

PALMETTO STATE NEWS

In loving memory of Ray High

SUMMER EDITION 2021

In this edition:

Message from Chapter President

Pictures from in-person events

Short story by Robert Taylor

Palmetto State News

Palmetto State News is the official publication of the South Carolina Chapter of the Healthcare Financial Management Association. Opinions expressed here are those of the author and do not reflect the views of HFMA or the South Carolina Chapter.

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Our Vision

The South Carolina Chapter of the Healthcare Financial Management Association will continue to be the leading professional resource for individuals seeking excellence in the area of financial management of integrated health systems and other healthcare organizations.



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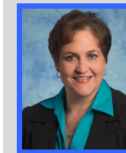
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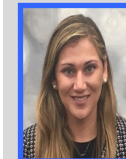
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A Message from the Chapter President



How wonderful it was to be back together in person for our Annual Institute in Myrtle Beach. It was so great to see you all and be able to share hugs, laughs and stories once again. A very special thank you to Heather Crowell and her AI Committee for putting such an incredible event together and to ALL of our sponsors for your extremely generous support of this annual gathering – we are truly grateful for EVERYTHING you do for our chapter!

Now that we are officially 6 months into 2021, we are starting to see a shift back to normalcy in some capacity. While our industry is still dealing with a global pandemic, we have found new ways to be digitally innovative throughout our communities, organizations and with our employees. We saw a tremendous rise in employee productivity as a result of shifting the workforce to remote, that the idea of employers sending their workforce back into the office setting could very well become a thing of the past.

2020 forever changed us. Life the way it used to be is not the same and we've had to learn how to pivot in a time of uncertainty. A lot has changed in the world from the pandemic, to social justice issues to the rise in mental health issues that it's time for us to not only make sure we are having some difficult conversations with our staff but also making sure we are checking in with them and just asking the simple question "are you okay". We have the opportunity to use our platform for bigger and better ideas and to really think outside of the healthcare finance box so I challenge you to take this opportunity and get uncomfortable to get comfortable.

As we embark on a new chapter year, our new chair theme takes on the approach of "Bolder, Better, Brighter". Much as I am challenging you, our membership, to think outside of the box, take risks and to get uncomfortable to get comfortable, the new chair theme focuses on what follows the "after" and determine what our "better" looks like for we know we are bolder because of this experience.

As we focus on bringing back our in-person educational opportunities this year, another in-person activity we will be launching is in-person networking events. We plan to have events in Greenville, Columbia and Charleston throughout the chapter year so please be sure to check our chapter website and social media sites regularly for updates.

CRCA sign-ups will be opening towards the end of this month so be on the lookout for registration announcements on our chapter website and social media pages.

If you are interested in serving on any of our committees please feel free to reach out to me or reach out to any of our committee chairs that are listed on the Committees page on our chapter website – we would LOVE to have you serve with us!!

Stay healthy, stay safe and I look forward to seeing you all in Greenville in October for our Fall Institute!

Danielle Gori, FHFMA, CRCA
SC Chapter President, 2020-2022



CMS Introduces the Rural Emergency Hospital Provider Type

HFMA Article prepared by: Barney Osborne, FHFMA
VP of Finance and Reimbursement of SC Hospital Assoc.

Introduction

Many of us older healthcare finance professionals assume that everyone else remembers the evolution of present-day hospital payment, while in actuality, many joined our profession long after the changes occurred. While still more members in other healthcare finance service occupations have never been required to register an account, bill an account, post a contractual, negotiate a payment or write a journal entry. All of our HFMA members were not nurtured in the revenue cycle environment. Before we discuss the latest liberator from CMS targeted to save many rural facilities, a summary might help understand what brought the rural hospital to where it is today and the relief the new Rural Emergency Hospital (REH) provider type may provide.

History lesson

In 1945 President Truman urged Congress to develop a national health insurance fund to be open to all Americans. His vision would have provided health coverage to individuals for primary healthcare. Truman was unsuccessful. It wasn't until 1965 under President Lyndon B. Johnson that Congress agreed to a national health coverage program. Medicare's hospital and medical insurance benefits first took effect in 1966. Americans age 65 and older were enrolled in Part A and millions of other seniors signed up for Part B. Medicare Part A (Hospital Insurance) helps cover your inpatient care in hospitals. Part A also includes coverage in critical access hospitals and skilled nursing facilities (not custodial or long-term care). It also covers hospice care and home health care. Medicare Part B (Medical Insurance) helps cover medically necessary services like doctors' services, outpatient care, and other medical services that Part A doesn't cover. Part B coverage, an option for eligible Medicare Part A, covered individually and typically cost the member a premium.

In 1972, President Richard Nixon signed into law the first major change to Medicare. The legislation expanded coverage to include individuals under the age of 65 with long-term disabilities and individuals with end-stage renal disease.

The Hill-Burton Era

The Hill-Burton program provided federal funding to construct hospitals in rural communities. This brought a significant increase in the number of small rural hospitals, particularly in the South. The construction of many small rural hospitals was primarily federally funded with small repayments made by the hospitals over a long period of time. The increased access to hospitals and the physicians they attracted made healthcare much more available to the small town rural population. Hill-Burton hospitals were popping up everywhere. These hospitals could depend on the average 80% received from their Medicare admissions and very small payments from the uninsured. Higher rates negotiated with insured carriers had to make up those losses.

Fast Forward to the Prospective Payment System

Typically, prior to the 1980s, Medicare paid at a rate based on charges billed by the provider. Rural hospital reimbursement has changed drastically since this time. The most significant change by far was the prospective payment system (PPS). Social Security Amendments mandated PPS for hospitals to become effective in October 1983. CMS' story was that the system was intended to motivate hospitals to reduce costs and change the way they deliver services. In contrast, many hospitals saw the program as a means to force hospitals to reduce cost, initially by shortening inpatient length of stays, moving many typically inpatient surgical procedures to be done as outpatient surgical procedures.

CMS Introduces the Rural Emergency Hospital Provider Type... continued

Medicare payments depended primarily on two variables; the International Classification of Diseases (ICD) and Diagnosis-Related Groups (DRGs.) The ICD grouper is the standard tool to codify mortality and morbidity data. The DRG system was developed at Yale University in the 1970s. DRGs are 5 digit codes assigned to every task and service a medical practitioner may provide to a patient including medical, surgical, and diagnostic services.

When Medicare DRGs were introduced, the only protection provided by CMS was the fact that CMS allowed for a periodic conversion to the fully prospective payment structure by paying a calculation based on a fixed DRG component and a variable costs component. An additional protection to the basic prospective payment amounts was made for cases incurring extraordinarily high costs called outliers. As CMS recognized their own financial benefit of PPS, they decided to apply the same theory to many outpatient surgical services. Today, Ambulatory payment classifications (APCs) determine the payment amount for most outpatient surgical procedures.

Finally responding to increasing concerns over rural health care access, congress made a step forward by implementing the Medicare Rural Hospital Flexibility (FLEX) Program of 1997 creating the Critical Access Hospital (CAH) provider type, which limits a hospital's inpatient acute average daily census to 25. Payment of inpatient and outpatient services was again made based on a "reasonable cost basis". To be classified a CAH, a hospital must have no more than 25 inpatient beds and must be 35 miles away by primary road from the nearest hospital. Over the past 10 years 135 of these hospitals have closed.¹ This includes four hospitals from South Carolina. A number of other small hospitals in South Carolina have found refuge under the umbrella of large urban systems allowing them to remain open.

New Hope for The Little Guys?

According to the US Census Bureau, nearly 20 percent of Americans live in rural areas and depend on small hospitals as their only source of care in the community.² Unfortunately however, rural hospital closures are at crisis levels, with over 135 rural hospitals closing since 2010 and more than 450 identified as vulnerable to closure based on performance levels.³ When a rural hospital closes, the mortality rate in that community increases and the local economy declines. The closure also impacts a community's future financial wellbeing as access to hospital care is one of the primary considerations of new businesses when deciding where to build new factories.

Over the years, when discussing the risk of the rural hospital, one issue is always raised. It now goes without saying that wealthier (insured) citizens in need of inpatient hospital care now have the capacity to travel to the urban areas. This has drastically increased the proportion of Medicaid and uninsured inpatients remaining at the community hospital. A problem that remains in rural areas, usually regardless of a patient's ability to pay, is the need for immediate care. The distance to an emergency room can often be the difference between life and death in critical health situations such as heart attacks, strokes, and Sudden Infant Death Syndrome (SIDS) cases.

Since the introduction of CAH payment system, congress has made no new provisions to protect the delivery of emergency care in rural areas; even for life threatening diagnoses where time is a crucial element of survival. Until now, there has been no provider classification which allows for Medicare payment to a hospital that provides only emergency department services and hospital outpatient services. Presently, only entities licensed by Medicare as a "hospital" can receive payment for emergency department and hospital outpatient services, and an entity must furnish inpatient hospital services in order to qualify as a "hospital." Although maybe a day late and a dollar short for many already-closed hospitals, the Consolidated Appropriation Act of 2021 includes legislation establishing a Rural Emergency Hospital (REH) designation as a new provider type. This designation becomes effective January 1, 2023.

¹Modern Healthcare, State-by-state breakdown of 134 rural hospital closures, Ayla Ellison ([Twitter](#)) - Tuesday, November 24th, 2020.

²United States Census Bureau. (2016 December 8). New Census Data Show Differences between Urban and Rural Populations. Release Number: CB16-210. Retrieved from: <https://www.census.gov/newsroom/press-releases/2016/cb16-210.htm>

CMS Introduces the Rural Emergency Hospital Provider Type... continued

The new REH program allows general acute care hospitals with no more than 50 beds located in a rural area and current critical access hospitals (CAHs) that meet criteria to be eligible to convert their Medicare enrollment category to a REH. A REH Provider cannot be created. The opportunity only applies to conversions from acute or CAH provider types. Among the requirements set forth in Act are the following⁴:

- * No provision of acute care inpatient services
- * An average per patient length of stay not to exceed 24 hours
- * Maintain a staffed emergency department, including staffing 24 hours a day, seven days a week by a physician, nurse practitioner, clinical nurse specialist or physician assistant
- * Meet CAH-equivalent Conditions of Participation (CoPs) for emergency services
- * REHs May convert back to a CAH or PPS hospital

REHs will be permitted to provide certain outpatient hospital services in addition to emergency department services. For these remaining services, REH facilities will be eligible for Medicare reimbursement at rates higher than those in an acute hospital. REHs will receive a fixed monthly payment for services, plus a 5% add-on to the Outpatient Prospective Payment System (OPPS) rate for outpatient services. REHs will be permitted to operate a distinct part skilled nursing facility (SNF) or off-campus provider-based departments, but without the 5% supplemental reimbursement. The fixed amount will be adjusted each year by the hospital market-basket update. Lastly, REHs that operated provider-based Rural Health Clinics prior to the conversion can still be considered hospitals with less than 50 beds and RHCs continue to receive un-capped Rural Health Clinic payments.

Winners and Losers

All of this sounds great, but like any other important decisions, a lot of investigation and estimation must be made. The new REH payments alone may be a struggle to estimate. The impact of the new REH standards will require a palm reader to evaluate. Estimating variable costs will likely require fortune teller. Ask any CAH about their own conversion from acute to CAH. One important reminder is that cost will not likely decrease proportionately to reimbursement or volume to all departments within the hospital. It should quickly become obvious that certain ancillary departments such as lab and radiology will still be required in the emergency setting and can provide outpatient services. These departments must be examined to determine the remaining volume, cost and reimbursement. Similarly, decision makers need to calculate expense savings produced from decreases in necessary service workers such as janitors, food preparation, maintenance workers and several other functions. Many departmental costs will not decrease proportionately to inpatient days.

Another easily recognizable risk of the REH standards in South Carolina is that small safety-net hospitals will still be required to provide emergency mental health or addiction treatments, often by simply stabilizing them and arranging for their transport to a mental health or acute facility. Perhaps one of the greatest difficulties will be the ability to find an available bed within the 24 hour minimum. South Carolina Emergency Departments currently have to house psychological patients for days, sometimes weeks, waiting for an available psychologically equipped and staffed bed. Bed placement for other acute diagnosis can be a risk to the 12-hour limit as well. Magically correcting these current length-of-stays to the 12-hour maximum is unlikely. This may negate the potential of some conversions. Additionally, there is always the potential for an ED to house multiple observation patients at once. Therefore, if overflow from ED has to move to beds outside of the ED making an observation unit necessary, some cost of at least minimum staffing level requirements must be considered.

An issue a little less obvious may be the impact the new status may have on state Medicaid Disproportionate Share programs. State Medicaid DSH programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid and other low-income patients. State DSH payments are limited by annual federal DSH allotments, which vary widely by state. DSH payments to hospitals are also limited by the total amount of uncompensated care that hospitals provide to Medicaid patients and the uninsured.⁵

⁴Cook, E.J., et. All. "Congress Establishes New Medicare Provider Category and Reimbursement for Rural Emergency Hospitals." January 5, 2021. Retrieved from <https://www.mwe.com/insights/congress-establishes-new-medicare-provider-category-and-reimbursement-for-rural-emergency-hospitals/>

⁵MACPAC, Overview-of-Medicaid-Policy-on-Disproportionate-Share-Hospital-Payments.pdf (macpac.gov), 2016

CMS Introduces the Rural Emergency Hospital Provider Type... continued

The Medicaid DSH program requires the recipient to be an acute hospital. CMS also requires a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians⁶ with staff privileges willing to treat Medicaid enrollees. The lack of licensed inpatient beds may remove the opportunity for new REH providers to participate in the DSH program, causing another potential for large financial loss to be studied.

A 2019 analysis from Navigant, a consulting firm based in Chicago, determined at-risk hospitals affect about 150,000 hospital-related jobs. As hospitals are often the largest employer in a rural community, the domino effect of a hospital can spread throughout the community. Hospital leaders should make every attempt to recognize these periphery matters and discuss them thoroughly with those impacted.

What to Do

I suspect that many qualifying small rural hospitals will take this opportunity with little hesitation because of the lack of other alternatives. This new provider type will likely prove to be exactly what some communities need to maintain a safe delivery of emergency care, but it could also be the demise of other hospitals if the necessary studies are not performed, and not all less obvious measures are considered. Every situation will be different, and all will require much preparation, some of which will need to be contracted by a commercial feasibility preparer. True leaders know what they don't know and are not afraid to ask for help. Many of these determinations will be new to your current financial staff and require too much time for them to thoroughly accomplish.

For now, hospitals will primarily wait for more information from CMS regarding the new provider type. Among the open questions for CMS to address are the following:⁷

- * Will hospitals that were or will be forced to close before January 1, 2023 be eligible to reopen as an REH?
- * What will be the complete scope of services eligible for payment at enhanced REH rates?
- * What are the steps and timing considerations for conversion to an REH?
- * What Conditions of Participation will be imposed on REHs?
- * What quality and data reporting will be required of REHs?
- * What requirements from SCDHED and SCDHHS create for the new provider type and how will it impact the federal guidelines?

Not becoming effective until 2023, those giving this option serious consideration will hopefully take the time to flush out all necessary positive and negative considerations and develop a strong reformation analysis.

Closing

High poverty and uninsured rates in rural communities, high rates of Medicare and Medicaid coverage, and declining populations challenge the stability of most small and rural hospitals. In each small community, poverty rates were higher than state and national averages and median incomes are lower, and the population is shrinking.⁸

As rural hospitals have long faced unique circumstances that can complicate healthcare delivery, provider groups have long advocated for a new delivery and payment model that would enable small rural hospitals to maintain access to at least vital emergency services for their patients. Although many questions remain regarding the implementation of the REH model, Congress should be applauded for finally recognizing the urgency of this situation and creating this new provider type. This new model may allow many at-risk rural facilities to continue to provide essential health services. It will be critical for many hospitals to engage in the REH review process, including understanding CMS's development of the Conditions of Participation (COPs), state licensing, the estimation of expense reductions, and the calculation of new reimbursement.

New models of health care delivery, along with new models of payment and financing, may be better able than current admissions and volume-driven systems to support the needs of rural communities. The REH may be the beginning of that effort, but much is left to do and much is still unknown.

⁶There are exceptions to this rule for children's hospitals, hospitals that do not offer non-emergency obstetric services, and certain rural hospitals. (§1923(d) of the Social Security Act. Congressional Research Service, Medicaid Disproportionate Share Hospital Payments, Alison Mitchell, June 17, 2016

⁷Congress Establishes New Medicare Provider Category and Reimbursement for Rural Emergency Hospitals, The National Review, July 5, 2021, Volume XI, Number 186

⁸A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies, Jane Wishner, Patricia Solleveld, Robin Rudowitz, Julia Paradise, and Larisa Antonisse, KFF Published: Jul 07, 2016

WOULD YOU LIKE TO GET INVOLVED? PLEASE FEEL FREE TO REACH OUT TO ANY OF THE COMMITTEE CHAIRS.



Contact information is listed on the SC Chapter website: <http://www.schfma.org/committees.html>

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Insurance Strategy Critical for Telehealth Surge

By: Christopher Fisher, CRCP-I, maxRTE Business Development

Like many industries, healthcare has become a victim of COVID, sustaining great economic injury. We spoke to one organization that was losing a million dollars a day due to COVID. And even last Fall, with elective surgery resumed, losses continued.

Beyond absorbing bottom line blows, clinical providers pivoted in order to serve patients both inside and outside of traditional practice venues. While televisits had been available, COVID drove a dramatic upswing in patient acceptance of telehealth as a legitimate form of interaction with medical professionals. This trend has gained exceptional steam in treating mental health and addiction issues, which the pandemic has fueled.

So after a year of COVID, professionals recognize that telehealth is here to stay, according to the professionals we've been in contact with. They've also shared the challenges they faced as a result of not being prepared for the telehealth surge with a registration process for insurance verification.

Essentially, the lack of a process for updating insurance information prior to the telehealth appointments results in:

- ◇ charges posted to "self-pay";
- ◇ uncollected co-pays that feed self-pay dollars;
- ◇ and increased denials (policy termination, policy no longer in effect, etc.) that lead to timely filing denials.

So what can be done to address this challenge? According to the following professionals, technology-based systems will help:*

Heather Nelson, senior vice president and CIO, U Chicago Medicine

"From my perspective, the best way to ensure telehealth remains a key part of healthcare delivery is to ensure the reimbursement and payment methods stay in place and even be enhanced as more and more patients want to have access to this model of care. We need those blanket waivers issued by CMS during the public health emergency to be made permanent. If we keep extending a few months at a time, it does not allow healthcare systems the confidence that we can continue this delivery of care, as well as invest in supporting technologies and operations."

Ash Goel, MD, senior vice president and CIO, Bronson Healthcare (Kalamazoo, Michigan): "Integration of telehealth technologies into a broad spectrum of offerings such as acute care, chronic care management, remote monitoring, social management, employee and employer-based services with a business model that supports this is essential. The technical platforms have to evolve to become flexible and yet integrated into existing EMRs to minimize friction, understand the patient experience and be UX design-centric."

Learn how healthcare organizations are using technology for [insurance eligibility verification](#) and [insurance discovery](#) for self-pay patients.

*As seen in Becker's Health IT, 2/22/2021

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April 3—6, 2022

Nashville, TN

SC HFMA Welcomes New Members

Prisma Health

(added 9 new members)

The Regional Medical Center

(added 15 new members)

Change Healthcare

(added 5 new members)

Webster, Rogers & Company, LLP

(added 2 new members)

The following companies added one new member:

Ensemble Health Partners

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Welcome back to in
person events!

We missed you!





Annual Institute 2021 Myrtle Beach, South Carolina





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IN CASE YOU MISSED IT...



Here are some of the sessions that were held at the 2021 Annual Institute

- ♦ Three Paths to Adopting AI and Automation
- ♦ The Evolution of Revenue Integrity
- ♦ Employment Law—All Things COVID
- ♦ Telehealth: The Next Shiny Object or the New Frontier?
- ♦ Burnout: Strategies for Preventing and Responding to this Occupational Hazard
- ♦ The Six Million Dollar Question
- ♦ Digital Doorways: Passageways to a Better Patient Experience
- ♦ Medical Debt Malpractice
- ♦ Opportunities in Healthcare Collections

You can visit the chapter website to view the presentations under the resources tab: <http://www.schfma.org/resources.html>

Helping Hand of Myrtle Beach



This year, the SC chapter selected Helping Hand of Myrtle Beach as the charity for the Annual Institute. Members donated food supplies and money to assist this wonderful organization. Overall, the chapter raised **Three Thousand, one hundred dollars (\$3,100)**

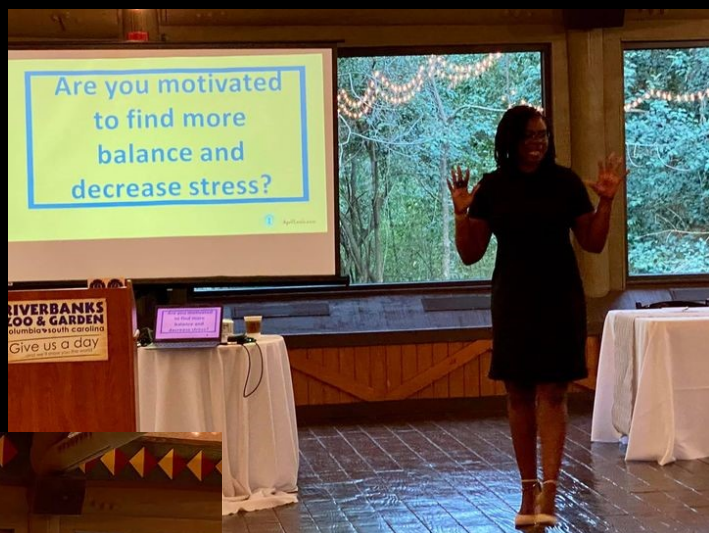
Helping Hand of Myrtle Beach was organized in 1971 by the First United Methodist Church as an outreach ministry for teen-age visitors to the beach.

Helping Hand is a short-term crisis and referral agency which seeks to address the needs of our community not met by other existing institutions. Our mission is to assist individuals and families with immediate, short-term needs such as food, rent, utilities, and other specialized services, which if not met, would threaten an individual's or family's stability. By providing these services Helping Hand seeks to prevent those in need of basic services from falling into homelessness.

For more information or to make a donation, please visit: <https://www.helpinghandmb.org/>



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March 26, 2021

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For details regarding these positions,
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Anniversary Milestones

February through June

Celebrating 40 Years

Mary Hubble * Kenneth Meinke

Celebrating 35 Years

Stanley Smith * Frank Grella

Celebrating 30 Years

S. Evans III

Celebrating 25 Years

Charles Acquisto * David Catoe * Lynn Waters

William Kusnierz * Estelle Barnes

Celebrating 20 Years

Jan Brooks * Don Hale * Richard Caffrey * Leslie Rodwell

Celebrating 15 Years

Bradford Rogers * Jacqueline Pittman * Jen Hayes

Anniversary Milestones

February through June

Celebrating 10 Years

Bridgitte Green

Susan Cribbs

Danielle Gori

Tara Gibson

Linda Kornman

Celebrating 5 Years

Julie Fowler

Marita Romine

Francis Cribb

Rodney Van Donkelaar

Andrea Mozingo

Renee Anderson

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Alex and the Terrible, Horrible, No Good, Very Bad Day (*A/R Salesperson Edition*)

Alex is a lovable and competent Executive director for one of the largest agencies in the country and enjoys success and the respect of his clients and peers. He is married with 2 great kids and a beautiful loving wife. He is just an all-around great guy. He was on cloud nine in his career and in his life, but what he didn't realize is that he was about to face the most unfortunate set of professional calamities he had ever faced in one 24-hour period. Sadly, it always seems that when you are on cloud nine a freight train comes to bring you back down to earth.



It was Monday and unlike Alex's friends and colleagues he embraced the dreaded Monday, and the challenges Mondays always seem to hold. He had plans to wake up early, go to the gym and come home ready to conquer the world of revenue cycle sales. Needless to say, he was extremely excited about the next 24 hours. First, he would attend a few virtual meetings that morning, have lunch with a local client and finally fly to Chicago for an early morning presentation with a prospect he had been trying to land for over a year. He had heard from a reliable source that this prospective was bringing their pen to the meeting in the event all went well. Everything felt great and Alex had the tiger by the tail. But that is when it all started. As Alex was on his way to the gym early that morning, he realized he left his air pods at home. He should have taken that as a small but significant sign that the stars were not aligned for him that day, but our generally positive character trudged forward to get some much-needed reps in at the gym. Sadly, Alex realizes with disappointment, that with no air pods he will have to suffer through the loud grunts of others working out and the constant ambient sounds of classic rock set on loop blasting through the gym sound system. Although Alex is indifferent about classic rock, it is not the desired playlist when he is trying to harness his inner Dwayne "The Rock" Johnson. As he arrives at the gym every machine is occupied so he had to resort to the less favorable elliptical and without air pods. Needless to say, this wasn't a very inspired workout session. Alex brushed off his athletic disappointment and headed home to join a series of important virtual meetings slated to start at 8 am sharp. To Alex's frustration his internet service provider had scheduled a routine service for the entire area and his internet was not working. "Oh No!" Alex said... "My boss is going to be on this call, and I'm expected to present sales numbers for the team." Filled with fright, frustration and disappointment Alex began to gather his emotions and began problem solving. "I'll just go on video chat from my phone," Alex said with a chuckle. "There's a solution for every problem" Alex said with a self-assured smile. Little did Alex know that his son had "borrowed" his only phone charger last night and Alex's phone may not have the battery life to last the morning call. Yes, it appears Alex is at the beginning of a terrible, horrible, no good, very bad day.

Even with the internet setback Alex is excited about the upcoming meeting and feels prepared to impress his boss and peers with the sales figures and projections. Alex, sweaty from the gym decides he should hop in the shower, then throw on a button up shirt for the video chat. Alex walks to the bathroom singing "Don't stop believing" a Journey hit he couldn't get out of his head since he left the gym and proceeded to turn on the shower. But nothing happened. He fiddled with knobs over and over but still nothing. After a few minutes had passed Alex decide he had better call the water company. The meeting is virtual but based on the attendee list he figured he'd better look his best. Alex was on hold for quite some time thinking all the while, *if my company had hold time times like this, we would lose all our clients*. Finally, a representative answered the phone and advised Alex that there was service interruption caused by damage to some pipes in the area and that they would have everything back up and running in a couple of hours. As Alex received more and more bad news his frustration grew and the positive salesman, we all know, and love began to succumb to the continued issues. Little did he know that the worse was yet to come.

Alex and the Terrible, Horrible, No Good, Very Bad Day ... *continued*

After wrapping up the call with the water company Alex glanced at his watch and realized that his meeting was starting in 2 minutes. Alex also realized that the long hold time had drained his battery life. He began the frantic search for his charger and the even more frantic search for a dress shirt that did not require ironing. Alex never found the charger but found a shirt but did not have time for pants. I guess our friend Alex would be wearing his "semi formal work from home attire". You know, your standard button-up shirt, tweed blazer and no pants.

Alex makes it to the meeting with 30 seconds to spare, video chatting from his phone, and watching his battery life like football fans watch the clock in church on Sundays, wondering how long this is going to last. The meeting starts and the CEO says to the team, "Team, we are going to have Tom give us a brief presentation before Alex gives his update". "NOT LONG TALKER TOM!!" Alex shouts, half hoping his phone was off mute. Alex cringes inside because Tom is notoriously longwinded, and he doesn't know if his phone will make it. Long Talking Tom or LTT as he is known by his coworkers, drags on for what seems like an hour as Alex's phone slowly dies. Suddenly Alex remembers that he has a car charger for his phone. So, he dashes outside dressed in a tweed blazer, powder blue button up and white boxers with smiley faces on them. He quickly starts his car, plugs in his phone, and attaches his phone to the magnetic docking station in his car, just in the nick of time. "Alex, are you ready?" the CEO says in a deep commanding voice. "Yes sir" Alex responds, slightly out of breath from the mad dash to the car. He turns on his camera prepared to present the numbers when he notices the looks on the faces of the meeting attendees. "Alex!" his CEO says interrupting his presentation. "You may need to reposition your camera, you are smiling at us this morning." Ashamed Alex realized that he had not harnessed his inner Martin Scorsese, and his camera angle had given his colleagues and his boss a shot of his smiley faced boxer. With great shame and embarrassment Alex regrouped, repositioned, and carried out the rest of the meeting in a subpar fashion. This was one of the worse starts to a week Alex had ever experienced. Little did he know it would get much worse before it got better. Between the air pods, gym, internet, water and charger, Alex was beginning to wonder who he had upset to deserve such bad luck. The meeting finally was over, and the water was on. Alex took a shower and headed to his lunch meeting with his client. Alex felt like he had regrouped, and things hopefully would begin moving in the right direction, but sadly he would face many, many more issues before the day winds down to its inevitable end.



By: Robert Taylor

Tune in next time to see what tragedy awaits Alex the A/R Salesman on his Terrible, Horrible, No Good, Very Bad Day!

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