive with Hylant has joined and looks forward to being involved. John is married with 3 kids (26, 13, 3) and they are currently fostering a 5-month old baby (the 3-year old's half-brother) who they are likely to adopt.

Ruby Sosa, has been in Healthcare for twenty years and recently completed a Masters in Healthcare Administration. Also, Ruby recently accepted a new position within OhioHealth as the OP-CDI Specialist/Charge Analyst for Grant Medical Center.

Stephen Saputra, Sr. Financial Planning Analyst with OhioHealth is working hard with the Central Ohio HFMA in the Communications Committee. Congratulations to Stephen on the birth of a baby boy, Even, on February 5th.

Randy Gabel has become the Sr. Director for the Revenue Cycle at OhioHealth. His area of responsibility includes Insurance Billing and Cash Posting.

Marty Dansack, has made it to Central Ohio having joined Mount Carmel in November 2017 as the VP, Financial Reporting and System Controller. Marty had previously been with Toledo based ProMedica for 18.5 years and was a member of the Northwest Ohio Chapter of HFMA.

Christine M. Parks, Revenue Excellence Reimbursement with Trinity Health has passed the second part of the CHFP

Women in Leadership Event Tops All

This year's event was not only the largest WIL conference we've held, it was the single most attended conference our chapter has put on to date! Thank you to all who attended for making it the great success it was!

Additionally, a big thank you goes to our sponsors. Huntington National Bank was the event sponsor. Along with being the event sponsor Huntington sponsored the reception afterwards. We had pens donated by Blue & Co. this year, lunch was sponsored by Credit Adjustments and the afternoon reception was sponsored by Arnett Carbis and Toothman.

Many attendees commented on how engaging the speakers were. The topics covered a wide range of relevant and relatable issues, providing attendees with actionable takeaways they can immediately apply to their own story. The energy of the speakers and guests alike have already spurred the programming committee to talking about next year!

Seven Steps to Maximize Electronic Health Record Adoption

LINDA BAILEY-WOODS

plante moran

Electronic health records offer advantages healthcare organizations need if they want to stay viable. But few providers realize the full potential of their EHR technology. These transformational steps can help ensure you maximize EHR adoption at your organization.

A doctor discussing a patients health chart on a tablet with two nurses.The past decade has seen a proliferation of electronic health record (EHR) technology. Healthcare organizations have made significant health information technology (HIT) investments of capital and operational expense, resources, and time. They've done this for many reasons, including to satisfy regulatory requirements, demonstrate meaningful use, comply with HIPAA, and share information through a health information exchange (HIE).

In addition, providers have invested and implemented HIT to realize the great promise: increased efficiency, staff reduction, improved physician satisfaction, better health outcomes and continuity of care, and decreased care costs.

The drive to realize these benefits is necessary for health systems that want to position their organizations to remain viable and succeed in today's fast-evolving healthcare environment. And yet, most organizations haven't seen the full breadth and depth of promised improvements with their EHR technology.

What's getting in the way?

There are many obstacles on the road to maximizing EHR adoption. Changes in payment methodologies, service delivery models, consumer engagement, and regulatory requirements all demand that providers change their approach for EHR to deliver a real return on investment. You can't trust the software vendor to drive EHR benefits realization. The implementation process must be orchestrated in tune with your strategic business plan and customized to facilitate your operations.

You cannot trust the software vendor to drive EHR benefits realization.

In addition to technical and funding issues, other broader organizational issues such as legal and policy, clinical, business and technical operations, universal workflows, maintenance and support and, most importantly, governance, all play a role in maximizing EHR adoption. In fact, these fundamental elements can galvanize nearly all EHR efforts, regardless of the particular product, to help realize latent potential.

Transformational steps to realize EHR benefits

Providers will have to work through the proper execution of the following seven transformational steps to maximizing EHR adoption and drive long-term success:

Provide adequate and effective EHR governance with active participation from all user constituents.
Develop an EHR funding model that incorporates the total cost of ownership and allowances for unanticipated costs associated with conversion revenue cycle issues, additional vendor fees for new modules or other technology requirements, and resource requirements.
Update EHR policies and procedures to support EHR workflows, functional and regulatory processes , the sharing of protected health information (PHI), and to meet PHI and HIE regulatory guidelines.
Define, assess, and test the technical infrastructure requirements with the EHR vendor.
Assess, consolidate, refine, and standardize clinical, business, and technical operations into universal workflows, and thoroughly vet these operations across the organization to stimulate end-user engagement.

Assess EHR security, HIPAA and HITRUST requirements. For any deficiencies identified, develop and execute a corrective action plan to address them.
Create a maintenance and support model in concert with your EHR implementation, and ensure the model is fully developed and in place at EHR activation.
These seven transformational steps aren't quick-hits; they'll take planning and time. But the return will be worthwhile, helping your organization maximize electronic health record adoption and make it a useful and effective clinical and business technology that supports the organization's strategic initiatives.

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Telemedicine and Fair Market Value – What You Need to Know

Chris W. David, CPA/ABV, ASA

Telemedicine (also known as telehealth) is a rapidly-evolving trend in the healthcare delivery space today. As the availability of medical providers decline and patient demand increases, many healthcare systems are searching for alternative solutions to traditional care models. Multiple studies have found that telemedicine can:

1. Provide access to care in underserved communities
2. Improve quality of care
3. Provide needed health education
4. Lower costs

The American Telemedicine Association (ATA) defines telemedicine as "the use of medical information exchanged from one site to another via electronic communication to improve a patient's clinical health status." Simply stated, telemedicine allows patients to connect remotely with physicians via phone or video conference to address healthcare concerns. This treatment method has been used for several years to conduct specialty consultations in rural areas with patients who have limited access to doctors.

Telemedicine health services are re typically divided into three categories:

1. Store and forward
2. Video conferencing, and
3. Remote patient monitoring.

Store and Forward

Store and forward technologies allow sensitive medical information, such as digital images, documents, and pre-recorded videos to be transmitted securely via email. This information can include X-rays, MRIs, photos, patient data, and even video-exam clips. Store and forward communications primarily take place among medical professionals to aid in diagnoses and medical consultations when live video or face-to-face contact is not necessary. Because telemedicine consultations do not require the specialist, primary care provider, or the patient to be available simultaneously, the treatment process is streamlined for the patient and the provider.

Video Conferencing

Video conferencing uses two-way interactive audio-video technology to connect users when a live, face-to-face interaction is necessary. Video devices can include video conferencing units, peripheral cameras, video scopes, or web cameras. Display devices include computer monitors, LED TVs, LCD projectors, and even tablet devices. Video conferencing is the most common form of telemedicine practiced today. It is a cost- effective tool for a variety of applications, including emergency room and intensive care unit support.

Remote Patient Monitoring

Remote patient monitoring (RPM) uses digital technologies to collect various forms of health-related data. Patients electronically transmit medical information securely to healthcare providers in a different location for assessment and recommendations. Monitoring programs collect a wide range of health data from the point of care, such as vital signs, weight, blood pressure, blood sugar, blood oxygen levels, heart rate, and electrocardiograms. Data is then relayed to monitoring centers in primary care settings, hospitals, intensive care units, skilled nursing facilities, and centralized off-site case management programs. Healthcare professionals monitor these patients remotely to provide care as part of their treatment plan.

Demand for Telemedicine

30% of Medicare payments are now tied to alternative payment models (APMs). The Department of Health and Human Services (HHS) plans to raise the percentage by 50% by the end of 2018. Many healthcare providers are looking for ways to increase quality of care and patient access while keeping costs down. The Medicare Shared Savings Program (MSSP) is an alternative payment model that recognizes telemedicine services as a clinical practice improvement activity, which is one of four components required for incentive payments. Physicians who provide patients with free equipment for remote monitoring are now eligible for fraud and abuse waivers under recent changes to the MSSP program.

With today's technology, a physician or mid-level provider can perform primary care consultations, psychiatric evaluations, emergency care, and other medical services remotely. At the same time, these new technologies create a cost-effective alternative to full-time physician employment. Telemedicine is especially attractive to rural health systems due to specialized physician access that is typically unavailable in these areas. Specialties, such as mental health, radiology, and dermatology are a few types of practices that are well-suited for telemedicine.

Telemedicine Reimbursement

Medicare

Medicare first began to reimburse telemedicine services after the Balanced Budget Act of 1997 was

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passed. As of January 2017, Medicare reimbursement only includes video conferencing services under very specifi¬c circumstances. Store and forward, or asynchronous services, is not permitted for reimbursement (except for federal telemedicine demonstration programs in Alaska or Hawaii, as stated by the Center for Medicaid and Medicare Services). Medicare claims for telemedicine services are billed using Current Procedural Terminology (CPT®) codes, along with the appropriate telemedicine modifier code "GT."

Medicare reimburses live-video conferencing telehealth services according to a model which includes an "originating site" and "distant site practitioner." The patient in need of care is located at the original site and the healthcare provider is located at the distant site.

In order to be reimbursed for video conferencing telemedicine, the patient must be located outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA). Additionally, Medicare limits the originating sites eligible to receive services through telemedicine to the following facilities:

- Provider offices
- Hospitals
- Critical access hospitals (CAHs)
- Rural health clinics
- Federally qualified health centers
- Hospital-based or CAH-based renal dialysis centers (including satellites)
- Skilled nursing facilities
- Community mental health centers

These sites are also eligible to receive a facility fee from Medicare to compensate for the use of their facility. A patient's home doesn't qualify as an originating site, in most cases.

The following list of distant-site providers qualify to deliver services via telemedicine through Medicare:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse midwives
- Clinical Nurse specialists
- Clinical Psychologists and clinical social workers
- Registered Dietitians or nutrition professionals

However, there is no limitation to the site where the healthcare provider chooses to practice telemedicine.

For telemedicine services provided in approved settings, healthcare professionals are reimbursed at 100% of the current non-facility fee schedule for the eligible service. Additionally, the originating site is eligible to receive a facility fee. The facility fee is billed under Healthcare Common Procedure Coding System (HCPCS) code Q3014 as a separately billable Part B payment.

Medicaid

Coverage of telemedicine services under Medicaid is determined on a state-by-state basis. The off¬icial policy indicates that states may reimburse for telemedicine under Medicaid as long as the service satisfies federal requirements of "e¬fficiency, economy, and quality of care." This policy enables states to have unique standards for what services they deem appropriate for reimbursement, which causes gaps in the system due to a massive lack of uniformity. This results in differing reimbursement policies for each state. Recently, the Center for Medicaid and Medicare Services granted states flexibility to define their own telemedicine policy. Similar to Medicare, video conferencing is the most common telemedicine modality that is reimbursed. As of January 2017, 48 states and DC were reimbursing for some form of live video telemedicine. However, there are often several restrictions on the type of provider, facility, service, or geographic location that can be reimbursed.

Reimbursement for the other two categories of telemedicine is less common. Store and forward is only reimbursed in nine states while remote patient monitoring is reimbursed in 16 states. There are often restrictions related to certain specialties and specific circumstances.

In addition to reimbursement to the healthcare provider, many state Medicaid programs provide a facility payment and in some cases, a transmission payment to cover the cost of connecting the patient to the distant site provider.

Private Payers

Private payers, such as Blue Cross Blue Shield, Aetna and Cigna are not required under federal law to provide coverage for any type of telemedicine service. For private payers that do reimburse for telemedicine services, there are no unique set of standards pertaining to insurance companies throughout the country. As of January 2017, 34 jurisdictions (including DC) have enacted (or will enact at a later date) laws that govern private payer telemedicine reimbursement. Some states mandate some sort of reimbursement, while others mandate reimbursement at the same level as in-person care under certain conditions. The existence of a state private payer law does not guarantee that all types of telehealth will be covered.

These laws often have restrictions, caveats, and limited applicability. These qualifying clauses may set up certain conditions where an insurer has the flexibility

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to restrict telemedicine reimbursement within their contract. For example, many states limit their coverage requirement to live video real-time interactions. Others include limitations on the location, facility type, condition treated, and eligible providers. Many private payer laws also often contain the caveat that telemedicine services must be covered, but make it subject to the terms and conditions of the contract between the enrollee and payer. This may set up certain conditions and situations providers and consumers should be aware of.

In the absence of a state law requiring telemedicine coverage, providers must carefully read the policies of each insurance company in order to determine whether or not they can be reimbursed for services delivered through telemedicine. Even when there is not a private payer law, some insurance companies still may pay for service.

Basic Model

As telemedicine continues to evolve, more health systems will begin forming remote care arrangements. A basic arrangement involves an originating site (usually a rural hospital) with patients in need of care and a distant site (usually a larger health system) employing or contracting with specialists who deliver care. This is a basic hub-and-spoke model which is illustrated below.

Under the hub-and-spoke model, the originating site refers their patients to the distant site for the specialized care they need. This model can be structured in two different ways:
1) The distant site would employ the physician on a full-time or part-time basis and the distant site hospital would bill and collect.
2) The distant site would enter into independent contractor arrangements with specialists to be on-call and provide certain telemedicine services when needed. The on-call physicians would provide the needed consult or service via the approved technology and subsequently bill and collect the professional fee. The distant site would collect a facility fee and possibly an additional data transmission fee to cover the telecommunication costs.

Fair Market Value (FMV) Concerns

Under scenario 1, the distant site facility simply employs the physician on a fulltime or part-time basis at a fair market value (FMV) compensation.

Under scenario 2, the dynamics get a little tricky. At first, the on-call arrangement appears to be very similar to a typical call arrangement for an emergency department. However, utilizing per diems reported in benchmark surveys to determine a telemedicine on-call rate is not exactly appropriate. It is important to remember that published call coverage data generally represents emergency department call coverage and will likely need to be adjusted when used for a telemedicine stipend calculation. Emergency department call coverage benchmarks typically consider the burden of responding in person to the emergency department to perform a consultation, surgery, or other procedure. In a telemedicine arrangement, the on-call physician can likely deliver the consult or examination at his home, office or over the telephone, which is much less burdensome than having to come into the emergency department. In this case, the per diem rates published in the compensation surveys should be discounted to account for the diminished burden.

In addition to the coverage stipend for availability, the on-call physician may be compensated a flat rate per consultation, exam, or an hourly rate. It's important to consider this component when analyzing the entire payment arrangement. For example, if a physician is going to be paid an hourly rate for his clinical time in addition to the per diem stipend, then the stipend may be a little lower. Or, if the physician is able to bill and collect for his professional services in a facility with a very favorable payer mix, then the daily stipend might be lower. However, if the physician does assume the risk of billing and collecting and the facility has a poor payer mix, then this factor would cause the daily stipend to be higher. Finally, the distant site would typically lease all the required hardware and terminals to the originating site at an FMV equipment lease rate.

Conclusion

Although the services offered under telemedicine arrangements may be similar to traditional on-call arrangements, determining the FMV of compensation for telemedicine requires a firm grasp of the legal and regulatory landscape surrounding these services. Providers are encouraged to consult with legal counsel when structuring a telemedicine arrangement. It is paramount to first have a proposed model or arrangement in place with a draft contract before seeking a third-party FMV appraisal. The appraiser needs to understand which parties will incur which costs and responsibilities in order to render a thorough and defensible FMV opinion.

By Chris W. David, CPA/ABV, ASA
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The redesigned CHFP Certification Program has officially launched and is now available for purchase on the HFMA website. The target audience has been broadened to include:

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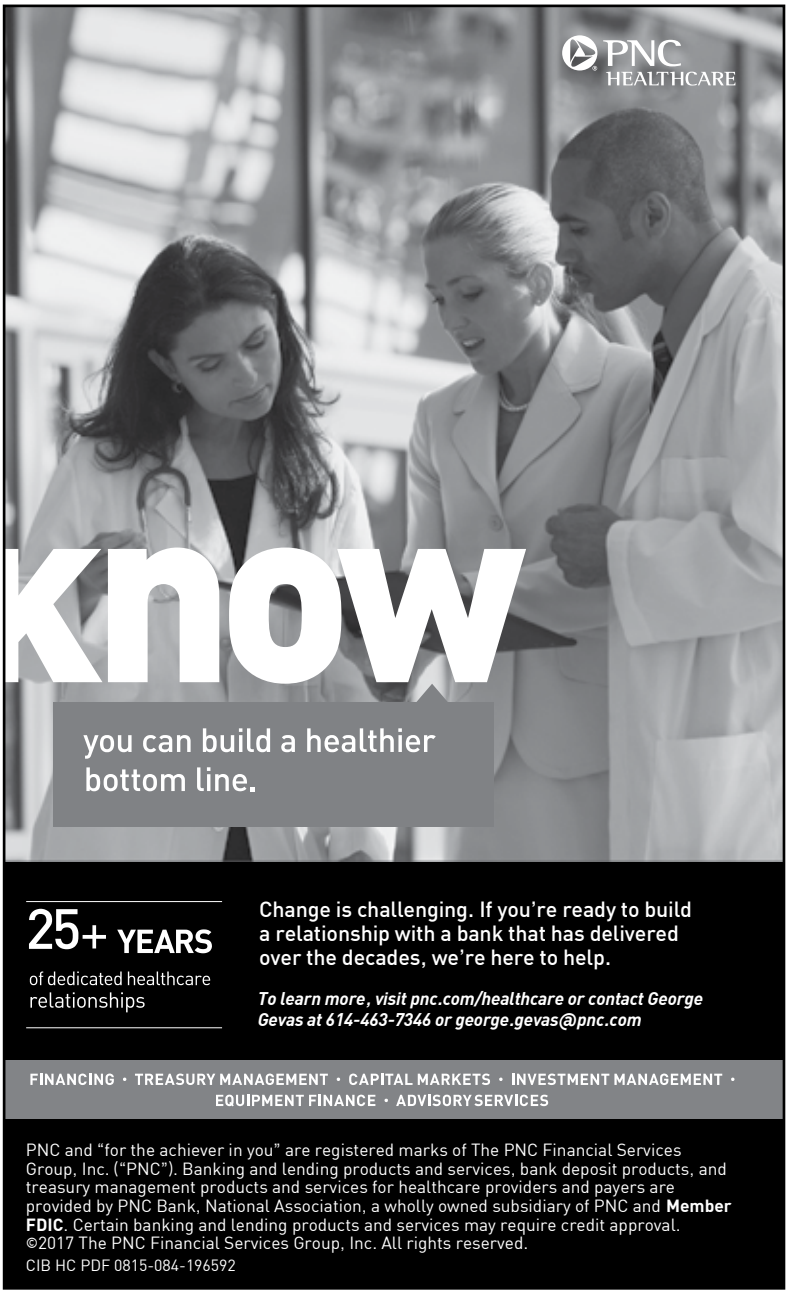

- **Module I:** HFMA's Business of Health Care - Healthcare environment overview, healthcare reform and evolving payment models, healthcare finance & accounting concepts, cost analysis principles, strategic financial issues, revenue cycle and the future of healthcare. This module contains a 75-question, 90-minute timed end-of-course assessment.
- **Module II:** Operational Excellence - Exercises and case studies on the application of business acumen in health care. This module is a 3 hour timed assessment.

Both modules are delivered via HFMA's e-learning platform on the HFMA website, so candidates will no longer need to travel to a testing location. Module I is now available to all members at a cost of $400. Upon successful completion of Module I, members may purchase Module II for an additional $300. There are no retake fees. However, both modules must be completed within a 24-month period to obtain the CHFP credential.

The Chapter has provided financial support for Members pursuing Certification in the past, and is currently evaluating how to best support the new Certification format. If you wish to be among the first to receive any updates, please express your interest in Certification to the Chapter Certification Chair, Brian Meinardi (brianme@fmchealth.org; 740-687-8048).

HFMA New Members

NEW MEMBERS SPRING 2018

Craig Larson
Park National Bank

Jeffrey Cook

Julie Houghtlen
OhioHealth

Timothy White
OhioHealth

Jamie Scroggins
Mount Carmel Health System

Jennifer Burchill
Trinity

Elijah Meyer
OhioHealth

Marcy Gifford
The Ohio State University

Somsavanh Chanthachoumpha
Mount Carmel Health

Charlene Kieffaber
Mount Carmel Health System

Chris Winiecki
Trinity Health

Mia Okinaga
OhioHealth

Raymond Romero
Mount Carmel Health System

Juan Du
Ohiohealth

Maresa Campbell
OhioHealth

Brittany Osborne
OhioHealth

Judith Davis
OhioHealth

Claudia Coleman
OhioHealth

Myron Raney
OhioHealth

Cindie Scott-Leach
OhioHealth

Jacquelyn Treadway
OhioHealth

Erica Ray
OhioHealth

Adam Long
OhioHealth

David Severance
Mount Carmel

Nicole Walker
OhioHealth

OhioHealth Marion General Hospital

Mary Alexander
OhioHealth

Kathy Adkins
OhioHealth

Rebecca Harlor
OhioHealth

Roxanne Poe
OhioHealth

Deborah Graves
OhioHealth

Jack Arthur

Jennifer Cade
Berger Health System

Kreigh Cook
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Randy Gabel
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Mindy Long
OhioHealth
Veda Greer-Ellison

Ruby Sosa
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Alexandra Kulp
OhioHealth

Yong Xia
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Andrew Widanka
OhioHealth

Ashton Shepherd
OhioHealth

Deborah Dingess
OhioHealth - Physician Group

Christopher Cornett
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Stephanie Alger
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Laurie Riegel
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Angie Dieringer
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John Dillis
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Sergey Girin
OhioHealth

Michael Udom

Nicholas Mills
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Brittany Elekes
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Francis Mwale
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Christopher Coen
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Kwadwo Amankwah
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Patricia Short
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Brent Phillips
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Christina Inkrott
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Jeanne Heinmiller
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Laura Rolland
OhioHealth

Matthew Chizmar
OhioHealth

Patricia Bookmeyer
OhioHealth

Wendy Timmons
OhioHealth

Scott Sprankle
OhioHealth

Donna Tiller
OhioHealth Marion General Hospital

Douglas Swayne
OhioHealth

Kelly Hale
OhioHealth

Cheryl Miller
OhioHealth

Mike Reichfield
OhioHealth Doctors Hospital

Brett Maynard
Mt. Carmel Health System

Gary Blair
OhioHealth

Gayle Hamilton
Mount Carmel Health System

Jacob Blank
Ohio Health

Kara Marquardt
Berger Health System

Holly Whittaker
OhioHealth

Steven Falasco
Mount Carmel Health System

Dot Stewart
Mount Carmel Health System

Abigail Hartung
OhioHealth

Curt Niekamp

Melissa Pickelheimer
OhioHealth

Kathy Spencer
OhioHealth

Jim Whitman
Red Apple Capital

Lee Petty
Ohio Health

Angela Hasley
Memorial Health System

Arlene Gattshall
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Julia Iaconis
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Morgan Hojnacki
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Dawn Buck
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Shannon Troutman
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Jessie Thompson
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Betsy Freese
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Julie Novotni
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KPMG

Eric Miller
MedComm Billing Consultants

Christopher Ortlieb
Ohio Health

Renee Hoschak
OhioHealth

Kathleen Stallard
OhioHealth Marion General Hospital

Sheri Meier
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Beth Armstrong
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Michelle Jolley
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Jacob Lowe
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Kevin Ridenbaugh
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Will Sharp, partner
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Dawn Stark, partner
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member spotlight: Dustin Kiaski

Name: Dustin (Dusty) Kiaski

Organization: Mount Carmel Health System

Position: Senior Financial Analyst

Hometown: Massillon/Jackson, Ohio

College: Otterbein University

First Post-Collegiate Job: Financial Analyst at NiSource

HFMA Experience: I have been a HFMA member for almost a year, and have recently become involved with the Central Ohio Chapter leadership team. I will serve as Co-Sponsorship Chair for the upcoming fiscal year alongside James Monroe. I also served on the planning committee for our All-Ohio event. I attended a mini LTC, networking events, the 2017 Holiday Gala, the Women and Leadership conference, and traveled with the leadership team to New Orleans for the National Leadership Training Conference (LTC). I have had an extremely positive experience with HFMA thus far. The organization serves as a means to knowledge sharing, networking, and building strong relationships – which I find extremely valuable. I am excited to see what the future holds for our chapter and for the HFMA organization as a whole.

Great HMFA Memory:
When traveling to New Orleans with our chapter's leadership team, I experienced first-hand how HFMA is home to many impressive finance and healthcare leaders from across the country. I enjoyed my time at the conference and learned a lot. Outside of the actual conference, our team enjoyed the liveliness and culture of the city. Through this experience, I made new friends and connections that I know I will have for many years to come.

If someone wrote a biography about you, what do you think the title should be?
The adventures of Mr. Chipper

What do you enjoy most about working in healthcare?
My wife works as a labor and delivery nurse. I love that we work in the same industry, even though our jobs are so different. We share stories and terms to help each other further understand the vast world of healthcare.

Aside from your busy work schedule, what else keeps you busy?
I played soccer through college and continue to play in men's leagues and coed leagues throughout the year. I am currently coaching three and four-year-old soccer players, which is the most stressful but rewarding part of my week! My other interests include lifting weights, playing basketball, playing music, and spending time with my family, friends and three-year-old goldendoodle.

What is your favorite vacation spot?
My honeymoon in St. Lucia was absolutely my favorite vacation to date.

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At OhioHealth, you'll find that we're making a difference. Together, inclusion and equal opportunity make us great.

Spring Conference Enters New Topic Territory Illuminating the Opioid Crisis Complexity

This March the Spring Conference stepped off the typical path for conference topics and devoted an entire day to looking at the opioid crisis in Ohio from multiple perspectives. Dr. Jeannine Abbott started the morning explaining how we got to this point. She shared how the body chemistry is changed when using opioids and who the prescribing of opioids became the norm. Dr. Abbott had the audience participate in an exercise where members started by standing and then were told to sit down as they were asked about knowing someone, or knowing of someone, impacted by opioids. No one was left standing.

We had the Franklin County Coroner, Dr. Anahi Ortiz, share statistics on the pervasiveness of the problem. Then we had the morning panel discussion with front line perspectives from the State Fire Marshall, the Whitehall Fire Marshall, the Chief of Addiction Policy from the City Attorney's Office and the CEO of the ADAMH Board.

While we ate a lunch, we had representatives from various community support agencies share the missions of their organizations in helping those affected.

The Afternoon continued with a round table discussion involving the CFOs of Mount Carmel, Paul Morris, and Ohio Health, Vinson Yates. From there the focus was on what is being done to help those in need in the community and we had powerful, personal stories from Wayne Campbell, CEO and Founder of Tyler's Light as well as Pastor Jeff Gill. We then finished with a panel discussion focusing on coordinating the effort that included the pharmacist perspective, alternative pain management solutions and what is being done in ERs.

We finished with a chance to network in the lounge area that was well attended.

The feedback was fantastic. So, we are encouraged to continue to stretch ourselves looking for new topics that the membership would like to have covered.

Thank you, again, to our event sponsor, Mount Carmel, to our lunch sponsor, Blue and Co. and reception sponsor, Cleverley & Associates.

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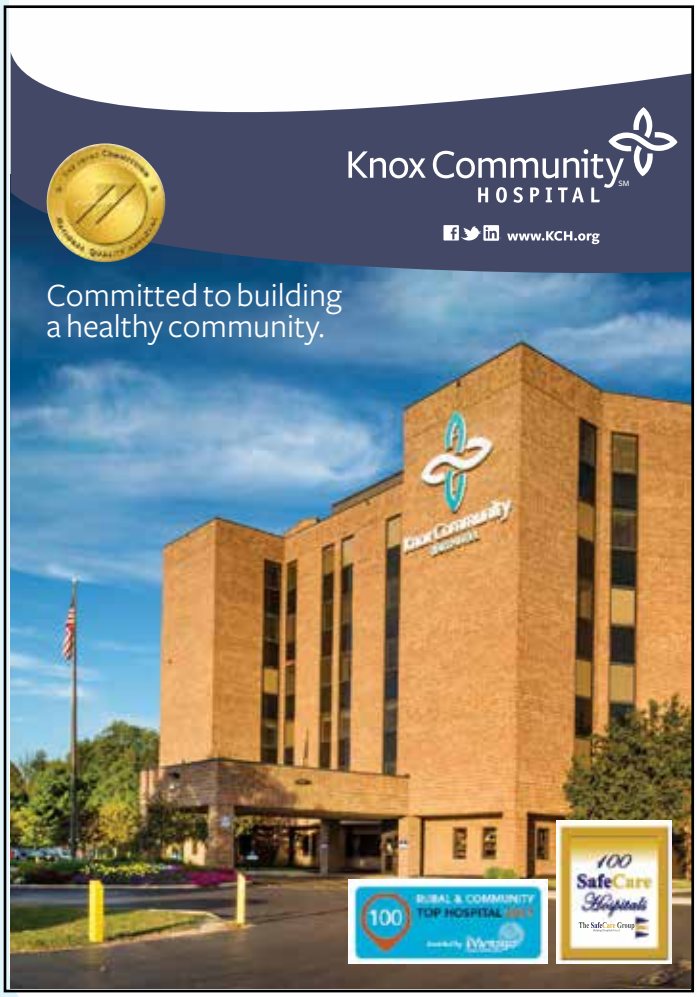
REGIONAL WEBINAR

Eastern MI Chapter Presents: Review of FY 2019 IPPS Proposed Rule. May 31, 2018 at 10:00 AM EDT.

The link to register is as follows - https://register.gotowebinar.com/register/6210896384360754177

Speaker Bio: Vickie Kunz:
Vickie is senior director, health finance in the MHA Policy Division. Since joining the MHA in August 2001, Vickie's efforts have been focused on health policy issues for the major payers, primarily Medicare and Medicaid, including hospital reimbursement, wage index and the quality assurance assessment program (QAAP).

Prior to joining the MHA, Vickie was a reimbursement specialist at Sparrow Health System in Lansing. She began her career in the reimbursement department of Hospital Corporation of America (HCA) in Nashville, TN, and worked there for nine years before relocating to Michigan in 1998. Vickie has a BBA in Accounting from Belmont University in Nashville.



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Comments, suggestions, articles?

Do you have comments or suggestions regarding the Central Ohio HFMA newsletter,programming ideas or other chapter matters? Have an article you would like to see published in a future newsletter? We would love to hear from you. Please send all correspondence to John Ziegler at john@ambsw.com.

More new members

Derrick Turner
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OhioHealth Marion General Hospital

Amanda Crosthwaite
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