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first illinois chapter

June 2022

FIRST ILLINOIS SPEAKS

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Message From Our Chapter Presidents

BY RICH SCHEFKE , FHFMA, CPA, 2021-22 PRESIDENT &
BRIAN PAVONA , FHFMA, CPA, 2022-23 PRESIDENT

Farewell from outgoing FIHFMA President, Rich Schefke

Dear Friends and Colleagues,

Our First Illinois Chapter was resilient in 2021-2022 as we all faced continuing uncertainty and challenges from a second full year of the pandemic. It was great to see one another again in person, starting with the high energy Transition Dinner in July 2021 and continuing for the rest of 2021 with the Executive Golf and Scholarship Outing, the Women in Leadership Retreat, and the Fall Summit. As 2022 began we experienced another high pandemic wave leading to a pivot of an over six-month gap until seeing each other in person again for the outstanding May Spring Forward Conference. The chapter leadership worked diligently to continue the top notch education and networking with multiple high quality virtual meetings, communications, and webinars.

During the Transition Dinner in 2021, I said we could use your help, which were the words said to me when my volunteer involvement began. Since that time, I have been impressed with the hard work our volunteers pour into each event and the great response from our membership in coming out to in-person events. In addition, we started the Past Presidents Advisory Council. This has brought in leaders of industry that have had this role and directly led to positive impacts in our chapter with promoting events and new partner referrals.

One of the biggest financial challenges is adjusting to a new model from the Association where no portion of member dues goes to chapters in exchange for some centrally provided services, like the website. Keeping our promise to hold more in-person events in a high inflation environment required additional commitments from business partners for sponsorships and key provider leader attendance support. I am so grateful for the help when we asked.

Stewardship has been a focus, and one of the ways we met it is by making it easier to invest in the next generation. We are one of the few chapters that has a scholarship program for our members' college students. In the past, there was not a mechanism for a tax deduction due to our chapter's organization status. This past chapter year, for the first time we were able to give a tax deduction for donations. Your donations increased 158% over the prior year.

Besides our members' college students, another path of stewardship we have highlighted this past year is broadening our diversity, equity, and inclusion focus. In Chicagoland, where most First Illinois Chapter members work and live, healthcare inequities are higher than in most communities around the country, and the pandemic has only exacerbated the problem. At the same time, the healthcare workforce, and especially those in finance leadership roles, are not representative of the populations their healthcare entities serve and thus make them inherently vulnerable to not fully understanding and addressing the issue. Accordingly, the newly formed First Illinois Diversity, Equity and Inclusion Committee developed and the chapter executed programs to:

- Drive awareness throughout our chapter and our community at large
- Educate those who are in healthcare financial leadership positions
- Dialogue with the membership at large through panels and book clubs
- Help those suffering from healthcare inequities through philanthropy

A model has been set to create momentum around a yearly theme for our chapter to rally around and make a difference that will continue as new themes are added. The true result will be seen over time as we take our actions and see more inclusion in our membership, and the life expectancy gaps close within our community.

I have one conclusion after the chapter's May 20 strategy planning session, the future of the chapter is bright and in great hands under the leadership of Brian Pavona and following leader Katie White! They will build on our accomplishments of the Fall Summit with our highest education survey results ever and our chapter and region earning rare success awards for accomplishments for communication and certification. Less than 15% of chapters earned this.

Finally, I want to extend my last official thanks as your outgoing president to my fellow members on the leadership team and to the many committee members and volunteers who continue to make First Illinois the premier membership organization in the Chicagoland area for healthcare finance leaders. I also want to thank my NorthShore Edward Elmhurst colleagues who supported me on this journey. And, to our chapter business partners without your continued support and confidence in First Illinois we would not be able to offer the level of resources and support we provide our community, thank you! Last but far from least, thank you to my family who backed me as I spent many hours of service to the chapter. It has been the honor and privilege of a lifetime to serve as your president, and I look forward to many years ahead serving alongside you.

Rich Schefke, FHFMA, CPA
2021-22 FIHFMA President
Director of Financial Planning, Analysis and Decision Support at Northwest Community Healthcare a part of NorthShore HealthSystem
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Incoming President's Message Brian Pavona, FHFMA, CPA 2022-2023 Chapter President

My Vision

I've been asked many times over the past year: "What's your vision for the chapter when you become president on June 1, 2022?"

Naturally, my response has evolved over the past 12 months as I've had the opportunity to listen to providers and partners across the First Illinois region. Whether through discussions with healthcare executives, meetings with provider boards, working with chapter volunteers, collaborating with hospital associations, strategizing with reimbursement departments, or coaching fellow employees, one theme has remained constant: It's time to look past COVID-19 and the impact of the public health emergency and focus on the future. And while the whole industry could use a break (and deserves one!), there's simply too much to do. The future of healthcare is here, and the First Illinois HFMA chapter needs to focus on the road ahead, including these critical issues:

- ***Health Equities:*** Most providers in the area have at least one of the following words in their mission when referring to healthcare:
  "advance"
  "quality"
  "improve"
  "excellence"

  It's clear from terms like these that the missions of our provider organizations cannot be achieved without providing quality healthcare. In turn, quality healthcare cannot be achieved without being equitable.

  We know that equitable healthcare cannot be achieved without assessing and addressing a patient's full needs. This means healthcare providers must address access to education, access to affordable healthy food, access to safe places to exercise and socialize, access to affordable housing, and access to quality healthcare providers. Providers may choose to tackle these issues head-on or partner with others to enhance the patient's environment.

  First Illinois HFMA can help by continuing to educate its membership on the issues, hosting safe environments for dialogue and setting goals to help our providers tackle the challenge.

- **Financial Acumen:** Addressing the full needs of the patient is complicated, and let's be frank.... It's expensive! This means funding to our healthcare providers must continue and be enhanced. Programs like 340B, expanded Medicaid, Section 330 grant funding, and other resources must continue. At the same time, healthcare organizations need to continue pursuing every dollar to which they are entitled, whether through renewed focus on reimbursement opportunities (wage index, SSI alignment, medical education funding, etc.) or enhanced controls over vendor management, purchasing, and other spending. Every dollar matters.

  First Illinois HFMA can help by continuing to bring innovative speakers, case studies, panels, and ideas to our providers to help them seize opportunities.

- **Workforce Matters:** There is a renewed focus on our teams, including creating work environments that are flexible, inclusive, and engaging. Further, employees throughout healthcare need additional support to do their jobs and do them well. Whether skills to help work with physicians and other operational leaders, networking opportunities to collaborate with other organizations, additional education about the industry as a whole, or simply opportunities to have fun with colleagues, First Illinois HFMA can definitely help here!

And so with that, my vision for the 2022-2023 chapter year is to show you we've listened. We'll enhance opportunities to:

- Gather in safe environments to discuss our industry's challenges
- Collaborate on how we'll work together to tackle the challenges
- Build content to help with both the hard and soft skills of healthcare finance
- Offer opportunities to connect and build out our networks
- Have some fun!

Thank you for offering me the opportunity to serve.

Brian Pavona, FHFMA, CPA
2022-23 FIHFMA President
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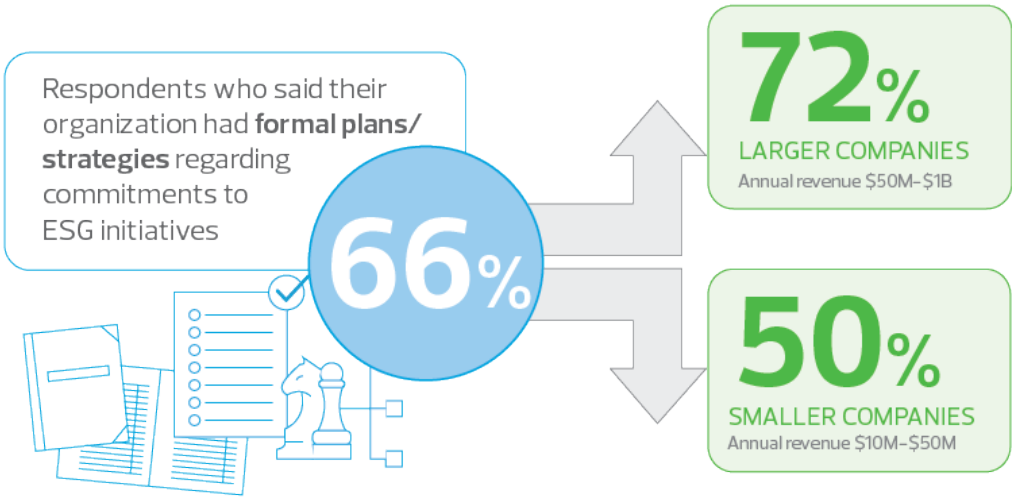
Environmental, Social, and Governance (ESG)'s growing impact on the health care industry: Spring 2022 outlook

- **Aside from the obvious benefits to community, culture and environment, another reason health care organizations are focused on ESG is to attract financing.**
- **Health care organizations will likely begin measuring and reporting ESG data as an evaluation tool for investors.**

Over the past few years, the world has increased its focus on environmental, social and governance issues, with consumers and investors alike seeking out companies that deliver on ESG promises related to community service, strong environmental protections, and interest in social justice, diversity and more. As a result, the focus on ESG by executives across all industries has also grown. In RSM surveys of middle market business executives in the fourth quarter of 2019 and then again in the third quarter of 2021, the percentage of respondents who said they were very familiar or somewhat familiar with using ESG criteria to measure performance rose from 39% to 69% in just two years. Clearly, ESG is becoming top of mind for businesses. Further confirming this increasing interest, according to RSM's ESG report, 66% middle market respondents said they had formalized plans related to their ESG initiatives.

Although, as reported by Modern Healthcare, health care organizations still lag in establishing and meeting goals related to diversity, inclusion and equity, many—in particular, nonprofit providers—deliver services to underserved and diverse communities. Some have boards actively involved in community service and other community-building efforts. For many health care organizations, ESG is a natural fit.



Source: RSM US Middle Market Business Index ESG Special Report, Q3 2021

Aside from the obvious benefits to community, culture and environment, another reason health care organizations are focused on ESG is to attract financing—with municipal bonds being one example. Many organizations are starting to include ESG data within their bond offering documents in hopes of securing financing opportunities. This has not gone unnoticed by the Municipal Securities Rulemaking Board, or MSRB. In fact, the MSRB recently issued a request for information to obtain details from market participants and the general public regarding ESG. The MSRB is curious to know how investors and the broader community look at ESG and which data elements they find meaningful.

We anticipate that this year the MSRB, and perhaps other regulatory bodies, will push for standardized reporting of ESG data. We also expect that if they have not already done so, health care organizations will begin measuring and reporting that data as an evaluation tool for investors. An open question is whether data demonstrating an organization's successful ESG efforts will provide any sort of "greenium," or bond discount; regardless of the answer, we anticipate that ESG data will likely become table stakes for bond issuances.

About the Author

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CLICK HERE to download RSM's 2021 ESG report.

4 Ways to Reduce the Impact of High Administrative Expenses

Financial excellence comes from creative solutions by competitive companies

Providers nationwide are greatly impacted by the nursing shortage. Administrative expenses for staffing – such as benefits, insurance, retention bonuses, hiring bonuses and headhunter fees – are soaring. At the same time, many nurses are leaving the profession as burnout reaches new heights. As a result, 81% of healthcare CFOs say the talent shortage poses a risk to their business in 2022. With reimbursement rates remaining static, providers need a way to manage the increasing administrative expenses.

Fortunately, providers have options for reducing the financial burden of these increasing costs, including:

1 **Switch to defined-contribution plans.** In the past, many healthcare providers offered a defined-benefit plan, which is a type of pension plan that offers a pension payment or lump sum upon an employee's retirement. By contrast, in a defined-contribution plan, the employee and the employer both regularly contribute to the employee's retirement fund over time. Many providers have already switched to a defined-contribution plan, but those who have not should consider doing so now, as these plans can rein in the upfront administrative costs associated with employment.

2 **Re-evaluate discretionary investments.** Recently, we've seen significant investment in innovation and research and development, particularly in larger health systems. While these investments are crucial to the development of more durable medical equipment, new pharmaceuticals and more, it may be necessary to temporarily reduce such investments to make up for increased administrative costs. Once hiring and staffing returns to a more stable state, these investments can be increased once again.

3 **Evaluate your M&A opportunities.** For smaller independent providers, like standalone hospitals in rural areas, high administrative costs can be debilitating and threaten the organization's future. The best solution to this problem may be to join a larger system that can afford to take on the administrative burden. For providers that are seeking to acquire organizations this year, it's important that they try to keep the overall number of vendors they work with low so they can access group purchasing discounts and possibly negotiate better acquisition terms.

4 **Review your insurance coverage strategy.** While it often feels daunting to providers, now is the time to review insurance plans. One possible consideration is self-insurance. By offering employees self-insurance plans, providers can save money on premiums. To determine whether this is the right move, providers need to use an actuarial calculation of covered lives to determine what their collective costs will be. From there, providers can determine if they have the funding to offer self-insurance. Self-insurance isn't the right move for every organization, but it's worth exploring, especially for providers whose insurance premiums are a significant financial burden right now.

Nearly all providers are struggling under the weight of high administrative costs. Finding creative solutions to mitigate their impact on the financial viability of your organization will set you apart from the competition and allow you to maintain continuity of care.

About the Author

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Evidence-Based Solutions to Help Prevent Physician Burnout

Physician burnout is a major threat and turnover by doctors in primary care is estimated to add $1 billion in additional costs to a system already burdened with waste.

Task burden—the inbound knowledge work that causes constant shifting of cognition and attention from patient to inbox task throughout a clinic day—is often the cause of burnout. The more tasks a provider takes on during the workday, the greater their risk of burnout.

Fortunately, evidence-based health care tools rooted in lean methodologies can help reduce physician burnout. A Mayo Clinic systematic review demonstrated lean-like process improvements towards team-based care can help reduce clerical tasks and documentation burden, decrease burnout, and improve job satisfaction.

Risks of Burnout

Burnout can have serious consequences. With surging patient loads during peak hours, providers start to rush and can demonstrate poor process flow as the hours progress. They increasingly defer complex decisions, experience decision fatigue, and lurch into low-value care decisions and practice patterns.

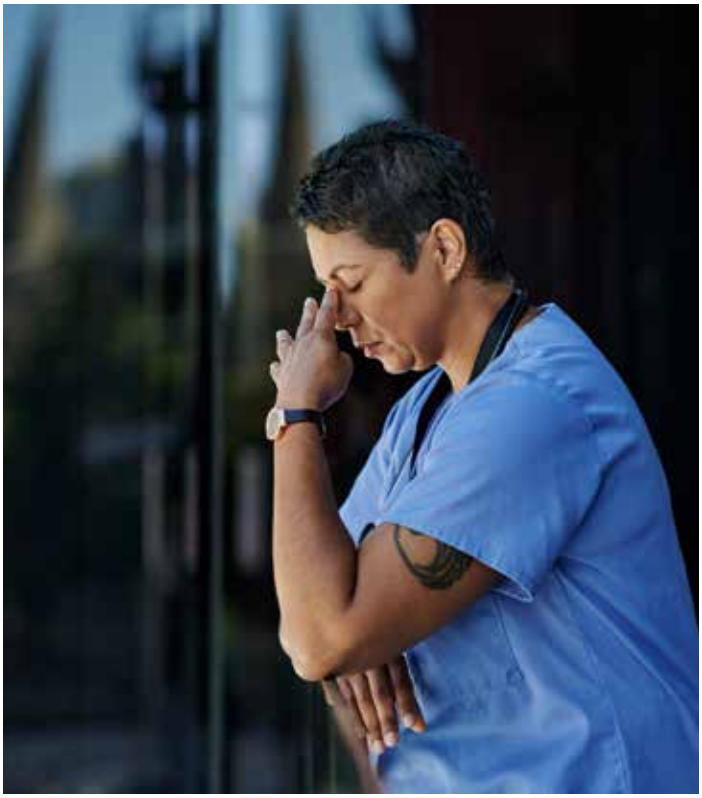
Falling behind can lead to risks including:

- Antibiotics increasingly prescribed for viral infections, which are useless and can cause increased resistance to bacterial infections
- Opiate prescriptions for painful conditions increase
- Statins for high-risk vascular disease patients decrease
- Mammograms and colon cancer screens decrease

Research estimates 25% of health care is wasteful and defective, costing $1.3 trillion annually with a range approaching $1 trillion in waste and upwards of $300 billion in opportunity savings through waste reduction interventions.

How Can Health Care Providers Reduce Burn Out and Task Burden?

Interventions to reduce task burden involve improving flow, which boosts quality and lessens burnout. Engineering care into a better flow preserves precious time for making high-value health care decisions. In 2021, the Joint Commission on Quality and Patient Safety demonstrated that for every 10% decrease in provider task load, the odds of experiencing burnout fell 33%.



Workflow process improvement projects and clinical quality improvement projects are also proven to reduce provider burnout scores. Providers naturally care more about clinical quality than clinical finances as such efforts align with their professional ethos and intrinsic motivations, improving the meaning in their work and their sense of efficacy. Loss of meaning and efficacy are core attributes of burn out.

Combined efforts that restructure care, reduce duty hours, and offer mindfulness programs can address this drop in morale. However, process improvements that restructure care and save time are more powerful than mindfulness offerings, which are helpful palliatives. Getting care into good flow saves time so that duty hours can be reduced without harming access to care.

How Can Health Care Providers Improve Process Flow and Work Burdens?

Lean principles can be especially effective in reducing task burden; therefore improving care quality and mitigating risk of burnout.

Lean interventions often start with the principles of 5S—sort, set-in-order, shine, standardize, and sustain, expanded as follows:

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Evidence-Based Solutions to Help Prevent Physician Burnout

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- Sort. Remove what isn't needed by separating necessary supplies and processes from the unnecessary.
- Set-in-order. Identify and organize the remaining necessary supplies, equipment and processes.
- Shine. Conduct regular so-called cleaning of the physical environment and tuning of processes to keep the work area organized and safe.
- Standardize. Create a standardized schedule for regular process shining and maintenance by following the sort, set-in-order, and shine methods.
- Sustain. Make 5S a part of your organization's mission by following the first four methods.

By organizing the real and virtual—for example, the InBasket—workplace, staff can declutter materials and processes, and reduce time wasted in searching, waiting, and over-documenting.

Beyond 5S, the standard suite of lean principles also form the centerpiece of team-based care.

Strategy Deployment

Everyone, from the executives to frontline teams, is clearly organized around the must-do, can't fail initiatives, which are visible and present, and tracked in all meetings daily.

Standard Work

Each team member should have standard work that sets up other team members with standard handoffs and protocols that speed the flow of information.

Flow

Improving flow can help reduce the cognitive burden and incessant choice-making that fuels burnout.

Rather than batching a cache of activities at the end of the day, everyone in the practice should take on bits of work throughout the day.

By moving from batched work into flow, providers make best use of their skills—and their team's skills. They have more energy and focus for what they're trained to do, which offers greater fulfillment, engagement, and joy in work, infusing energy and commitment back into daily work.

External Setup

Standardize the setup process for patient visits so staff can more efficiently receive information around patient histories, documents, review of systems, care gaps, standing orders, and procedures.

This effort includes teaming up on clerical processes to standardize and manage them by protocols, so providers just add a signature or bits of clinical information. This team-based management of clerical tasks can hopefully lead to automation of clerical tasks as the future unfolds.

With external setup, transitions and handoffs can become smoother and fewer errors are introduced.

Leveling, Team-Based Care

Promote skill-task alignment, which matches the right person and certification to the right task.

Electronic Health Record (EHR) improvements reduce burnout additionally and can be accomplished using 5S methods and lean principles that take documentation from batch to flow. In an evolved and redesigned team, task load can decrease, documentation is shared and leveled across the team, as are results reporting and inbox messages.

In lean redesigns, people at the point of care decide what task burdens to reduce by elimination and spreading tasks across the team. This counters the EHR's architecture, which concentrates tasks on the provider. Lean harnesses the experience and creativity of the people who do the work to align tasks to each team member's skills and reduce time and task burdens.

Social network theories and studies in provider groups suggest that friendship and patient-sharing ties drive clinical quality improvements, adoption of EHRs, and evidence-based care better than hierarchical exhortations and mandates. Developing the guiding coalitions that harness social networks and management structures can help ingrain quality improvement into daily work.

About the Author

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Digital payments are on the rise in healthcare:
Key data points + 3 technologies to watch

The accounts payable sector faces a complex and challenging future. One important strategy for coping with the expected disruption is to accelerate the adoption of digital payments.

A variety of digital payment modes are gaining wider B2B and B2C acceptance. Growth is being propelled by convenience, efficiencies, cash management and health safety, and is uniform across a range payment rails, including:

- **Real time payments (RTP).** This mode forms a $13.5 billion worldwide market, expanding at an annual clip of 33% through 2028. Real-time healthcare bill payments and disbursements are projected to reach over 70 million in 2022.
- **Electronic Funds Transfers (EFT).** Healthcare processed 108 million EFTs in the second quarter of 2021, up almost 36% from the same 2020 period.
- **Mobile wallets.** This facilitator of RTP is likewise surging. New mobile wallet users are projected to come onstream at a rate of 6.5 million per year between 2021 and 2025, with average spending reaching $4,064 annually per user. Wallets are also becoming a force in all e-commerce as the forecast.

Digital payments should expand in 2022 as part of e-commerce protocols necessary to support telehealth. COVID-19 concerns will provide further stimulus.

Here are three technologies to keep on the planning radar:

1. **Biometric authentication.** Security is paramount in electronic payments, and research suggests that consumers prefer voice, fingerprint and other biometrics.
2. **Open banking APIs.** These tools allow strong integration between bank and provider systems to provide patients a more seamless payment experience.
3. **Cryptocurrency.** The future remains cloudy for this mode, but it is already being used for a number of consumer transactions.

It is important to note that effective payments innovation is about more than just processing digital payments. A "closed loop" system is needed that unites payments and data to permit complete reconciliation and tracking of fund flows.

Additional Data and Takeaways

- Cost control, convenience and continuing needs to support a remote workforce should drive momentum of digital B2B payment modes in healthcare.
- Dependencies to consider in promoting these forms of payment: the persistence of legacy systems and minimal system integration, both of which may hamper effective use.
- Regulatory compliance and security are paramount requirements in the digital realm – a reason banks have become preferred partners.
- A cross-industry study showed the dynamism of the payment space, with healthy majorities of companies offering more methods, boosted by consumer behavior changes from the pandemic.
- Use of cryptocurrencies for healthcare B2B payments is still in its infancy, but heightened attention and rapid technological development may hasten adoption by providers, payers and suppliers.

Balancing patient payments priorities will be crucial going forward. For more information, read CommerceHealthcare®'s eBook ***Healthcare Finance Trends for 2022***.

About the Author

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5 Ways KSB Hospital Transformed Patient Access and Saved $20M in Revenue

In 2019, revenue cycle leaders at KSB Hospital took a hard look at our patient access department and realized status quo was no longer acceptable. Registration times were long, staff turnover was high, and we were losing millions in revenue to preventable denials. It was time for change.

Using AccuReg EngageCare® Provider as our foundation, we implemented a five-step strategy to improve inefficiencies, reduce denials and create a high-performing patient access department—a two-year journey that ultimately saved the organization $20 million in revenue.

Manual, Outdated Patient Access Processes

Patient access was operating with outdated pen-and-paper processes, and our staff had no method for tracking patient registration accuracy or POS collections. Further, registration staff in the eight outlying clinics operated under different management than the main hospital staff. Siloed and lacking proper training and measurement tools, patient access staff didn't understand the significant role scheduling and registration processes had on the revenue cycle. Registrations were error-prone, causing unnecessary and costly rework, and millions in denials.

In addition, our patient access department:

- Lacked automation, efficiency and effective tools for communicating to service areas and patients
- Had no measurement and training tools to track and improve patient registration accuracy rates, staff performance or POS collections
- Faced high staff turnover due to a lack of education and training, automated tools to support their work, or opportunities for advancement

Reinventing Patient Access, Increasing Hospital Revenue

Using one integrated platform for front-end revenue cycle management and implementing strategies for career growth and recognition revolutionized patient access and shifted the mindset of our entire organization.

In just two years, KSB:

- Reduced denials from 21% to 7%
- Prevented an average of $800,000 per month in denied charges—a savings of $20M in revenue
- Improved first-pass initial accuracy rates from 63% to 95% and final accuracy from 80% to 99%
- Reduced staff turnover from 42% to 25%

In addition, KSB has created a substantial method for tracking POS collections, which total between $11,000 and $30,000 each week. Patient access staff are more confident in their roles and understand their impact on the revenue cycle.

5-Step Strategy for Transforming Patient Access

1. Consolidate Patient Access Staff

- Consolidate registration staff in the main hospital and eight outlying clinics under one patient access umbrella
- Increase the size of the patient access department from 21 to 70 people
- Improve communication, collaboration among staff

2. Implement Pre-Registration

- Implement pre-registration by phone to increase patient privacy and expedite check-ins
- Reduce check-in times for preregistered patients from three-to-five minutes on average to 45 seconds per registration, an overall improvement of 82 percent

3. Use AccuReg Front-End Revenue Cycle Technology

- Increase patient registration accuracy using quality assurance and real-time, automated eligibility verification
- Improve POS tracking and collections using price estimation and payments
- Integrate trainings and measurement tools to improve accuracy rates

4. Support Staff Education and Create New Leadership Roles

- Implement new QA analyst and educator position to streamline processes, and to train and educate staff on AccuReg features and functionality
- Appoint team leads for departments (central scheduling, insurance verification, preregistration, etc)

5. Build a Career Ladder for Success

- Implement a career ladder and a three-tiered pay scale, from entry-level check-in roles and pre-registration to more advanced authorization and financial counseling roles
- Reduce staff turnover from 42% to 25%

EngageCare Provider significantly improved our patient access processes, giving staff the tools needed to produce clean claims and avoid revenue loss. Staff satisfaction increased and turnover decreased, despite COVID-19 challenges and reduced staff numbers due to temporary furloughs. We're thrilled to see staff thriving in their roles, and it's recognized throughout the hospital.

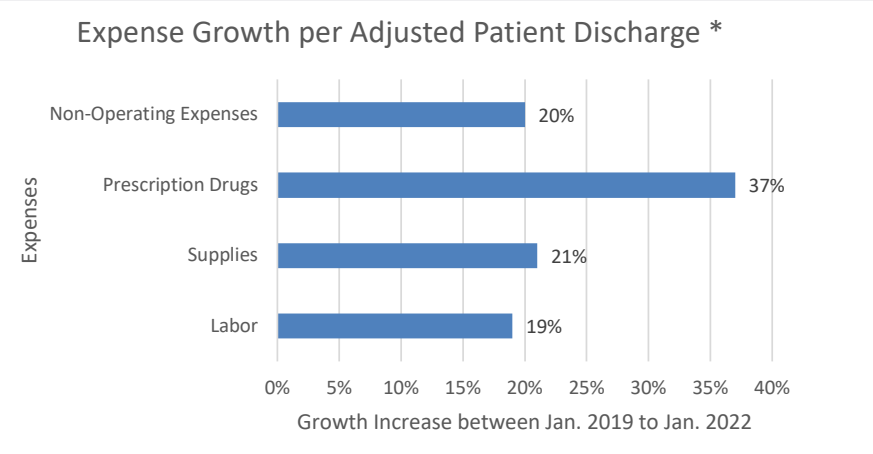
About the Author

Alicia Auman *is Regional Sales Director-Central at AccuReg. You can reach Alicia at aauman@accuregsoftware.com. To learn more about KSB's successful two-year journey and patient access outcomes, CLICK HERE to download the case study.*

Margin Improvement Strategies for the Post-COVID-19 Financials

Without a doubt, the COVID-19 pandemic has placed immense emotional, clinical, and financial strains on the U.S. and global economies. At the peak of this disruption in the health care sector, it was not uncommon for hospitals of all sizes and particularly mid-sized hospitals to be ***losing millions of dollars per week.*** Federal stimulus packages were a welcome sight and served as a financial lifeline for many over the last two years. Fast forward to today, those funding sources have come to an end revealing the unvarnished impact of COVID-19 on hospital margins. Numerous hospitals are hovering near or at bond defaults this year and are scrambling to assess and forecast cash flows—some organizations are even selling investments to realize gains to meet debt covenant compliance for their June 30, 2022, deadlines. Now more than ever it is critical for hospital leaders to communicate a message of financial resilience and action-taking with their boards and management teams.

Implementing revenue growth strategies alone may not move the needle enough to achieve much needed and desired hospital margins. What's more, the sluggish patient volumes of Q1 and Q2 2022 are creating worrisome forecasts and prompting many CFOs to look for cost management options. A recent survey identified expense growth per adjusted patient discharge from January 2019 through January 2022 had significantly increased in the areas of labor, supplies, prescription drugs and non-operating expenses*:



The following roadmap of margin improvement strategies should be considered for achieving much needed and desired margin improvements in the Post-COVID-19 environment.

Step 1: Recast net margin financial projections WITHOUT stimulus funds, and WITH increased labor, supplies, pharmaceutical drugs and non-operating costs to quantify the margin gap needing to be closed. Look at this margin gap as a dollar amount rather than a percentage. Visualizing a margin improvement "dollar target" whether $8M or $40M that is needed to fill the margin gap can help Management stay focused on the goal and tracking of real time results.

Step 2a: Assess for non-labor cost management opportunities such as supplies, pharmaceutical drugs, purchased services and employee benefits. The supply chain for most health care organizations is vast and complex. However, with the right strategy and skills around contract negotiations and management, the supply chain can be leveraged to generate reliable year over year savings. Average cost reduction initiatives can successfully increase net margins between 1% to 3.5%. The most common post-COVID-19 margin opportunities are occurring in the areas of:

- Medical/Surgical supplies
- Medical devices and implants
- Pharmaceutical drugs
- Food and nutrition
- Lab reagents and blood products
- Utilities
- Biomed
- Technology
- Purchased services
- Employee benefits

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Margin Improvement Strategies for the Post-COVID-19 Financials

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Step 2b: Assess for labor cost management opportunities. This may seem counter intuitive as nearly all hospitals have struggled to maintain core staffing levels over the last two years. However, as COVID-19 volumes decline, staff productivity metrices should be rebased and monitored closely as we return to pre-pandemic volumes. This may mean historic units of service and/or benchmarks need to be re-evaluated. At the height of the pandemic, contract labor expense as a percentage of payroll rose to an all-time high of 5.6%. ** Management and Human Resources should work closely to bring the contract labor percentage back down to pre-COVID-19 ranges of between 1.5% and 2% of payroll. Hospitals in markets where staffing shortages are still prevalent and contract labor is required should consider negotiating at least a 10% discount from their staffing vendors. Other post-COVID-19 labor initiatives include:

- Assessing staffing mix (RN vs LPN vs MA)
- Policies and application of overtime, differential, PTO accrual, and use of exempt vs non-exempt status
- Span of control

Alternative strategies should be considered as they relate to flexibility in the workforce of the now and future. The vast majority of health care professional say they want flexibility and approximately half say they would leave their current employer if they were offered more flexibility elsewhere. Management and Human Resources should assess and implement programs that offer flexibility while maintaining appropriate levels of quality and productivity. Turnover especially as it relates to new-hires within the first year is extremely disruptive and costly if you can even find candidates to fill the open requisitions.

Step 2c: Assess for revenue cycle cash collection opportunities. When the pandemic started, many hospitals made the difficult decision to halt patient liability collections both on the front-end and back-end. Most hospitals have since resumed patient liability collection efforts and are playing post-COVID-19 catch up which is on top of the previously historical catch up. We have seen significant increases in patient liability/ accounts receivables aging over the last two years.

In addition, we have seen revenue cycle teams struggle to recruit, train, and maintain staffing needed to address these account receivable backlogs and improve revenue cycle performance as competition for staffing increases across industries. Organizations see 2% to 5% improvement to patient net revenue through improvement of core revenue cycle functions. The most common post-COVID-19 margin opportunities are occurring in the areas of:

- Pre-service and post-service patient liability collections strategy
- Insurance denial management and prevention
- Assessing internal and vendor revenue cycle staffing and alignment of resources

Step 3: Quantify the annualized financial benefit of each identified opportunity in 2a, 2b and 2c. Set both conservative and aggressive targets for each opportunity.

Step 4: Perform gap analysis to determine internal capabilities, bandwidth and understanding of best practice to implement initiatives.

Step 5: Gain executive sponsorship and assign accountable executives to each initiative or group of initiatives and develop timelines and milestones for implementation, and additionally, define success for each initiative.

Step 6: Monitor, adjust and repeat.

*"Financial Effects of COVID-19: Hospital Outlook for the Remainder of 2021," *KaufmanHall,* September 2021; "Medical cost trend: Behind the numbers 2022," *PWC,* 2022; "National Hospital Flash Report," *KaufmanHall, January 2022.*

**Source: Advisory Board Turnover, Vacancy, and Premium Labor Benchmarks, March 2022; "AHA and AHC/NCAL Send Letter to White House on Exploitation of Staffing Agencies," Health Innovation; NBC News; Time Magazine*

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Notification vs. Authorization:
Knowing the Difference is Vital to Working With the VA

With the introduction of the Maintaining Internal System and Strengthening Integrated Outside Networks ("MISSION") Act, the VA restructured and streamlined their authorization process. At the same time, when the VA stood up the Community Care Network ("CCN"), the VA also strengthened the notification system for emergency care. While these processes are known throughout the community, the VA utilizes them in different manners. Let's look at how they work and how it will impact your Veteran population.

Definition of Authorization:

Authorization is the more straight-forward concept of the two. Essentially, even though a Veteran now has the option to seek care from a hospital or clinic that is not a VA facility, the VA still must approve that care via an authorization. It's not a guarantee as the Veteran must meet one of these five criteria set forth by the VA to determine eligibility.

1. The Veteran needs a service not available at a VA medical facility.
2. The Veteran lives in a U.S. state or territory without a full-service VA medical facility.
3. The Veteran qualifies under the "grandfather" provision related to distance eligibility under the Veteran Access, Choice, and Accountability Act ("VACA Act").
4. The Veteran contacts an authorized VA official to request the care required, but the VA has determined that they cannot furnish it.
5. Authorization is in the Veteran's best medical interest, of the Veteran to access care or services when looking at a host of factors: distance, nature, frequency, timeliness, improved continuity of care, quality of care, or the Veteran faces an unusual burden.

Authorizations can be found in the Health Share Referral Management Portal ("HRSM") as the VA coordinates that care with the CCN. Also, if your organization is planning a specific test, the VA publishes the Standardized Episodes of Care Billing Code listing. This list possesses the codes that require pre-authorization versus those that do not.

We've seen how the VA has modernized what happens with planned services, let's look at how the VA treats care that is emergent in nature.

Definition of Notification:

Emergency care is unexpected and unplanned, which means that a Veteran cannot get a prior authorization for hospital care. Veterans can seek emergency care when there is an injury, illness, or symptom so severe that without immediate treatment, an individual believes their life or health is in danger. When a Veteran arrives for emergency treatment, a hospital has 72 hours to notify the VA of the Veteran arriving for treatment. The hospital can utilize one of three methods to notify the VA:

1. Online at https://emergencycarereporting.communitycare.va.gov/#/request
2. By phone at 844-724-7842
3. In person with the appropriate VA official at the nearest VA medical facility

This notification period allows the VA an opportunity to see if one of their facilities can receive the patient as a bed or a bay is available. If there is an opportunity to transfer the Veteran, the VA will coordinate that care and move the patient from the hospital. However, if the VA finds that there is no bed or bay available, the VA will look to authorize the care for a certain number of days until discharge is appropriate or a transfer can occur without incident. By utilizing one of the three methods listed above, the VA will establish a connection with the hospital and request updates to the Veteran's care. If a request from the VA is not completed, the VA can review the case for an adverse determination. Therefore, it is important to follow up with the VA at a regular interval as this notification will transform into an authorization.

The information needed to successfully initiate a notification is listed below.

Veteran Information	Treating Facility Information
Name	National Provider Identifier (NPI)
Gender	Name
Social Security Number	Address
Date of Birth	Point of Contact (POC) Name
Veteran Address	POC Phone #
Date Presenting to Facility	POC Fax #
Date of Discharge	POC Email
Admitted? (Yes/No)	*NOTE: POC will receive VA authorization decision information*
Chief Complaint/Admission DX and/or Discharge DX	
Originating Location (address where the emergency event occurred)	
Mode of Arrival	
Other Health Insurance	

It is imperative that a hospital notify the VA within the 72 hours from when treatment begins. The window is set up to see if the Veteran can be transferred in real time. The window does not start at discharge, but admission. If the Veteran presents unconscious, mentally altered, or fails to present their VA coverage information, the hospital can still initiate the notification period. However, a hospital must present those facts to the VA while they consider the case.

As we continue to see elevated levels of Veterans seeking treatment outside the VA network, knowing and understanding the intricacies of the VA is vital to getting your claims authorized. This step is just the first part in getting your claim processed and paid by the VA. Most hospitals find that navigating the VA claims process is best accomplished by a dedicated VA specialist, either internal or outsourced, who can focus exclusively on mastering the VA's regulations and processes.

About the Author

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No Surprises Act: How to Avoid Noncompliance and Unwanted Surprises

The No Surprises Act became effective on January 1, 2022. Here's how to ensure compliance and avoid unwanted surprises in your healthcare organization.

The No Surprises Act (the act) is here, and healthcare organizations have work to do to understand its complexities, update policies, train staff, and ensure compliance at facilities.

Overview of the act

In a nutshell, the goal of the act is to protect patients from receiving surprise medical bills. Its scope includes items and services provided to individuals enrolled in health coverage through their employer, the Health Insurance Marketplace (the marketplace), or an individual health insurance plan purchased directly from an insurance company. It also includes protections for uninsured or self-pay patients. It doesn't include patients covered by Medicare or Medicaid since these patients are already protected and aren't at risk for surprise billing.

Balance billing for insured patients

Balance billing, also known as "surprise billing," happens when a provider bills patients for the difference between its or the healthcare facility's charge and the amount allowed by the insurance provider, i.e., the difference between the total cost of services being charged and the amount the insurance pays. For example, if the provider's charge is $1,000 and the amount allowed by insurance is $900, the provider may seek to "balance bill" the remaining $100 to the patient.

The act prohibits balance billing in the following types of situations:

- Emergency services: In this scenario, an insured patient receives covered emergency services but from an out-of-network provider and/or emergency facility.
    - To illustrate: Bob, who has marketplace coverage, has severe chest pains and calls 911. He's taken via ground ambulance to the nearest hospital facility with an emergency department where he receives stabilizing treatment. Bob can't be balance billed. If his marketplace provider denies all or part of the services due to the patient being out-of-network, the healthcare facility can't balance bill the patient for the denied charges. Note that the act requires the marketplace provider to pay reasonable charges for services in these situations, with the exception of the ground ambulance company that can balance bill for out-of-network transportation services because the act doesn't cover ground ambulance services.

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No Surprises Act: How to Avoid Noncompliance and Unwanted Surprises

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- Nonemergency services: In this situation, an insured patient receives covered nonemergency services from an out-of-network provider delivered as part of a visit to an in-network healthcare facility.
  - For example, Kim, who has employer-sponsored health insurance, discovers a lump in her breast. Her primary care provider orders a mammogram that shows a suspicious mass. She's referred to the local in-network hospital's outpatient department for a biopsy. The biopsy is reviewed by a pathologist who is out-of-network. The act bans the pathologist from billing Kim more than the in-network cost sharing amounts determined by her health plan.
- Air ambulance services: A person gets covered air ambulance services provided by an out-of-network provider of air ambulance services.

Notice and consent exceptions

In certain situations, a hospital facility can bill the patient for the balance for services, but only in limited situations, and only when the "notice and consent" requirements of the act are followed.

In situations where the healthcare facility provides the patient with notice of the out-of-network charges—and the patient consents to the charges—the act doesn't regulate billing for nonemergency services for:

- Nonemergency covered items or services provided in an out-of-network hospital, outpatient hospital department, or ambulatory surgical center.
- In-network items or services that aren't covered under the terms of an individual's healthcare plan or coverage.

Good faith estimates for uninsured or self-pay patients

State-licensed or certified healthcare providers are required to give good faith estimates of healthcare charges to every new and continuing patient who's either uninsured or isn't planning to submit a claim to their insurance.

Providers are also required to inform every uninsured or self-pay client of their right to receive a good faith estimate.

The list of services to be provided should differentiate between the services that the provider will be offering and those offered through what the act defines as "co-providers" and "co-facilities."

The good faith estimate must be provided in accordance with the following timing:

- If a service is scheduled at least 10 business days in advance, the estimate must be provided within three business days of when the scheduling was made.
- If a service is scheduled at least three business days in advance, the estimate must be provided within one business day of scheduling.
- If a service is scheduled less than three business days in advance, an estimate is not required.
- If an individual requests a good faith estimate, it must be provided within three business days.

There are no provisions within the act that allow patients to waive their right to a good faith estimate.

The patient has the right to engage in a dispute resolution process if the actual costs of services significantly exceed those listed in the good faith estimate.

A compliance checklist

To avoid surprises and ensure your organization is on track for compliance with the act, consider taking these steps:

- Analyze your billing data and determine if your healthcare facility will perform any balance billing of out-of-network patients. Determine the situations where balance billing is allowed and procedures for providing proper notice and consent.
- Establish a No Surprises Act policy that formally establishes how your healthcare facility will comply with the requirements.
- Establish monitoring processes to identify—before services are provided—self-pay patients for whom good faith estimates are required.
- Establish a process to provide disclosure statements to emergency and nonemergency patients of their rights under the act.
- Establish monitoring processes before billing occurs to identify out-of-network denials so that prohibited balance billing doesn't occur.
- Train employees on the new processes.
- Provide education to medical groups and independent physicians who provide services at your facility on the balance billing prohibitions.
- Prepare and implement plans for internal audit and compliance testing.

Preparing for these changes will take time and effort, so start sooner rather than later. And remember, you don't have to do it alone.

About the Authors

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4 Ways to Use Benchmarks to Reduce Corporate Cost

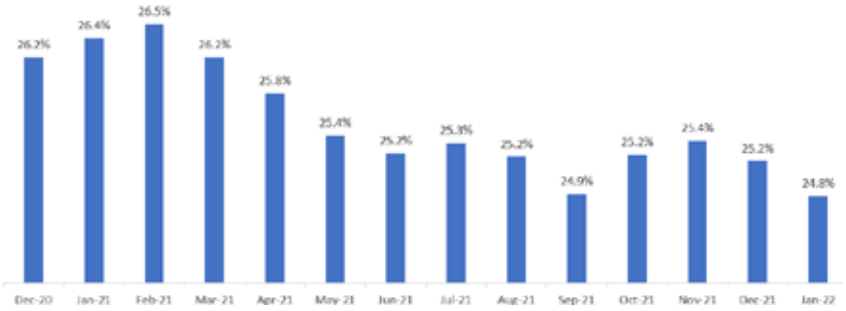
The average health system spends nearly 25% of its median expenses on corporate services, taken as a percent of net operating revenue. As such a significant share of overall hospital expenses, health system leaders simply cannot afford to overlook corporate services when assessing how to lower hospital costs, as discussed in a recent Healthcare Financial Management Association (HFMA) webinar.

Examples of corporate services include administration, finance, revenue cycle, human resources, information technology (IT), legal, and marketing. Why is cost reduction important in healthcare? Hospitals and health systems historically operate on tight operating margins, and incremental reductions in corporate expenses can make a huge difference. A five percentage-point reduction in corporate services costs could save an average health system in the U.S. an estimated $3.6 million annually.

Using data and benchmarking to identify high-cost areas and build cost saving measures for hospitals can help reduce corporate expenses and divert those dollars to critical patient care services. Taking four key steps will help your organization target opportunities to reduce corporate hospital expenses:

1. Measure
2. Compare
3. Evaluate
4. Act

Figure 1. Median Corporate Service Expense as Percent of Net Operating Revenue
Source: Syntellis' Axiom Comparative Analytics



Step 1: Measure

Benchmarking hospital performance is a standard, long-standing practice in evaluating patient care services. Yet benchmarking is far less common in corporate services. An old adage holds true across all health system expenses: "You can't manage what you can't measure."

The first step is to understand what to measure. Corporate services expenses can be measured in different ways. Three common metrics to consider are Expense as a Percent of Net Operating Revenue, Expense per Full-Time Equivalent (FTE), or Expense per Adjusted Discharge.

The key is to put costs into an appropriate context. For example, Expense as a Percent of Net Operating Revenue is a good general measure to use because it frames corporate services expenses within overall expenditures so you can begin to see how your organization performs compared to peers, as well as against itself.

For areas such as IT or legal, Expense per FTE can be a good measure to use because expenses in those areas typically shift significantly based on the number of FTEs. For smaller health systems with fewer FTEs, an examination of Expense per Adjusted Discharge may make more sense.

Step 2: Compare

Once you know how to measure specific services, you'll need to determine appropriate benchmark comparisons for those metrics. Identifying the right peer groups for comparison will ensure fair, accurate, and actionable results. Common criteria to consider include your organization's size, geographic location or region, and specific department or job code comparisons.

Again, the key is to put your health system's performance into the right context. Making the wrong comparison can easily skew the picture and make it appear that your organization is performing much better—or much worse—than it is.

One of the first comparisons to look at is by region. As one illustration of this, labor costs can vary depending on the region due to different costs of living in different parts of the country. There can be variances within regions, too, such as between rural versus urban areas.

An urban hospital in the South might find general administration labor expenses significantly lower than the national median or peer hospitals in other regions. Compared to other hospitals in the South or within other urban areas within the South, however, those same expenses may not appear so rosy.

The second dimension to consider is number of beds. Many aspects of a health system's costs are driven by its size. For instance, Expense per FTE for an IT department changes depending on your organization's

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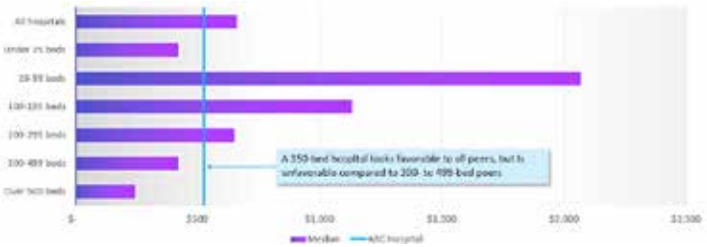
4 Ways to Use Benchmarks to Reduce Corporate Cost (continued from page 19)

bed size. While IT Expense per FTE for a 350-bed hospital may appear favorable compared to hospitals of different bed-size cohorts, it could be unfavorable compared to like-size peer hospitals with 300-499 beds (see Figure 2).

The more granular the comparison, the better for making an apples-to-apples comparison. From region and bed-size, you can drill down further to department-level or job-code comparisons. Ultimately, finding the most relevant comparisons will show how your organization performs relative to its peers within your market.

Figure 2. IT Expense per FTE
Source: Syntellis' Axiom Comparative Analytics



Step Three: Evaluate

Benchmarking corporate services reveals potential cost reduction opportunities when there is a sizable variance between peer medians and actual performance at your organization. Every variance, however, does not necessarily indicate a true opportunity.

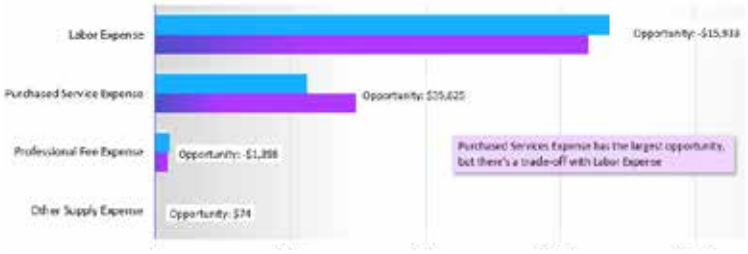
During step three, you'll evaluate comparisons to thoroughly assess your findings and may need to make trade-offs. Hospital cost cutting strategies in purchased services, for instance, could have repercussions on labor costs if you need to hire additional FTEs to make up for those losses and maintain adequate operations.

Drilling down to department-level comparisons can reveal cost saving ideas for hospitals in areas with the largest variances. For example, let's say an analysis of Expense per Adjusted Discharge reveals a $175,000 variance between revenue cycle expenses at your organization compared to those at peer hospitals.

Let's evaluate further using Figure 3. Here, the Revenue Cycle Management Department's purchased services expense appears to have the largest opportunity for cost reductions at $35,625, but we must also factor in how reductions here may increase spending elsewhere, such as labor expense. When assessing possible initiatives to reduce purchased services costs and bring them closer to median performance, remember to evaluate the impacts on labor expenses so you don't negate the improvements in purchased services.

Everything is a balancing act. Before implementing healthcare cost control strategies, it is important to fully understand the various cost reduction opportunities and other changes those reductions might bring to your organization, both positive and negative.

Figure 3. Expense per Adjusted Discharge, Revenue Cycle Management Department
Source: Syntellis' Axiom Comparative Analytics



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4 Ways to Use Benchmarks to Reduce Corporate Cost (continued from page 20)

Step Four: Act

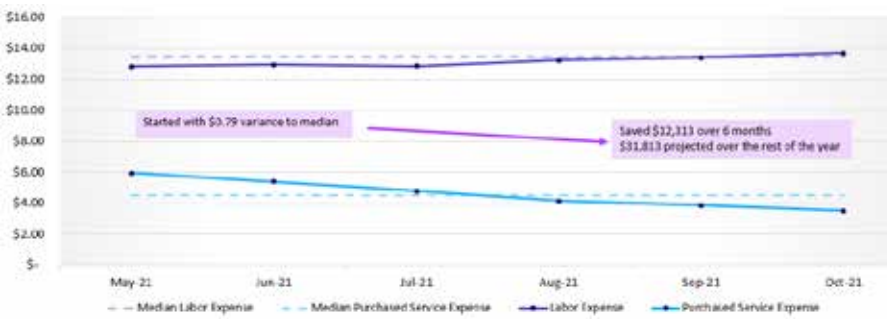
Finally, it's time to act on the hospital expense reduction ideas you identified. For this step, work together with the people who will execute the cost containment effort. In our Revenue Cycle Management Department example, finance leaders would work with those in charge of purchased services and leaders in specific departments to gain buy-in, so they can help make adjustments to offset any losses with labor or productivity increases.

Having the data and benchmarks to demonstrate the reasoning behind your actions will help build that buy-in. Clear lines of accountability and milestones to measure progress will ensure proper execution of the plan.

Strategies to reduce healthcare costs should be realistic and achievable; a phased approach often works best. For example, a health system seeking to reduce IT expenses that are in the 40th percentile of the median compared to its peers may seek to progress to the 45th percentile within the next year and the 50th within two years. The idea is to move the needle little by little to ensure sustainable results.

As with all hospital cost reduction strategies, controlling corporate services spending should be an ongoing process (see Figure 4). Organizations should continuously reevaluate their performance against an ever-changing market. Integrating hospital cost reduction and containment processes into everyday operations involves routinely going through the cycle of measuring, comparing, and evaluating benchmarks to determine viable opportunities. Without continuous improvement, costs tend to creep back in overtime and can negate prior, hard-fought reductions.

Figure 4. Expense per Adjusted Discharge, Revenue Cycle Management Department
Source: Syntellis' Axiom Comparative Analytics



Conclusion

If left unchecked, the high costs associated with corporate services can eat into already tight hospital and health system operating margins.

Healthcare leaders should continuously ask: How can hospitals cut costs? To identify cost reduction opportunities, it is important to look at costs from different angles and in different dimensions. For example, in evaluating IT expense per FTE across a large health system, you should break it down and examine measures of that metric from each individual facility within the broader system. You may find that a specific site is driving a disproportionate share of the overall costs.

Breaking down corporate services costs and measuring them against appropriate peer-group comparisons will help your organization prevent missed opportunities and avoid false opportunities. Through continuous improvement, you can achieve sustainable cost reduction in healthcare to operate more efficiently and optimize resources for patient care.

About the Author

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Professionals Helping Professionals in Their Careers:
Q&A with a First Illinois Chapter Mentor and Mentee

We recently participated in the First Illinois HFMA Mentor Program and found the experience to be enriching from both a mentee's perspective and a mentor's perspective. In general, helping someone else can be an enriching experience. In the mentor program, we found that we learned much about the other person and discovered things that we did not know about ourselves. For each of us, we found the greatest reward in this professional and interpersonal experience was seeing the value we could bring to others, which also helped grow our confidence. During the process, the trust and respect, open and honest communication, flexibility, and understanding of others' perspectives that the mentor and mentee bring lay the foundation for a successful mentoring relationship. Ultimately, the mentor benefits because they can lead the future generation in an area they care about and ensure that best practices are passed along, and the mentee benefits because they can be better prepared to demonstrate that they are ready to take the next step in their career and can receive real-life practical advice and support to facilitate working towards that advancement. We want to share below a brief introduction about each of us and more specifics, in a Question & Answer format, about our experience with the mentor program.

Brief Introduction of Mentee and Mentor

Meagan Edgren (the mentee).

I am a Senior Financial Analyst in Net Revenue and Reimbursement for Rush University Medical Center. I earned a Master of Science in Accountancy (MSA) from Aurora University in Aurora, Illinois, in 2015 and hold both the Certified Healthcare Finance Professional (CHFP) and Certified Revenue Cycle Representative (CRCR) through HFMA. I have spent my entire professional career in the healthcare industry. I actively volunteer with the First Illinois HFMA as the Certification Committee Co-Chair. In my free time, I enjoy spending time with my fiancé planning our wedding for May 2023 and hitting the trails with our two Siberian Huskies.

Victoria Levitske (the mentor).

I am the Financial Director for the University of Chicago Physicians Group. I have over 30 years of experience as a Financial Director, Chief Financial Officer, and Chief Operating Officer for multi-specialty/multi-site group medical practices and healthcare plans with large inter-city, regional, community, university academic-based, public, and private healthcare systems. I earned a Master of Public Management (MPM) degree with highest distinction, health systems concentration, from Carnegie Mellon University, and a Bachelor of Science in Business Administration degree, majoring in accounting, from Duquesne University. Also, I hold HFMA's CHFP. My husband and I enjoy spending time with our three children and their activities: our oldest daughter is a new medical doctor beginning her residency, our son is graduating this spring with a master's degree in architecture, and our youngest daughter is a college softball pitcher and pursuing a master's degree in architecture.

Questions and Answers

1. Did you know each other prior to being partnered through the First Illinois Chapter's mentor program? If not, what did you do to establish a relationship quickly and how did that impact your ability to have meaningful conversations?

No, we did not know each before the mentor program. The Mentor Program Committee reviewed our backgrounds and assigned us. We quickly established a mentor/mentee relationship by telling each other about ourselves, our experiences, and where we are currently positioned in our careers. After the initial meeting, we were more comfortable discussing various other topics within the business of healthcare. Mostly, we met through Zoom video and telephone calls. We also met in person at HFMA in-person events.

2. What is your favorite takeaway or benefit from the mentor/mentee relationship, both as mentor and mentee? What did you learn from each other?

The experience has been enriching for both of us. We found that meeting someone new and from another healthcare organization was great. We have shared different perspectives on challenges our organizations have been facing, not just those related to the COVID-19 pandemic.

Mentee: My favorite take-away from this experience was Vickie's willingness to help and guide me as I approached the next move in my career. She was an incredible resource for resume review and helped instill confidence within me to discuss my accomplishments thus far in my career.

Mentor: I appreciated Meagan's willingness to openly share her thoughts and perspectives, such as her reminders to keep things simple. Sometimes as mentors, we know so very much about a topic. However, it is often still necessary to "keep things simple" enough to keep matters focused on practicing what is possible to achieve a positive outcome. I found it a privilege to serve as an experienced and trusted advisor to someone like Meagan, who is moving forward in her professional career.

3. What advice do you have for others who have a mentor/mentee relationship or are interested in seeking one out?

Do it and make the time. As professionals at all levels, each has something important to share with others, and sharing is a two-way street. Some advice we would give others regarding a program is:

- Both individuals must be willing to build and grow a new relationship.
- Try to choose someone who shares some similar values to your own.
- Choose someone within your current organization but looking outside of those walls may provide a distinct perspective or solutions to challenges.
- As a mentor, it is helpful to have a mentee at an earlier level in their career. This allows the mentor to share prior

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Professionals Helping Professionals in Their Careers: Q&A with a First Illinois Chapter Mentor and MenteeSurprises

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experiences and advice on how to avoid mistakes that the mentor may have made at their own earlier level.

- As a mentee, it is helpful to have a mentor whose career the mentee aspires to. This helps the mentee assess the next steps in career growth and provides the opportunity to ask questions about past situational experiences.
- Jointly commit to the process and set mutual goals.
- Establish a communication plan and agree on regular touchpoints and accountability check-ins.

4. Has the mentor/mentee relationship been different in the remote/hybrid work environment? If so, in what ways?

With the remote working environment, nearly all our meetings took place via Zoom video or audio call. We began working together in the summer of 2020 and were finally able to meet in person for the first time at the October 2021 First Illinois Chapter's Fall Summit Conference. We found that the remote/hybrid work environment did not hinder the mentor/mentee relationship. While it would have been great to meet more often in person, we felt that the remote environment did make scheduling easier.

Recommendations

We appreciated the opportunity to participate in the First Illinois Chapter's Mentor Program and recommend that those interested in the program contact the chapter at education@firstillinoishfma.org.

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Victoria Levitske, *MPM, CHFP*
University of Chicago Physicians Group

First Illinois Chapter Invitational Executive Golf and Scholarship Event 2022

Friday, August 19, 2022
8:30 am Shotgun Start

Willow Crest Golf Club
Oak Brook, IL 60523-2573

Join us for golfing, camaraderie and good food in support of the First Illinois Chapter's scholarship fund. Annually, the First Illinois Chapter awards $15,000 in scholarship monies to collegebound students of chapter members. The August golf event is the chapter's only golf event of the year and the largest source of funding for this worthy cause.

Located adjacent to the estate of Hilton Chicago Oak Brook Hills Resort and Conference Center, the 18-hole, 6,433 yard par 70 Willow Crest Golf Club offers premiere course conditions combined with a spectacular natural setting for a memorable golf experience.

All scholarship donations are 100% tax-deductiible and used only for the scholarship program. Gifts of any size are greatly appreciated . To make your 100% tax deductible donation, **CLICK HERE.**

For more information about golfing or event sponsorship opportunities, contact Golf Event and Partnership Coordinator at ecrow@firstillinoishfma.org.

HFMA Region 7 Midwest Conference

October 23- 25, 2022

REGISTRATION NOW OPEN!

CLICK HERE to learn more.

Hilton Chicago/Oak Brook Hills
Resort & Conference Center
3500 Midwest Road
Oak Brook, IL 60523

HFMA's Region 7 Chapters are bringing together healthcare industry executives and experts for a two and a half-day premier event, with education sessions including a keynote address from HFMA's current chair Aaron Crane, an executive panel of the regions top leaders discussing their careers in healthcare, a panel discussion with presidents of each state's hospital association and many more.

Other highlights of the conference:

- Over 300 healthcare financial professionals expected to attend
- Valuable networking opportunities including a social event on Sunday & Monday evening with great food, drinks, and music.
- Earn up to 12 CPE Credits

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Volunteering for a First Illinois Chapter committee or event is a great way to get the most out of your chapter membership. Answer the call to be a chapter leader in four easy steps:

1. Visit **firstillinoishfma.org**
2. Click on the **Volunteer Opportunities tab**
3. Check out the **Volunteer Opportunity Description**
4. Fill out the **volunteer form** and become more active today!

Or simply drop us an email at admin@firstillinoishfma.org.

First Illinois Chapter 2022 Scholarship Program Recipients

Please join us in congratulating this year's First Illinois Chapter's scholarship recipients. The recipients were formally recognized at the Annual Tradition's Dinner on June 16.

- **Jerry Quan** received a $5,000 scholarship to Brown University
- **Lucas Ruhe** received a $4,000 scholarship to DePaul University
- **Mary Powers** received a $2,000 scholarship to University of Iowa
- **Morgan DeHaan** received a $2,000 scholarship to the Massachusetts Institute of Technology (MIT)
- **Ariel Pomierski** received a $1,000 scholarship to the University of Wisconsin - Whitewater
- **Brittany Pomierski** received a $1,000 scholarship to the Grand Valley State University

Help Continue the Tradition Make Your Tax-Deductible Donation Today

Over the years many of you have expressed tremendous support and pride in our chapter's ability to assist our future leaders pursue their educational dreams, so please take a moment to consider providing some level of financial support to continue this program.

All donations are 100% tax-deductiible and used only for the scholarship program. Gifts of any size are greatly appreciated.
To make your 100% tax deductible donation, **CLICK HERE.**

Thank you for supporting our efforts to make a difference.

2022 Spring Forward Conference, Fairmont Chicago Millennium Part Hotel

May 19-20, 2022

Fairmont Chicago,
Millennium Park
200 North Columbus Drive,
Chicago, IL 60601

Welcome New Members

February 7–June 10, 2022

Sharice Adkins
Patient Access, OSF Little Company of Mary

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Welcome New Members (continued from page 27)

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Welcome New Members (continued from page 28)

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Welcome New Members (continued from page 29)

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