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WINTER 2017 ISSUE

in this issue

events calendar

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

OHA Annual Conference
June 2017

New Member Reception
July/August 2017

OHA - Medicare Update
August 2017

Tri-State Event
September 20-22, 2017

Accounting and Auditing Update
November 2017

OHSCPA Event
TBD

Holiday Gala
December 2017

president's message

Income statement analyses, balance sheet reconciliation reviews, multiplication tables test prep, science project, Valentine's Day cookies … I could go on. Work life has me slammed. Parent life keeps me hopping. Volunteer life? How can I possibly fit one more thing onto my plate?! Well some days I really don't know the answer, other than Because I choose to. I want to. I know it's the right thing to do – for myself and those relying on me. All three facets of my life are very important to me, serve me in different ways, and also allow me to give back in different ways.

The truth is, you figure it out. We all have to find that balance between what others need from us and what makes us happy. I heard someone explain once that it isn't as much a "balance", because all parts don't get the same level of attention all at once. It's more of a work life juggle, or integration. Some moments demand full attention to your family – i.e. a child is ill. Some moments demand full attention to your work – i.e. a deadline is coming that cannot be missed. It's a juggling act because it requires give and take. You can't be everything to everyone in your life all the time. Let me say that again: YOU CAN'T DO EVERYTHING.

The only thing we can all do, is give it our best, in that moment. Nothing more, and we should give nothing less. I say all of this because I'm going to go out on a limb here and contend that I am not the only one who beats myself up for overextending and falling short of accomplishing everything I want. But we must never give up. If the work is something you are passionate about, or at the least something you deem to be important to you and yours, you will find a way. The same is equally true when adding volunteerism to your life. Don't let a hectic schedule hold you back from throwing your hat in the ring. If you want to participate in an organization, do it. Sure, be aware of over-committing and wade into the role slowly, but don't avoid it entirely for Pete's sake. Get out there and be active in what matters to you, fellow members! These are the things on the mind of your current chapter President.

Sincerely,

Lynette Vermillion
President, Central Ohio HFMA Chapter
Lynette.Vermillion@ohiohealth.com

Membership Benefits: Fun at the Holiday Gala!

The True Cost of Non-Compliance

SAUD JUMAN

With the constant emergence of new standards and regulations across all areas of health care, hospital and health system leaders are working hard to ensure that they have effective compliance programs in place. Compliance is an active process that entails staying abreast of regulations, maintaining relevant policies and procedures, implementing continuous training and professional development, and dealing with discipline and breaches when necessary. The process is arduous, but the consequences for noncompliance are exponentially worse.

According to a 2014 survey, about one-third of healthcare providers estimate their total annual budget for compliance to be $1 million to 5 million.a Thirty-eight percent state that their compliance budget has increased in the past year, and 52 percent state that it has stayed the same. The cost of compliance makes a compelling argument for investment in a strong program. Across industries, a compliance program costs about $222 per employee, versus the $820 per employee for non-compliance.b Two factors are responsible for the high costs in the latter case: poor patient outcomes and litigation.

Costs of Poor Patient Outcomes

A 2010 study examined the costs of Methicillin-resistant Staphylococcus aureus (MRSA) infections among patients who acquired the infection as a result of a nurse's lack of compliance with a hand hygiene policy.c The study found that a 200-bed hospital incurs $1,779,283 annually in MRSA-infection-related expenses, directly attributable to hand hygiene noncompliance. A 1 percent increase in hand hygiene compliance resulted in annual savings of $39,650 for the hospital.

Costs of Litigation

In 2014, New York-Presbyterian Hospital and Columbia University paid a combined $4.8 million to the Office of Civil Rights (OCR) to settle a 2010 HIPAA violation. The breach occurred when a physician tried to deactivate a personal computer that was connected to the hospitals' shared network. The protected health information (PHI) of 6,800 patients, including vital signs, medications, and lab test results, was compromised. The OCR's investigation found that neither hospital had conducted an adequate risk assessment or documented a risk management plan for their IT systems that access PHI. Neither did NewYork-Presbyterian Hospital have appropriate policies and procedures in place for authorizing access to its database. The hospitals paid the settlement, and both agreed to a corrective action plan.

In addition to the financial costs of noncompliance, there are intangible costs as well. A lack of compliance can lead to a loss of accreditation, resulting in a detrimental impact on the hospital's reputation. If a provider has had a breach of PHI of more than 500 residents of a state, media outlets must be notified, further damaging a hospital's reputation and potentially bringing about a loss of trust among patients, staff, and the wider community. Recent research found that 65 percent of patients would consider changing providers after a HIPAA data breach.d

A well-organized approach to managing compliance is the most critical component to mitigating risk exposure. Over the past five years, both the industry and most leading analysts have deemed effective compliance programs and strategies such as policy management to be the nucleus of a sound governance, risk, and compliance strategy.

Implementing an electronic, cloud-based policy management program is one proactive method to invest in compliance. Such a system can aid a hospital each step of the way, from writing policies and procedures that reflect current standards and regulations, to training and disciplining employees, and managing breaches. There are, unfortunately, no shortcuts to executing an effective compliance program. It requires continuous monitoring, evaluation, and improvement. But in today's healthcare environment, an investment in compliance pays off in spades.

Saud Juman is the President and CEO of PolicyMedical in Richmond Hill, Ontario, Canada.

Key Questions Focus Attention on Healthcare Real Estate

By Sydney Scarborough

PROPERTY, PLANT, AND EQUIPMENT OCCUPANCY COSTS ARE TYPICALLY THE THIRD LARGEST OPERATING EXPENSE AND REPRESENT ALMOST 40 PERCENT OF A HOSPITAL'S BALANCE SHEET. REDUCING THEM NOT ONLY IMPROVES FLEXIBILITY, BUT FREES UP MORE FUNDS FOR CLINICAL IMPROVEMENTS.

The Affordable Care Act (ACA) has had considerable financial, operating, and regulatory impact on hospitals and health systems. There is no real dispute among executives to its influence on patient accessibility. Yet there has been little attention paid to its effect on providers' real estate portfolios.

The following are critical issues and trends related to the ACA and important questions to ask from a real estate perspective.

THIS IS A SAMPLE ARTICLE FROM HFMA'S STRATEGIC FINANCIAL PLANNING NEWSLETTER.

Reimbursement Changes and Cost Control

A variety of factors are converging to change healthcare payment processes and generally lower rates from Medicare/Medicaid, the public and private exchanges, and commercial payers. There is an unprecedented need to restructure healthcare organizations to meet demands by consumers, employers, and the government to provide greater value, but at a lower cost.

Property, plant, and equipment occupancy costs are typically the third largest operating expense and represent almost 40 percent of a hospital's balance sheet; so they impact finances tremendously. Reducing them not only improves flexibility, but frees up more funds for clinical improvements.

Healthcare organizations are collaborating and forming alliances to increase purchasing power, consolidate services, and cut costs. The same can be done for real estate. By streamlining and restructuring operations through centralization and standardization of real estate practices and processes, providers can reduce risk and increase efficiency.

For example, Adventist Health developed a strategy to reduce the number of vendors for soft services (e.g., environmental services, security, grounds/landscaping, linen, and supplies) by partnering with vendors who are leaders in their respective industries. Adventist Health's spend for these soft services is approximately $60 million annually. By building a consistent program in each area with the same protocols, products, and methods, the health system will not only achieve a 15-25 percent savings when fully implemented, but quality will improve and compliance risks will decrease.

With 545 properties spread across four states, there are some instances where a single vendor is not practical for Adventist. For example, there is not a single vendor who can service all four states for linen services. Yet by regionalizing linen services, a 13 percent savings has been achieved.

Healthcare finance leaders should consider the following questions regarding their real estate cost control:

Can you document what your system spends on occupancy costs? Occupancy cost—or the total of all space expenses associated with operating and maintaining owned and leased properties—is rarely well tracked because these costs are dispersed across multiple cost centers and buried in other operating costs.

Are we managing our portfolio in a consistent fashion across all locations? Too often, especially in the

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wake of expansion through mergers and acquisitions, real estate management is inconsistent. Managing a portfolio in a centralized manner with established best practices can reduce waste and variability. These best practices include:

- A culture of ongoing innovation
- Functional operational risk management programs
- Consistent procedures throughout the provider's system and at each facility location
- Empowered employee work groups to drive service delivery improvements
- Annual operations audits of safety performance

Are we partnering with facility/project management organizations for services outside our core competency? Looking beyond common vendors, such as food service and cleaning, to experts who can drive value in facility management, lease administration, transaction services, and project management can bring state-of-the-art technologies, processes, systems, and personnel to the organization.

Capital Allocation Challenges

The past decade has seen fierce competition for available healthcare capital. Potential uses all are compelling: investing in medical equipment technology, acquiring leading edge electronic health record systems, updating or replacing aging hospital infrastructure, and others. Compounding the problem, some investor analysts have assigned the healthcare sector a negative outlook since 2008. This makes it even tougher for hospital leaders to acquire capital at the best rates.

With negative outlooks from the traditional bond market analysts, many hospital executives have been limiting real estate investment to critical infrastructure maintenance and improvement programs. This has resulted in a steady increase in the average age of plant. From 2011 to 2014, the median age of hospitals increased from 10.5 to 11.3 years, according to data reported in the February 2015 hfm magazine. Any level at or above the 10-year mark is a concern to rating agencies.

Even if a system offers the latest medical technology and treatments, patients will take notice if the buildings housing them are aging and not well maintained. Health care is becoming much more retail focused. The front door matters.

Some alternative financing options are available, such as credit-tenant leases and sales of real estate assets. Developing relationships with healthcare real estate investors can pay off.

- Healthcare real estate investors appreciate the stable income-producing qualities of healthcare real estate.
- Healthcare real estate offers higher investor returns relative to other traditional property types (i.e., office, industrial, retail). For example, on a particular day earlier this month, public healthcare REIT dividend yield was 5.49 percent versus office/industrial REIT dividend yield at 4.72 percent, according to a recent update from Dividend.com.
- Continued low interest rates help fuel increased pricing.

Healthcare finance leaders should ask the following questions related to capital allocation:

Have we done a thorough risk assessment of our capital assets? What is their serviceable life expectancy? What is the risk of equipment failure?

Is the look of our facilities consistent with the level of our services? Does it convey the message we desire to patients?

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Are our environments comfortable and inviting for both patients and staff? A clean, safe, pleasant working environment adds to patient and employee satisfaction and can have an impact on HCAHPS patient satisfaction scores.

Have we considered real estate financing options to increase capital availability? Some alternatives include owning with mortgage debt, owning with tax-exempt debt, tax-exempt synthetic leasing, long-term sale leaseback, joint venture, and build to suit to own or to lease. Considerations will include cash proceeds, the cost of capital, ease of completion, control, and flexibility.

Consumer Choice

Consumers are exerting more influence on healthcare purchasing decisions due to changes in the reimbursement model. Convenience of location and facility appearance will play a role in these decisions.

Like other consumer services, healthcare systems will be measured on the basis of overall value as a combination of quality, price, and location. The "look and feel" of a hospital—which often takes a back seat to the focus on medical attention—will drive consumer decisions. Hospitals and health systems are evaluating their appearance to be perceived as leading edge, accessible, and easily identified by patients.

For example, Reliant Medical Group in central Massachusetts used a strategic real estate assessment to develop a real estate plan for the group's primary care operations. The plan included the following objectives:

- Evaluating the performance of facilities and identifying opportunities to better use capacity
- Measuring the system's readiness to handle an increase in patient visits
- Determining if the current locations were optimal for serving the current patient base and identifying future locations needed to serve targeted growth areas

The analysis revealed variances in performance across the group, as well as opportunities for growth within the existing facilities. Reliant developed a three-pronged strategy to address future growth:

- Leverage the current network, filling it to capacity before adding new space.
- Secure new markets in selected additional sites and expand into growth markets to the greatest extent possible, while remaining on REIT leases at some present locations for several years.
- Consolidate current locations into optimal site configurations as leases expire or—worst case—renegotiate.

Healthcare finance leaders might ask the following questions related to improve patient satisfaction:

Where do we realistically stand in terms of quality, price, and convenience versus our competitors? A thorough inventory of your current locations relative to your competitors and population demographics is a starting point. Location intelligence services offered by healthcare real estate firms can provide data and analysis.

How does this align with where we want to be? In essence, what is our system's brand, and what do we want to be in the minds of consumers?

How convenient are our access points to our target market? For example, for patients with chronic illnesses, are physical locations close enough to the community served so patients with chronic illnesses don't have to travel long distances?

Targeted Attention

Your organization's real estate deserves close scrutiny because it is a major factor in supporting your operations and mission. Asking the questions above will help tighten the focus on this important area.

Sydney Scarboroughis managing director, JLL, Chicago, and is a member of HFMA's First Illinois Chapter.

The Essential Elements of CJR

By Maria C. Miranda, FACHE, Director of Reimbursement Services, BESLER Consulting

Introduction

While the Comprehensive Care for Joint Replacement (CJR) program is positioned as a "test," given the infrastructure being put in place by CMS to run the program, CJR is likely just the start of a larger effort by CMS to implement additional mandatory bundled payment programs. Therefore, it's very important that hospital financial stakeholders become familiar with CJR even if their hospital isn't currently a participant.

Program Summary

The Comprehensive Care for Joint Replacement (CJR) bundled payment model is effective April 1, 2016 and is set to continue through five performance periods ending on December 31, 2020. CMS is implementing this model via its authority under section 1115A of the Social Security Act as modified by Section 3021 of the Affordable Care Act, which established the Center for Medicare and Medicaid Innovation (CMMI). CMMI was created to test new payment and service delivery models with the goals of reducing CMS program expenditures while maintaining or improving outcomes.

CJR will test a new bundled payment model for inpatient lower extremity (i.e. hip and knee) joint replacements.

Unlike voluntary programs such as BPCI, with few exceptions participation in CJR is mandatory for hospitals in 67 selected MSAs.

CJR Episodes

A CJR episode starts with admission of an eligible beneficiary for an LEJR procedure ultimately discharged under one of the following two MS-DRGs:

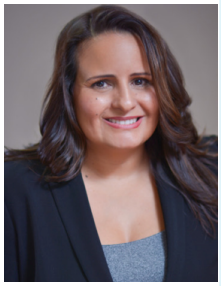
- MS-DRG 469: Major Joint Replacement or Reattachment of Lower Extremity with MCC
- MS-DRG 470: Major Joint Replacement or Reattachment of Lower Extremity without MCC

CMS refers to these two MS-DRGs as "anchor MS-DRGs."

The episode also includes all related Medicare Part A and Part B care for 90 days after discharge. This includes additional hospital stays, care received at SNFs and other post-acute providers, physician visits, physical therapy, etc. unless the provided service is on a CMS exclusion list.

The day of discharge counts as the first day of the 90 day post-discharge period.

CMS will exclude subsequent unrelated hospital stays from the episode based on MS-DRG.



Similarly, CMS will identify unrelated outpatient care based on ICD-9 / ICD-10 code. CMS will update the lists for both exclusion types on an annual basis, at a minimum, during the CJR program. The exclusions will apply to the calculation of both target prices and episode spending.

Target Prices

CMS uses three years of historical data to set target prices. The historical data will be updated every other year during the program. Both hospital-specific and regional data is used. Regional pricing is included in the calculations to provide gainsharing opportunities for hospitals that are already well-performing.

CMS will provide hospitals with a number of target prices for each performance year, segmented by MS-DRG, presence of hip fracture and submission of optional quality data. In addition, since CMS will normalize prices based on various IPPS and OPPS program changes (which go into effect on 10/1 and 1/1 of each calendar year, respectively), CMS will further distinguish target prices for episodes initiated between January 1 and September 30 vs. episodes initiated between October 1 and December 31.

CMS applies a discount factor to the target prices, which is Medicare's portion of the reduced expenditures from the CJR episodes.

Episode Spending

CMS calculates the spending for an episode by summing payments for qualified hospitalizations under MS-DRG 469 and 470 and all subsequent related Part A and Part B care for 90 days post-discharge.

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Regional Executive Spot

We are well into 2017 at the point you are reading this, and my year as RE is quickly coming to a close. I am excited about the decisions your Regional Executive Council made this past fall regarding benchmarks for the 2018-19 chapter year. I think they are in keeping with the strategic direction of National, and they make sense at the local level. If you are one of the chapter leaders, you will be hearing the full details at LTC. And after LTC, your leaders will be bringing back plans and strategies to support and service all members.

The role of the Regional Executive is changing a bit and will continue to do so, as the definition of chapters and regions evolve. As such, the nomination process for the 19-20 RE is different. In the past, our region had a seven-year rotation plan. A chapter could nominate a person for the RE position only when it was their turn. That process has worked fairly well, but isn't optimal. For instance, I would have preferred to have served as RE right after I finished the role of President for NW Ohio, not four years later when our chapter came up in the rotation.

To that end, there is no longer a rotation. There is a job description with requirements. If you feel you meet these requirements and would like to serve as a Regional Executive, please contact your chapter President and President-elect. They will send names on to Amy Bilyea, our RE2, and me for review. We will set up interviews and have discussions with all interested people. The Presidents and President-elects will vote and finalize the nomination at LTC.

I would encourage anyone who has been a chapter president in the past to consider serving as a Regional Executive. It has been a wonderful opportunity to understand more from a national perspective and to network with other leaders from across the country. The ideas and sharing have been fantastic. If you are committed to HFMA and to professional growth, this may indeed be a great fit for you.

Take care,
Dawn Balduf
Region 6 Regional Executive

2016 – 2017 Central Ohio HFMA

Officers and Committee Chairs

Officers:

Board Chair - Mary Laile
President - Lynette Vermillion
President-Elect - Matt Rakay
Secretary - Patti McFeely
Treasurer - Jeffrey Carranza

Committee Chairs:

Communications - John Ziegler & Saurabh Sharma
Membership - Lauree Handlon
Sponsorship - James Monroe
Programming - Mary Britton & Aaron Fields

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HFMA.ORG/MGAM

March 23 & 24, 2017

SAVE THE DATE

FOR OUR ANNUAL SPRING CONFERENCE

Embassy Suites by Hilton – Columbus Airport
2886 Airport Drive, Columbus, Ohio,

Thursday March 23rd

Central Ohio HFMA Presents:

Finance and Accounting Hot Topics Day: including keynote speaker Kevin McCarthy *"The BlindSpot Zone"*

Friday March 24th

Central Ohio HFMA and COPAM Presents:

Revenue Cycle Hot Topics Day

hfma central ohio chapter
healthcare financial management association

COPAM
CENTRAL OHIO PATIENT ACCOUNT MANAGERS
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Quality Measures

CMS is implementing a composite quality score to detemine eligibility for reconciliation payments and to potentially reduce the discount factor applied to episode spending when determining the amount of repayment or reconciliation payment.

The composite quality score is based on three weighted measures:

• Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty (THA) and / or total knee arthroplasty (TKA)
• Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
• THA/TKA voluntary patient-reported outcome and limited risk variable data submission

Reconciling Payments

After each CJR performance year, CMS will perform a retrospective reconciliation of CJR episode spending compared to the target prices by calculating the Net Payment Reconciliation Amount (NPRA). The NPRA is the sum of the amounts above and below the target price for each CJR episode in the performance period.

If the final NPRA is below zero, that amount is paid to the hospital as a "reconciliation payment" as long as the hospital meets a minimum composite quality score. If the NPRA is above zero, that amount is owed to CMS by the hospital as a "repayment amount."

Hospitals will not be responsible for any repayment amount due for the first performance year, but may earn reconciliation payments for all performance years.

Data Sharing

CMS will provide detailed and summary claim and payment data related to CJR episodes to participant hospitals so that they may better understand their target price calculations and operational performance and identify areas for improvement.

Financial Agreements with Other Providers

Since CMS considers care coordination critical for successful LEJR outcomes, they are allowing CJR hospitals to establish risk-sharing and gain-sharing relationships ("sharing arrangements" described in "collaborator agreements") with other providers ("CJR collaborators").

When risk-sharing payments are made to a hospital by a CJR collaborator, CMS refers to the payment as an "alignment payment." A hospital that shares a reconciliation payment with a CJR collaborator makes a "gainsharing payment."

Waivers

In order to make the implementation and operation of the CJR program more efficient and potentially more effective, CMS is introducing a number of program waivers related to home health visits, telehealth and the SNF 3-Day Rule.

Conclusion

Providers should be working now to proactively identify areas of risk under CJR and put a program in place that measures their ongoing performance.

A special report is available at besler.com/cjr that further explains how CJR works and expands on the responsibilities of participating providers.

About the Author
Maria Miranda is the Director of Reimbursement Services. Maria has 25 years of progressive experience in healthcare administration and is a longstanding member of the Health Care Financial Management Association and a Fellow of the American College of Health Care Executives. Maria holds a Bachelor of Science degree in Health Care Administration from St. John's University and a Master of Public Administration in Health Services from Fairleigh Dickinson University.

New HFMA CHFP Certification Program Available Now!

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:

- **Professional Staff – new to healthcare/early careerist**
- **Management – experienced, seeking to advance career**
- **Executive – experienced, need to develop staff**
- **Those who aspire to be managers, leaders in healthcare roles, clinical and non-clinical providers, vendors, and payers.**

Certification is now a learning program designed to build comprehensive industry understanding and sharpen business skills. The program consists of two learning modules:

• **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).

The Central Ohio HFMA Chapter Presents

2017 Women In Leadership

SAVE THE DATE
04.20.17

The Medallion Club – 5000 Club Drive, Westerville, OH 43082, 43219

HFMA New Members

NEW MEMBERS WINTER 2017

Christine Chrysler
OhioHealth
Parent Controller

Sarah Fahl
OhioHealth
Senior Financial Analyst

Ashley Jones
Blue and Co., LLC
Audit Manager

Walter Kalosi
OhioHealth
Staff Accountant

Jimmy Kuhn
OhioHealth
Budget Finance Coordinator

Benjamin McBride
OhioHealth
Senior Accountant

Kinal Patel
Squire Patton Boggs (US) LLP
Associate

George Reed
OhioHealth
Sr. Business Systems Analysyt

Nikki Stone
Mary Rutan Hospital
Manager, Patient Financial Services

Teresa Turnbull
Medone Hospital Physicians
Director, Finance and Accounting

Abu Ullah
OhioHealth
Manager- Revenue Cycle Financial Reporting

Greg Uszak
OhioHealth
Tax Analyst

Melissa Weiner
OhioHealth
Finance Coordinator

Jacob Wethington
Blue and Co., LLC
Senior Accountant

Ron Whitby
OhioHealth
Lead Business System Analyst

Siyu Zou
OhioHealth
Financial Analyst

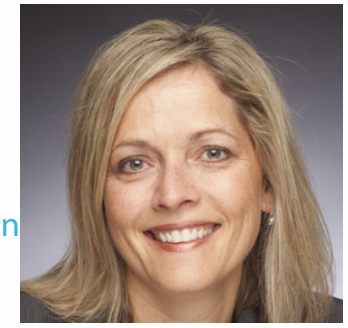
Regional Webinars

March 21, 2017: Home Health & Hospice Balance Sheet Test best practices (1 p.m.)

April 12, 2017: Navigating the World of Self Pay Collections (12-1 p.m.)

March 30, 2017: Ohio Medicaid: State Innovation Model Update (12-1 p.m.)

member spotlight: Jackie Nussbaum



Name: Jackie Nussbaum
Organization: BKD, LLP
Position: Director
Hometown: Westerville, Ohio

College: Undergraduate: James Madison University, Harrisonburg, VA; Graduate: Xavier University, Cincinnati – Master of Healthcare Administration

First Post-Collegiate Job: Budget Analyst, University of Maryland Medical System (Baltimore, MD)

HFMA Experience: I joined HFMA in 1997. I've been a member of the Central Ohio Chapter since 1999. I've served as Board member (currently serving for the second time), President, President-Elect, Secretary, and Sponsorship Committee chair.

Great HFMA Memory: I have a lot of great HFMA memories, but one that I'm most proud of is being part of the committee to bring the first Women in Healthcare conference to the Central Ohio Chapter. This year will be the fourth year for the event (now called Women In Leadership). It's such a terrific event and it's been an honor working with the planning committee to bring such high-caliber, impactful speakers to the members of our chapter.

If someone wrote a biography about you, what do you think the title should be? So Far, So Great!

What do you enjoy most about working in healthcare? As a consultant, I love collaborating with my clients to find solutions to the complex and continuously changing issues they are facing. There is never a dull moment in healthcare and I am energized by the fast pace and the dedication my colleagues and clients have to our profession.

Aside from your busy work schedule, what else keeps you busy? These days, my life pretty much resolves around whatever my kids are doing. My son is a high school freshman playing basketball and baseball and my daughter is a sixth grader who is very involved with dance. While I spend a lot of time driving them around and attending their activities, I still manage to have fun with family and friends as well as my new workout obsession, Orange Theory Fitness.

What is your favorite vacation spot? For the past ten summers, we have been going to the Outerbanks (Corolla, NC) with my husband's family. It's such an amazing time to relax and reconnect with my family.

National Webinars

FEB 14	AN OVERVIEW OF THE OFFICE OF INSPECTOR GENERAL'S 2017 WORK PLAN
FEB 28	HEALTHCARE'S IDENTITY CRISIS: MANAGING IDENTITIES AND AUTHENTICATION PATHWAYS IN HEALTH CARE
MAR 7	THE IMPACT OF MACRA: PRACTICAL APPLICATIONS AND YOUR PREPARATION
MAR 21	DRIVING ORGANIZATIONAL EFFECTIVENESS THROUGH DATA TRANSPARENCY

healthcare financial management association leadership team

President: Lynette Vermillion (OhioHealth) 614-788-4568

President Elect: Matt Rakay (Plante Moran) 614-222-9173

Secretary: Patti McFeely (StreamlineMD) 330-316-0394

Treasurer: Jeffrey Carranza (OhioHealth) 614-544-4160

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Mary Laile & Matt Julien

Programming Co-Chairman
Mary Britton & Aaron Fields

Sponsorship Chairman
James Monroe

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.

Visit the HFMA website!

www.centralohiohfma.org

Stay updated on the latest chapter information, upcoming events, and healthcare news!

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For information regarding corporate sponsorship, please contact Sponsorship Chair, Bryan Gordon at bgordon@cleverleyassociates.com, or 888-779-5663 x 235.

Stephanie Pilgrim, Designer (419) 654-1158