First Illinois Speaks
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LEADING the CHANGE

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News, Events & Updates

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The New Frontier of Telehealth: Providing Personalized, Targeted Care in an Electronic Age

BY DANIEL T. YUNKER, CEO OF MCHC, CEO LAND OF LINCOLN HEALTH AND IMMEDIATE PAST PRESIDENT, FIRST ILLINOIS HFMA

In today's fast-paced world, consumers increasingly turn to technology-based services for everything from take-out sushi to graduate courses. Face-to-face interaction seems to be less and less the norm. And the health care industry certainly isn't immune to this trend. In fact, I'd argue that tech and health care are more *connected* than ever (pun intended, of course).

On-the-go parents with an achy-eared teenager might log in to a virtual provider's office via a phone or tablet app. The provider, by asking a few questions, can give a diagnosis, prescribe a medication and help the busy family get back to soccer practice and orchestra lessons. Or a physician seeking a second opinion on a complicated case can videoconference with a colleague across the country, ensuring the patient is receiving the most thorough and highest quality of care.

These virtual visits could never replace the comprehensiveness of a patient's annual physical or mend a broken bone, but for increasingly busy consumers and providers, they've proven popular for routine and specialty care in a pinch.

From apps to wristbands, we all know the consumer-facing aspect of this industry. But equally important, if not more, is how technology can empower physicians and other providers in diagnosing, treating and following up with those in their care in order to achieve the best outcomes. From the example above to electronic health records to online databases and toolkits, health care has turned the technology corner. And there's no going back.

More than convenience, telehealth allows us to tap into resources and experts in a way we could not previously do so. It connects a primary care provider in far-flung Alaska with a cancer specialist in one of Chicago's top hospitals. It gives a nurse practitioner in Chicago access to the whole picture of a new chronically ill patient's health—without running dozens of tests—when he moves to the suburbs. In what

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The New Frontier of Telehealth: Providing Personalized, Targeted Care in an Electronic Age

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might seem like a decreasingly personalized world, telehealth actually permits providers the opportunities to deliver more personalized and convenient care than ever before.

As a result of budgetary cuts at the state and federal levels, among other factors, emergency departments (EDs) across the region have seen a 47% increase in the number of behavioral health patients. Most institutions, due to these budgetary restrictions or to location, do not have round-the-clock access to psychiatric support, leading to average boarding times for this population that are *three times* those of the typical ED patient.

In the Chicago market, the Midwest Telepsychiatry Consortium (MTC) is collaborating with participating institutions to improve outcomes by increasing access to psychiatric care, enhancing the quality and efficiency of ED treatment and *significantly reducing boarding times for behavioral health patients in distress.*

Through the service, on-site emergency physicians can obtain patient assessment, treatment and admission decisions from board-certified psychiatrists. Initial response times are typically less than 60 minutes. Using real-time, interactive audio and video technology, patients can receive an appropriate, personalized care plan that is consistent with their needs.

Consortium hospitals are seeing reductions in admissions, reduced lengths of stay, improved ED throughput, increased regulatory compliance and enhanced satisfaction for all patients. Efficient care of behavioral health patients, in turn, frees up department resources to most effectively treat all ED patients.

As a final thought, budgetary cuts, reallocation of resources and the changing model of health care delivery have led us into unprecedented territory. But, with patient safety and the highest quality of care top-of-mind, the industry is finding ways to respond to these opportunities, particularly through technology. Nothing will ever replace yearly exams or emergency department visits. But the continued connection of health care and technology, I am absolutely certain, will find limitless ways to enhance those experiences.

Dan Yunker

President and CEO MCHC, CEO Land of Lincoln Health and Immediate Past President, First Illinois HFMA

President's Message

It has been an honor and a privilege to lead the First Illinois Chapter of HFMA for the past year. As always, when things come to an end one has a tendency to look back and assess. When working with an organization with over 1,400 members, change can happen gradually and incrementally. However, we worked together to make change happen and continue the plans put in place several years ago. Before this year began we invited the 22 committee chairs and 11 board members to a strategic planning session that focused on four areas: provider involvement, membership, education and sponsorship. Throughout the year we focused on ways to engage and saw provider turnout at our programs increase significantly. The chapter delivered over 16,000 education hours and collaborated with outside organizations on seven of their events on a wide array of topics. We attracted many new members who will see the benefits HFMA can provide in career growth and professional development. Our values of service, excellence, innovation, teamwork and financial responsibility guided us well throughout the year. We measure our success in part by the member satisfaction survey, which was above the goal for the second consecutive year.

I joined HFMA in 1982 and have met many along the way. I could not have reached the successes I enjoyed without the educational benefits and networking opportunities the chapter provides. For that I am blessed and grateful. With an organization of this size it takes a small army of people to keep things moving forward. Thank you to my fellow officers and board members for their energy and leadership. Thank you to the many, many volunteers who led a committee, participated as a committee member, and otherwise gave their time and talent to HFMA. As a volunteer organization, it is truly amazing that so many people engage to give without compensation. The vision of FIHFMA to be the indispensible resource for healthcare finance will continue to challenge us as I pass the torch to Adam Lynch.

Carl Pelletieri
2014 – 2015 First Illinois,
HFMA Chapter President

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Proper Physician Documentation:
More than Just Your Bottom Line

BY JOHN D. ZELEM, MD, FACS, EXECUTIVE MEDICAL DIRECTOR OF CLIENT RELATIONS AND EDUCATION, EXECUTIVE HEALTH RESOURCES, NEWTOWN SQUARE, PA

Physician documentation in the medical record helps provide the cornerstone of medical necessity that not only can help validate the level of patient care provided, but also help to ensure proper reimbursement to the hospital.

An increase in denials by Recovery Auditors (RAs), Medicare Administrative Contractors (MACs), Commercial Payers and others has propelled documentation into the spotlight as a critical part of the equation.

The Benefits

I highly doubt that anyone would argue that accurate and complete physician documentation is essential, but there are definitely a number of clear cut benefits—beyond helping to ensure proper reimbursement is received from cases submitted.

Quality of Care. Increased quality tops the list of benefits that comes to mind. A 2008 *Archives of Internal Medicine*[1] article indicated that "medical records for patients with NSTEMI often lack key elements of the history and physical examination. Patients treated at hospitals with better medical records quality have significantly lower mortality … (and) the relationship between better medical charting and better medical care could lead to new ways to monitor and improve the quality of medical care." The article also points out that patients cared for at hospitals that had better medical recordkeeping experienced lower in-hospital mortality compared to patients who did not have this experience.

Increased Patient Safety. Although not as noticeable a benefit at first, patient safety and the quality of physician documentation within the medical record can run hand in hand. According to a recent study published in the September 2013 issue of the *Journal of Patient Safety*[2], between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death. Staggering numbers, such as these, can help stress the need for better documentation to provide a clear picture of the care provided.

Increased Accuracy and Specificity. A third notable benefit as the result of proper physician documentation is the increase in accuracy and specificity within the medical record. In addition to this, timeliness of the information recorded tends to lead to higher accuracy within documentation. With increased proficiency in accuracy and specificity from better documentation comes a better description of services provided to the patient. This outcome can also lead to an increase in quality scores—the higher the quality scores, the more a reflection of patient acuity. This can have collateral benefit to 30 day risk adjusted mortality and readmission rates amongst some other metrics being measured.

Potential Roadblocks

Although improvements to the physician documentation process have evolved over the years, the road traveled has been a rocky one, to say the least, with some even claiming that documentation has even deteriorated the more it progresses.

Among these factors, two stand out as the prime culprits impacting physician documentation: the emergence of the electronic medical record (EMR) and the uneasy transition from a source-oriented record to a problem-oriented record.

Electronic Medical Record. The future of EMR holds so much promise that, according to *The New York Times*[3], "the federal government is spending more than $22 billion to encourage hospitals and physicians to adopt electronic health records." But the problems can start basically from the planning stage, as EMRs are typically designed by non-clinicians, i.e., programmers who are not as familiar with how hospitals and clinicians actually function.

As reported in the *Times* article, "cutting and pasting" (C&P), commonly referred to as "copy forward," may allow for "information to be quickly copied from one portion of a document to another, as well as reduce the time that a doctor spends inputting recurring patient data," but it also leaves the window open to potential fraud. In an effort to cut down on C&P abuse by physicians who are performing less work than they actually bill, the Office of the Inspector General (OIG) has named the issue of cloning in the medical record as a priority in 2015, the Times reported.

To further muddy the concerns on documentation, the EMR is limited in providing the opportunity for physicians to include their own thoughts and comments. So much within the record is a template, a checkbox, etc., which prevents physicians from documenting their impressions, assessments and courses of action for the patient.

Problem-Oriented Record. The creation of the problem-oriented medical record (POMR) by Dr. Lawrence Weed in the late 1960s provided a disciplined approach for physicians to include proper documentation in the medical record. Through POMR, Weed created the SOAP note (an acronym for "Subjective, Objective, Assessment, Plan"), which gave physicians a structured approach to gathering and evaluating the volumes of information contained in the medical record and provided them with an avenue to better communicate with each other.

Over the years, physicians have essentially abandoned the fundamentals of the SOAP approach to the more straight-forward, but not necessarily well-rounded "Problem List" approach. But in order for this transition to be effective, physicians must be able to successfully address all of the following factors:

- The problem list was actually designed to help with treatment progress. Many times, the initial problem list is copied and pasted, unchanged, from one day to the next with no original thought or comment. This practice can present challenges for Utilization Management, coding, discharge planning, as well as others.

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Proper Physician Documentation: More than Just Your Bottom Line

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- The problem list may not adequately express the physician's concerns for what is actually going on with the patient.
- The problem list may not connect the risks and acuity with which the patient presents.

The Importance of Quality

Physicians need to lead the charge in documentation improvements in the medical record. As budgets get tighter and resources become fewer, one misconception rears its ugly head— that hospitals are forcing improvements in this area solely to benefit coding and help increase revenue. As a matter a fact, it's just the opposite. Medicare actually encourages hospitals to improve their coding to support proper reimbursement, which may be higher or lower based on the documentation, but also for better reflection of the patient acuity. This improved accuracy can only increase cost measures, such as the case mix index (CMI), over time, as well as the previously mentioned quality scores. Accurate and specific documentation may also favorably impact audit findings and prevent reimbursement delays or take backs, due to incorrectly denied hospital and physician claims.

Better documentation can benefit both hospitals and physicians through quality scores that are now readily available in publicly recorded data, such as Healthgrades. The road to improved physician documentation has not been without its bumps and curves over the years, but physicians remain on the front line of this issue, and need to take an active part in ensuring that the quality and thoroughness of their documentation stands as a true record of the care provided.

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About the Author

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Stage 2 Meaningful Use in 2015

BY CHRISTINE O'MALLEY, HEALTHCARE CONSULTANT, PBC ADVISORS, LLC

Many physicians are anxiously waiting to hear from CMS how long the reporting period will be for Meaningful Use in 2015. On January 29, CMS indicated it will reduce the period to 90 consecutive days for 2015, but that has not been finalized and as of right now the reporting period remains the entire year regardless of which stage.

Stage 2 has the same structure as Stage 1, however now EPs must report on 17 core objectives and three out of six menu objectives. Some of the most significant changes from Stage 1 to Stage 2 are increased thresholds for many of the objectives. There are not many measures with exclusions, making it more difficult for EPs to meet objectives.

Most of the new items for Stage 2 are the menu objectives. New criteria for summary of care, transition of patients and e-prescribing leads to major changes and the health information exchange playing a large part for Stage 2 measures. Planning to meet meaningful use with all these changes will affect workflow and use of technology for EPs. See below for all objectives, thresholds and exclusions for Stage 2 - 2015. All this information can be reviewed at:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Guide_EPs_9_23_13.pdf

Core Objectives - Report on all 17

Number	Objective	Measurement	Exclusion
1	Computerized Provider Order Entry (CPOE)	More than 60% Medication, more than 30% of Lab, and 30% of Radiology	Fewer than 100 Medication, Radiology and Lab orders
2	Generate and transmit prescriptions electronically or e-prescribing (eRx)	More than 50% of all prescriptions written compared to drug formulary and sent electronically using EHR	Write fewer than 100 prescriptions
3	Record demographics	More than 80% have language, gender, race, ethnicity and date of birth	There are no exclusions
4	Record vital signs	More than 80% for patients age 3 and over have blood pressure, height and weight	Can be excluded from recording all three vital signs if: 1) Don't believe these vital signs are relevant to your scope of practice, 2) Can also be excluded from recording just blood pressure if you don't believe blood pressure is relevant for you, 3) Just height and weight if you don't believe height and weight are relevant for you, 4) Excluded from recording blood pressure if you see no patients age 3 or older
5	Record smoking status	More than 80% for patients age 13 and over	Do not see patients 13 & Older
6	Clinical decision support rule	1) Implement 5 clinical decision support interventions related to 4 or more clinical quality measures; 2) Enable drug-drug and drug-allergy interaction checks	1) No exclusion for first objective, 2) Write fewer than 100 medication orders
7	Provide patients ability to view online, download and transmit their health information	More than 50% provided access to their health info within 4 business days	Do not order or create any of the required information
8	Provide clinical summaries for patients for each office visit	More than 50% within one business day from visit	Do not conduct office visits
9	Protect electronic health information created or maintained by EHR	Meet the same HIPAA requirements using EMR as you do with paper records. Conduct security review of your system, correct and create action plan	There are no exclusions
10	Incorporate Clinical-Lab Test Results into	Results from over 55% of lab tests ordered during the reporting period are recorded in the EHR as structured data - as long as the tests yield a number or a positive/negative response	Did not order any lab tests during the reporting period or if none of the results from the tests you ordered came back as a number or as a positive/ negative response

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Stage 2 Meaningful Use in 2015 (continued from page 6)

11	Generate list of patients by specific condition	Generate relevant list of patients using EMR	There are no exclusions
12	Reminders for preventive/follow-up care	More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder	No office visits 24 months before reporting period
13	Patient specific education	More than 10% of your patients use education resources from EMR	Do not conduct office visits
14	Perform medication reconciliation	More than 50% of patients you see after receiving care from another provider; you should update medication information by comparing the patient's medical record to an external list of medications obtained from a patient, hospital or other provider	Did not see any patients after they received care from another provider
15	Provide summary care record for each transition of care or referral	1) Summary of care record for more than 50% of transitions of care and referrals, 2) Summary of care documents you send, more than 10% must be sent electronically - either directly to a recipient or using the eHealth Exchange standards, 3) At least one of the summary of care documents that is sent electronically must be sent to someone who is using a completely different EHR vendor or to the CMS designated test EHR	Transfer a patient to another setting or refer a patient to another provider less than 100 times during the reporting period
16	Submit electronic data to immunization registries	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry	1) Do not administer immunizations 2) Operate where no immunization registry capable of accepting
17	Secure electronic messaging	A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients	Do not conduct office visits

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Menu Objectives - Report on 3			
Number	Objective	Measurement	Exclusion
1	Submit electronic syndromic surveillance data	Successfully submit syndromic surveillance data to a public health agency throughout the EHR reporting period on an ongoing basis	1) Does not collect ambulatory syndromic surveillance info on patients, 2) Operate in jurisdiction for which no public health agency is capable of receiving electronic syndromic data required by EHR, 3) Operate in jurisdiction where no public health agency capable of receiving data, 4) Operate in jurisdiction for which no public health agency is capable of accepting specific standards required by EHR
2	Record electronic notes in patient records	More than 30% of patients	There are no exclusions
3	Imaging results accessible through CEHRT	More than 10% of all tests whose result is one or more images	Less than 100 tests that yield an image or don't have access to electronic imaging
4	Record patient family health history	More than 20% of all unique patients have structured data entry for one or more first degree relatives	Do not conduct office visits
5	Identify and report cancer cases to state cancer registry	Ongoing submission of cancer case information from CEHRT to public health cancer registry	1) Do not diagnose or directly treat cancer, 2) Operate in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for your HER, 3) Operate in a jurisdiction where no public health agency for which you are eligible provides timely info on the capability to receive electronic info, 4) Operate in a jurisdiction for which no public health agency is capable of receiving electronic cancer case info in the specific standards required for your EHR can enroll additional EP
6	Identify and report specific cases to specialized registry	Ongoing submission of cancer case information from CEHRT to public health specialized registry	1) Do not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society or the public health agencies in your jurisdiction, 2) Operate in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which you are eligible is capable of receiving electronic specific case information in the specific standards required by your EHR, 3) Operate in a jurisdiction where no public health agency or national specialty for which you are eligible provides timely info on the capability to receive, 4) Operate in a jurisdiction for which no specialized registry is capable of receiving electronic specific case info in required by your EHR

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Stage 2 Meaningful Use in 2015 (continued from page 8)

Many are worried that if they do not meet the entire year they will not only miss out on incentive payments, but are at risk for payment adjustments, too. Depending on what year an EP began participating iin meaningful use determines incentive payment schedule. However, failure to report in 2015 leads to a payment adjustment in 2017.

Payment Amount	First Payment Received in 2011	First Payment Received in 2012	First Payment Received in 2013	First Payment Received in 2014
2011	$18,000			
2012	$12,000	$18,000		
2013	$7,840	$11,760	$14,700	
2014	$3,920	$7,840	$11,760	$11,760
2015	$1,960	$3,920	$7,840	$7,840
2016		$1,960	$3,920	$3,920
TOTAL Incentive Payments	**$43,720**	**$43,480**	**$38,220**	**$23,520**

Payment Adjustment Year	2016	2017	2018	2019
90 Day Reporting Period	2014			
Full Year Reporting Period		2015	2016	2017

Salient Trends in Capital Investment and Revenue Cycle

BY PHIL GAUGHAN, SENIOR DIRECTOR, OPERATIONAL IMPROVEMENT TRUVEN HEALTH ANALYTICS

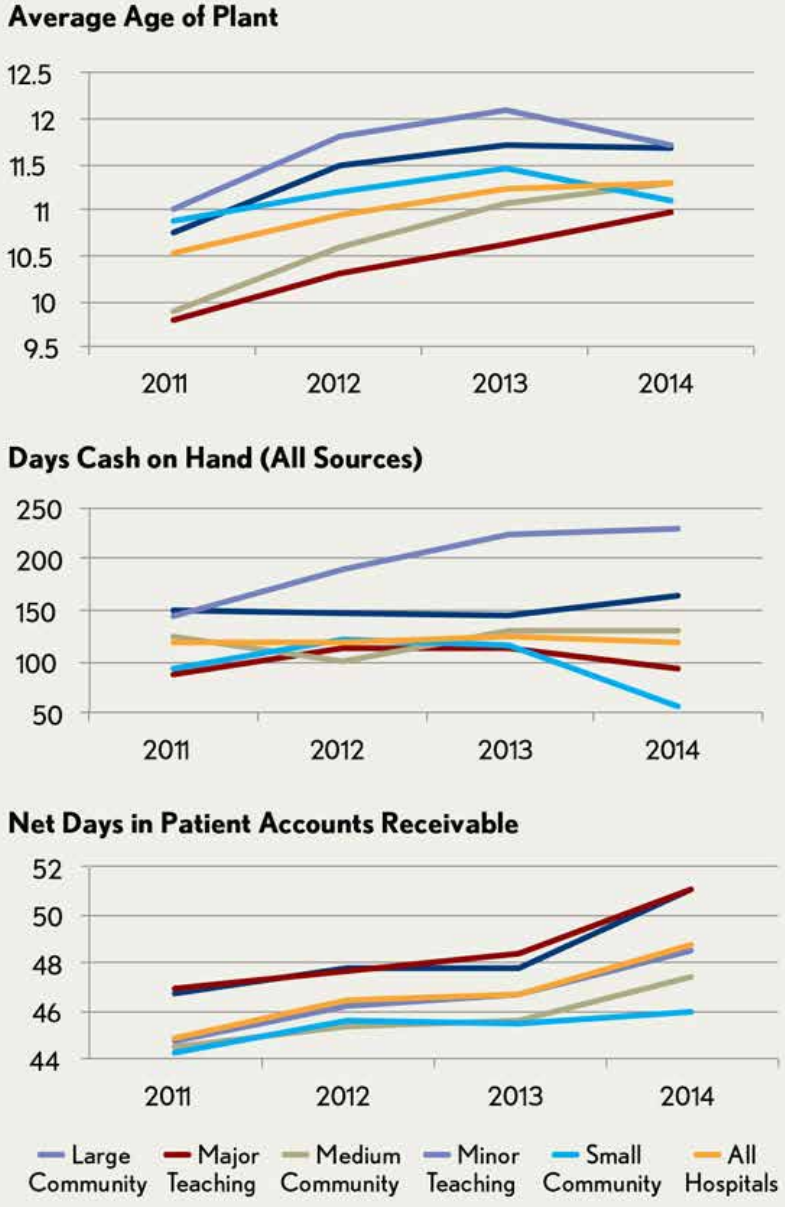
Although seemingly unrelated, three trends are worthy of healthcare finance leaders' time and consideration.

- **First,** Average Age of Plant for U.S. hospitals has been consistently at or around nine years for decades, yet the past four years (12 months ending June, 2011–2014) have seen marked increases in this measure among all comparative groups of hospitals identified for this analysis.a During this time, the median measure for all hospitals included in the analysis increased from 10.5 to 11.3 years.
- **Second,** also looking at the median measures, Days Cash on Hand remained flat for all hospitals during this four-year time frame, with varying trends among the various comparative groups. Many hospitals are deferring investments in capital while accumulating cash. Remember the oil filter slogan: "Pay me now or pay me later."
- **Third,** after years of declining Days in Accounts Receivable, medians for all six comparative groups have grown over the 2011-2014 period. Small community hospitals recorded the smallest increase at 1.77 days while the median for all hospitals increased by 3.88 days. Whether attributable to the continuing shortage of coders, transitioning work processes to the EMR, or other factors, this trend requires attention and correction.

Long term financial health requires revenue cycle tools and practices to retain the operating income needed as a basis for capital reinvestment.

This article was originally published in *hfm*, February 2015. Read the latest issue of *hfm* at hfma.org/hfm.

THREE TRENDS DEMANDING FINANCE LEADERS' ATTENTION



Source: Truven Health Analytics.

A Message from Joe Fifer, HFMA National President:

Introducing Chapters 2.0: HFMA's Chapter Volunteer Initiative

BY JOE FIFER, HFMA NATIONAL PRESIDENT

I'm reaching out to you today to provide an update on HFMA's Chapter Volunteer Initiative which we are now calling **Chapters 2.0.** As I outlined in my communication in January, a Chapter Volunteer Initiative Task Force was chartered to examine the current chapter infrastructure to position HFMA for continual high levels of performance and service to our membership. This included assessing the current state of membership, the role of the volunteer, trends in volunteerism, chapter succession planning, and the administrative burden on chapter volunteers. Based on the feedback from chapters, the alternatives heavily considered the increasing demands on volunteers' time both personally and professionally, as well as, new generational attitudes regarding membership and volunteerism.

The work of the Chapter Volunteer Initiative Task Force presented a vision and framework for a "New Local HFMA" that would offer a variety of programs to help members learn, share, connect and act. While traditional in many respects, the programs will reflect a primary emphasis on quality and incorporate 21st century technology. A Steering Committee of volunteer leaders has been appointed to manage, investigate, pilot and then, ultimately, make recommendations to the HFMA Board of Directors and Regional Executive Council on the elements of the proposal. The following individuals have been appointed to the Steering Committee:

Debi Kuchka-Craig, Committee Chair, Region 4
Reggie Albert, Region 1
Marianne Muise, Region 2
Pete DeAngelis, Region 3
Bill Eikost, Region 5
Ken Stoll, Region 6
Mike Allen, Region 7
Randy Hoffman, Region 8
Brenda Cox, Region 9
Jeff O'Malley, Region 10
Diana Gernhart, Region 11

Other committee members will include the Chair and Vice Chair of the Regional Executive Council, currently Carol Friesen and Mike Dewerff.

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Introducing Chapters 2.0: HFMA's Chapter Volunteer Initiative

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Also serving on the committee will be staff members Susan Brenkus, HFMA's Vice President of Chapter Relations and Human Resources and Carla DeFlorio, HFMA's Director of Chapter Relations in ex-officio roles. I personally want to thank all of these individuals for their commitment to this important initiative and all the work ahead of them over the next 3-4 years.

To carry out the work of **Chapters 2.0,** a number of small, nimble Ad Hoc Task Forces, one for each of the elements of the framework, will also be formed with specific charters, recommended competencies, and representation. Shortly after the first meeting of the Steering Committee on March 20, a survey will be sent to chapter leaders asking about your interest and experience related to these Task Forces. This will provide the Committee with a database of interested volunteers to call upon as Ad Hoc Task Forces are formed. We will continue to send periodic updates to chapter leaders as more information becomes available. If you have any questions or need further information, please feel free to contact Susan Brenkus at sbrenkus@hfma.org or Carla DeFlorio at cdeflorio@hfma.org. Thank you again for your commitment to HFMA and our members.

Five Things to Know About Infusion Billing

BY MELISSA BLANK-HARBERT, VICE PRESIDENT OF INFUSION SERVICES, BOTTOME LINE SYSTEMS, INC.

Hospital based infusion billing is one the most complex areas of billing and one of the most difficult areas in which to build a variance system model. Accommodating billing requirements for multiple payors creates a significant strain on resources in a hospital's billing department. In establishing control measures, financial managers should consider these key indicators to ensure proper payments are collected under the terms of the provider's managed care agreements:

1 **Billing Correct Units for the Drugs - What Do Payors Really Want to See?** For drug units or descriptions, payors can differ as to the information required on a claim form. Some payors require that drug units be billed in HCPCS units with no additional description. However, when billing unclassified drugs, claims need National Drug Codes, units of measure and quantity added, which may or may not be the same as the HCPCS units. Yet, Medicaid as well as managed Medicaid plans require this information whether or not the drugs are considered unclassified.

2 **Billing for Waste—To Bill or Not to Bill and How?** CMS encourages the administration of drugs and biologicals in the most efficient manner. So, providers should avoid waste whenever possible. However, according to the Medicare processing manual, Chapter 17, CMS recognizes instances when this cannot be avoided, particularly with single dose vials of medication. In these cases, Medicare reimburses providers up to the total billable units on the vial size used. Depending on the local contractor, this may require using a "JW" modifier to distinguish the discarded portion of the vial from the administered portion. Still, some contractors do not require this modifier and list the entire dose administered and discarded on one line. Additionally, the JW modifier is never used on CAP (Competitive Acquisition Program) drugs. Regardless of the waste reporting method, the exact amount discarded versus administered should always be clearly documented in the patient's medical record.

3 **Billing services when the patient is in the SNF.** When a patient resides in a SNF (Skilled Nursing Facility) but is transported to a hospital-based clinic, some services can be excluded from the SNF consolidated payment. If so, these services should be separately payable to the hospital or outpatient clinic. For example, some chemotherapy drugs are specifically excluded from the SNF payment and are separately payable if the claim is submitted with the appropriate codes.

4 **Infusion Administration Coding – More than Choosing the Correct Initial Code.*** The American Medical Association's (AMA)'s CPT* guidelines differ in many ways from CMS' guidelines. For example, CMS requires an initial code ***per episode*** of care while the AMA's CPT guidelines require an initial code ***per each date of service.*** This is crucial, especially in instances of billing emergency department and observation claims that span multiple dates of service. Moreover, Medicare advantage plans may or may not follow CMS guidelines and commercial payers may use either set of guidelines. Further, there are even instances when it is appropriate to bill more than one initial code such as when there are two vascular access sites. In this case it is appropriate to bill two initial codes. Another instance occurs when there are multiple encounters on the same day. In either case, modifier 59 is required on one of the initial codes to avoid triggering edits within the billing system.

5 **Pursue Reimbursement on Bundled Denials.** A hospital's reimbursement department should watch for denials on infusion charges provided in the ER. Payors consistently underpay claims for ER infusion services when they are not incidental to an imaging procedure. However, providers should be fully paid for hydration, pain management medication or other types of infused treatment protocols. Ensuring modifier 59 is used when billing will identify the infusion code as separate and distinct, and payable under the terms of the contract or rate schedule.

These are a few of the complex rules to be considered when modeling Infusion claims in a billing system or variance program. Business office administrators are constantly challenged to stay current on billing and

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Five Things to Know About Infusion Billing

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coding rules, and must do so while managing the rest of the revenue cycle. Infusion finance managers gain significant advantages by retaining an associate business partner well-versed on the complexities of the infusion arena. Online resources, such as subscription service RevenueCyclePro.com** and Centers for Medicare and Medicaid Services (www.cms.gov) as well as industry trade publications, can assist an organization in staying up-to-date on the countless issues surrounding infusion billing and payment.

Contact Information

Melissa Blank-Harbert is vice president of Infusion Services for Bottom Line Systems, Inc. She has over 20 years of experience in the hospital based infusion and home infusion field, which includes DME, home health, and hospice. She is a member of the National Home Infusion Association (NHIA) and the Healthcare Financial Managers Association (HFMA). She can be reached at: mblank@onlinebls.com; 859-426-3329.

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Melissa Blank-Harbert

Vice President of Infusion Services, Bottome Line Systems, Inc

Time to Prepare for SNF Value-Based Purchasing

BY CHAD MULVANY, DIRECTOR, HEALTHCARE FINANCE POLICY, STRATEGY AND DEVELOPMENT, HFMA, WASHINGTON, D.C.

Even though Medicare's skilled nursing facility (SNF) readmissions penalty doesn't take effect until FY19, hospitals will see its impact much sooner. To reduce preventable admissions from SNFs to hospitals, language implementing value-based purchasing for SNFs was included in last year's legislative patch of Medicare physician payments as a "pay for." Although Congress called the program value-based purchasing, it is currently limited to a readmissions penalty. Hospitals and health systems should understand how the penalty will be applied and the timing of related provisions. SNF value-based purchasing will pose challenges to facilities that ignore the requirements while presenting opportunities to those that position themselves properly.

Acute Admissions from SNFs

A 2013 report by the Office of Inspector General (OIG) found that in 2011, more than 825,000 Medicare beneficiaries were admitted from a SNF to a hospital, with more than 30 percent of those patients admitted more than once for a total of approximately 1.3 million admissions (roughly 5 percent of Medicare hospitalizations) at a cost of over $14 billion.a The OIG report also found that 65 percent of these admissions were concentrated into 15 diagnosis categories, including some—such as sepsis (20 percent), pneumonia (5.9 percent), heart failure (4.5 percent), and urinary tract infection (3 percent)—that could be managed in a SNF, assuming it had the necessary capabilities.

Furthermore, according to the OIG report, acute admission rates from SNFs vary significantly based on quality rating and geography. While the national average readmission rate is 25 percent, SNFs receiving more than three stars on the Centers for Medicare & Medicaid Services' (CMS's) Nursing Home Compare website have re-hospitalization rates that are approximately four percentage points lower than organizations receiving three or fewer stars. Geographically, there is a threefold difference in readmission rates between the best- and worst-performing states as shown in the attached exhibit.

Given such variation, and the fact that many conditions are manageable in the postacute setting and do not require re-hospitalization, it's not surprising that Congress would see an opportunity to generate savings for the Medicare program while improving outcomes for beneficiaries.

A Closer Look at the Program

Although the Affordable Care Act directed CMS to evaluate value-based purchasing for SNFs, there was no explicit legislative mandate prior to the passage of the Protecting Access to Medicare Act of 2014. The Congressional Budget Office estimates the Value-Based Purchasing program will save CMS $2 billion in 2019 – 2024. The authorizing language was included as a partial offset to pay for the cost of the most recent patch of the Medicare sustainable growth rate. Therefore, the program is not budget-neutral as hospital value-based purchasing is.

All Medicare SNF payments will be subject to a 2 percent withhold starting Oct. 1, 2018 (FY19). As with the hospital readmissions penalty, SNFs will be evaluated based on the ratio of their actual readmissions to their expected readmissions, relative to the national average. Facilities that perform in the bottom 40 percent will see their per diems reduced, while those finishing higher will receive their full per diem and may be eligible for a bonus payment. The legislation sets aside between 50 and 70 percent of the withheld amount to repay the withhold, and these funds could also be used to increase payments to SNFs with low readmission rates relative to their peers.

The legislation mandates the development of two hospital readmission measures for SNFs: an all-cause, all-condition hospital readmission measure and a measure to reflect the all-condition, risk-adjusted rate of potentially preventable readmissions. CMS will provide SNFs with quarterly confidential reports on both measures beginning Oct. 1, 2016 (FY17). Public reporting of the measures is required by Oct. 1, 2017 (FY18) on the Nursing Home Compare website.

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The Timing of Behavioral Change

It might be tempting to temporarily overlook the SNF value-based purchasing program, given that the penalties are almost four years away. However, that perspective ignores two factors. First, public reporting (which begins in less than three years) has been shown to motivate behavioral change in healthcare providers, and in other programs has led to incremental improvements in quality. Second, the data displayed on Nursing Home Compare and used to determine SNF VBP scores will come from prior periods.

CMS hasn't specified rules for the program yet, but a useful analogy might be the hospital readmissions reduction program. The first year of the program (FY13) used claims from dates of service spanning July 1, 2008, through June 30, 2011, to calculate the penalty. As a result, facility-level efforts to reduce readmissions began well before FY 2013. A noticeable decrease in all-cause readmissions occurred approximately 21 months before the first penalties were applied.[c]

Assuming CMS uses a similar time frame to ensure the volume of claims is sufficient to support the statistical stability of the readmissions measure, SNFs very likely are already sitting in the performance window for both reporting and penalties. Given that it takes an estimated 12 to 14 months for interventions to reduce re-hospitalizations from SNFs to take effect, improvement efforts should be well underway lest organizations be left behind in the race to reduce readmissions.[d]

Implications for Hospitals and Health Systems

Any change in financial incentives in a payment system along the care continuum poses both challenges and opportunities for hospitals and health systems. Although some of the challenges are theoretical (for now), others are very tangible. Some stakeholders have expressed concern that even though the readmission penalty is risk-adjusted, SNF value-based purchasing will make some SNFs less willing to accept referrals of patients who are more likely to be readmitted. Both CMS and hospitals will need to closely monitor that potential issue.

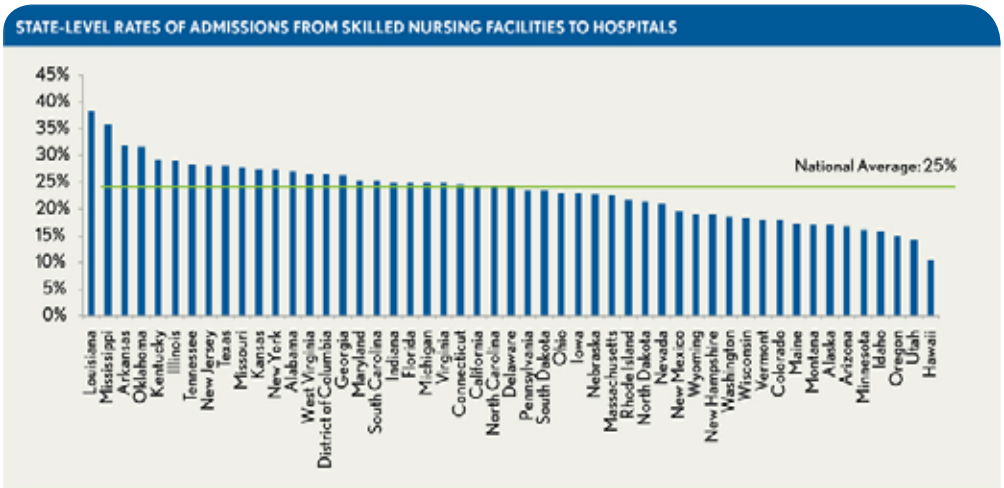
The SNF value-based purchasing program should have a tangible impact on hospital volumes. Several programs (e.g., the Programs of All-Inclusive Care for the Elderly demonstration, Medicare Shared Savings Program, Pioneer accountable care organizations, and the Center for Medicare and Medicaid Innovation's Bundled Payments for Care Improvement Models Two and Three) already are putting downward pressure on Medicare admissions from SNFs, with the impact varying based on the extent to which the programs are present in a hospital's market. SNF value-based purchasing should start to reduce Medicare admissions from SNFs over the next 12 months in all markets.

At a minimum, if all SNFs could replicate the average readmissions rate of those rated with four or more stars, Medicare acute admissions would decrease by 8.8 percent, based on HFMA's analysis. Admission rates from SNFs most likely will fall more dramatically given the pressure on all SNFs to improve. Furthermore, it is expected that the steepest declines will occur in states with the highest admission rates from SNFs. Hospitals and health systems should account for this additional downward pressure on Medicare volumes as part of their strategic and financial planning, including by developing backfill strategies to replace the lost volume that was attributed to unnecessary utilization.

Despite the impact on volume, the emphasis on SNF admissions creates multiple opportunities for hospitals and health systems. Aligning incentives between the acute and skilled nursing settings around readmissions will improve care transitions and general collaboration across settings, as HFMA has encouraged CMS to do in multiple comment letters. Doing so also should reduce hospitals' risk of incurring readmission penalties?

SNF value-based purchasing also creates an opening for organizations to experiment with long-term care episodes and population health management payment systems. Given that the penalty is not time-bound, as is the hospital readmissions penalty, SNFs will be concerned with admissions that occur beyond 30 days past discharge. They will want to collaborate with the service lines in local facilities that refer high volumes of patients to develop care plans for ensuring that these individuals can be managed in the SNF. Where these collaborations between the acute and postacute settings have occurred, rates of readmissions from SNFs have dropped as much as 50 percent.[e] These circumstances should open opportunities for hospitals to partner with SNF providers in episodic or other payment innovations that extend past the acute discharge.

Regardless of your organization's focus, now is the time to reach out to SNFs in your community to assess opportunities to coordinate care transitions and reduce readmissions. Such coordination will help both organizations reduce their exposure to penalties related to readmissions and, more important, will improve outcomes for patients.



Source: Office of Inspector General, "Average Annual Rate of Hospitalization of Nursing Home Residents by State," Appendix C, *Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring*, November 2013.

This article was originally published in *hfm*, February 2015. Read the most recent issue of *hfm* at hfma.org/hfm.

Retained Surgical Items–Tips to Reduce Risk

BY JEREMY A. WALE, JD, PROASSURANCE RISK RESOURCE ADVISOR

The Centers for Medicare and Medicaid Services (CMS) defines a retained surgical item, or RSI, (also known as "retained foreign object") as a "never event."1 A never event is a "particularly shocking medical error that should never occur."2 Anywhere from 3,000 to 6,000 times per year, patients leave hospitals following surgery with an RSI.3 And, despite the existence of appropriate precautions (e.g., time-outs, sponge counts, or sharps counts), additional care can be taken.

Common risk factors

A meta-analysis published in May 20144 reviewed three retrospective, case-control studies to identify common risk factors of RSIs. The analysis revealed seven variables that seemed to elevate risk:

- Intraoperative blood loss exceeding 500 mL
- Duration of operation
- More than one sub-procedure
- Lack of surgical counts
- More than one surgical team
- Unexpected intraoperative factors
- Incorrect surgical counts

There was no significant increased risk associated with changes in nursing staff, emergency procedures, increased BMI, or "after-hours" procedures. The Joint Commission states common root causes of RSIs are:

- Absence of or failure to comply with policies and procedures
- Hierarchical or intimidation problems within the surgical team
- Physician communication failures
- Failure of staff to communicate relevant patient information
- Inadequate or incomplete staff education5

As evidenced above, both opinions and case studies vary widely regarding RSI causation. Regardless, these situations can heighten your awareness and highlight the importance of thorough, consistent policies and procedures to reduce your facility's risk of RSIs.

Ways to reduce risk

There are several options for minimizing and preventing RSIs. The following chart outlines potential solutions and the known pros and cons of each.

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POTENTIALSOLUTIONS	PROS	CONS
1. Manual Counting Procedures A nurse counts all sponges and instruments prior to surgery. Once the procedure is completed, a nurse counts all sponges and instruments to ensure nothing was left inside the cavity.	i. Done properly, this can help reduce the risk of RSIs. ii. Cost effective.	i. Humans make mistakes. ii. Cases show RSIs still occur following " accurate" counts.
2. Intraoperative Radiography Most organizations use radiography only when pre- and post-operative counts do not match.	i. More reliable than counting so long as radiopaque surgical items are used. ii. May detect items that cannot otherwise be detected by a surgeon or nurse.	i. Can be expensive – estimates place "the cost of performing routine intraoperative radiography to prevent RSIs" around "$11.5 million for every clinically harmful object detected."19 ii. Time consuming. iii. Radiation exposure.
3. Bar-coded Counting Systems This requires each individual sponge contain a bar-code label that is scanned both before and after the surgery. The computer system detects whether counts match.	i. Tends to be more accurate than human counting. ii. More cost-effective than radiography.	i. Longer count times. ii. Barcodes are unreadable if a sponge is inside a patient.
4. Radiofrequency Detection Systems These typically use a wand that is passed over a patient to determine whether a sponge has been left behind. This technology requires special sponges containing radio- frequency chips. The wand does not count the sponges, but it can determine whether a sponge is left behind. These systems have been shown to have 100% sensitivity in identifying retained sponges (97% sensitivity in morbidly obese patients).	i. More cost effective than radiography. ii. Can detect sponges left inside a patient after closing the cavity. iii. Can also be used to detect sponges that may have been dropped on the floor or accidently discarded in a waste container.	i. Additional per-surgery costs. ii. Typically this technology is used in addition to manual counts, so there is a slight increase in time used to perform counts. iii. Doesn't capture all RSIs.
5. Radio-frequency Identification Systems This combination of radio- frequency detection and bar-code technologies both detects and counts sponges.	i. This is fairly new technology, but has shown to be the most accurate of all options (100% accuracy in a clinical feasibility study involving six patients).	i. More time consuming. ii. Cost effectiveness currently unknown. iii. Unknown return on investment.

Sources:

[1] Fact Sheets: Incorporating selected national quality forum and never events into Medicare's list of hospital-acquired conditions. Centers for Medicare & Medicaid Services Website. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2008-Fact-Sheets-Items/2008-04-142.html.

[2] Patient safety primers. Agency for Healthcare Research and Quality Web site. http://psnet.ahrq.gov/primer.aspx?primerID=3. Updated October, 2012. Accessed November 25, 2014.

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story/news/nation/2013/03/08/surgery-sponges-lost-suppliespatients-fatal-risk/1969603/. Accessed November 20, 2014.

[4] Williams T, Tung D, Steelman V, Chang P, Szekendi M. Retained surgical sponges: findings from incident reports and a cost-benefit analysis of radiofrequency technology. JAm Coll Surg. 2014; 219(3): 354-364. doi: http://dx.doi.org/10.1016/j.jamcollsurg.2014.03.052.

[5]Action urged to prevent retained surgical items. American College of Surgeons Web site. http://bulletin.facs.org/2014/01/action-urged-to-revent-retained-surgical-items/. Published January 3, 2014. Accessed November 20, 2014.

ProAssurance is a national provider of medical professional liability insurance and risk resource services. For more information about the company, visit ProAssurance.com.

Another Sold Out FIHFMA Managed Care Program Held at University Club

BY CATHY PETERSON, PRESIDENT, PETERSON CONSULTING AND DENISE CAMERON, VP, NETWORK DEVELOPMENT & MEMBER RELATIONS, RUSH HEALTH

On January 29, 2015, FIHFMA held its Annual Managed Care Program at the University Club, Chicago. The sold-out event was once again developed and hosted by Managed Care Program Chairs Denise Cameron and Cathy Peterson, who have co-chaired the Managed Care Committee and Program for the past nine years. The FIHFMA Managed Care Committee includes senior leadership from Chicago area health systems and the payor community. This year's event was co-sponsored and marketed with the Chicago Health Executives Forum (CHEF). Highlights of the day included:

- The day kicked off with a presentation by Kaveh Safavi, MD JD, Managing Director of Global Health Business at Accenture. Dr. Safavi has been an FIHFMA favorite presenter for years, and of late has grown to an internationally respected physician leader and lecturer. As usual, his presentation was informative, insightful and engaging.
- Elena Butkus (VP, Aetna's State Government Affairs) returned for her annual Legislative Update, which is especially noteworthy this year with Illinois Medicaid Reform in full swing.
- The day also included the popular Payer and Employer Panel Discussion, which included esteemed participants Bill Berenson (AETNA Regional President) Steve Hamman (Divisional Senior Vice President, Network Management, Blue Cross Blue Shield of Illinois) Michael Phillips (President and General Manager, Midwest Market, CIGNA) and Larry Boress (President and CEO, Midwest Business Group on Health).

The day also featured three presentations from industry thought leaders on Population Health Management, and Accountable Care Network and Contracting Models:

- Lori Fox Ward, Senior Vice President of Strategic Initiatives, Valence Health
- Dennis P. Hesch, EVP and Chief Financial Officer, The Carle Foundation Hospital
- Michael Nugent, Managing Director, Navigant

The program session underscored how providers and payers have an increasing need to address market pressures and prepare for the future of the aging population, the increase in chronic conditions and how health care costs will be controlled. Strategies include:

- Closed networks of providers
- Shared or full risk for cost, quality and access
- Increased reliance on health information technology
- Further consolidation in the payer and provider industries
- Employer direct contracting
- Increased consumerism in health care purchasing
- Demand for excellence in data management and analytics

The day ended with a social hour, giving attendees a chance to mingle and network with friends and colleagues old and new. Many of the day's presentations are available on the following link:

http://firstillinoishfma.org/2015-managed-care-presentations/.

2015 HFMA 101 Educational Program and Membership Drive

BY LANA DUBINSKY, CHAIR, MEMBERSHIP & DIRECTORY, FIRST ILLINOIS HFMA

We had a very successful HFMA 101 and Membership Drive event with nearly 50 attendees. Various chapter leaders shared their own experiences with HFMA and our local chapter. A common theme was how HFMA is an important part of the career path for our local leaders.

Our local chapter, First Illinois, offers great opportunities to get involved and work with a variety of committees. Certification is also something that both HFMA and the First Illinois Chapter provides a lot of resources and support for. It's not too late to get involved; please visit our website to find opportunities for involvement.

Through the efforts of the attendees who came out to the event, we were able to recruit 18 new members for our two-month free trial promotion. Let's all take a minute and make sure our new members feel welcome and are able to take advantage of all that HFMA has to offer.

One of the top goals of the First Illinois Chapter of HFMA is to make sure we are actively recruiting and retaining members throughout our community, and we could not do this without all of your support and involvement. On behalf of the board and the Membership Committee, we thank all of you for your participation and referrals.

HFMA 101, Adam Lynch

Brian Sinclair, Mary Treacy Shiff & Brian Katz

Carl Pelletteri

David Tomlinson, Rich Franco, & Mike Nichols

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2015 HFMA 101 Educational Program and Membership Drive (continued from page 20)

Greg Kahn & Lana Dubinsky

Mary Treacy Shiff, Steve Legler & Jackie Blanco

Vince Pryor & Al Staidl

Muncie Gold Merit Award Recipient

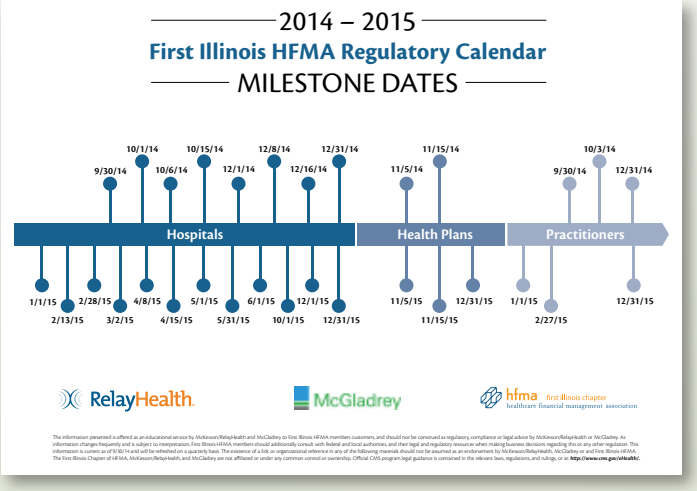
Tracey Coyne, Past FIHFMA President received the Muncie Gold Merit Award from Brian Sinclair FIFHMA Awards Chair on March 20, 2015 at FIHFMA Annual Strategic Planning Meeting at the MCHC offices.

Tracey Coyne & Brian Sinclair

Attention Providers:
Regulatory Calendar of Due Dates and Deadlines Forthcoming

This year, under the strategic direction of our chapter president we have initiated a Provider Value Committee. The first asset the Provider Value Committee has created is a Regulatory Calendar of Due Dates and Deadlines (FIHFMA Regulatory Calendar). The calendar of due dates is segregated into the three segments of our membership: Hospitals, Practitioners and Health Plans. Thank you to RelayHealth and McGladrey for sponsoring and authoring. This regulatory calendar will also be posted on our First Illinois HFMA website at: firstillinoishfma.org/resources/regulatory calendar and refreshed on a quarterly basis.

For more information or if you have questions, please contact Tracey Coyne, committee chair, tracey.coyne@us.gt.com.

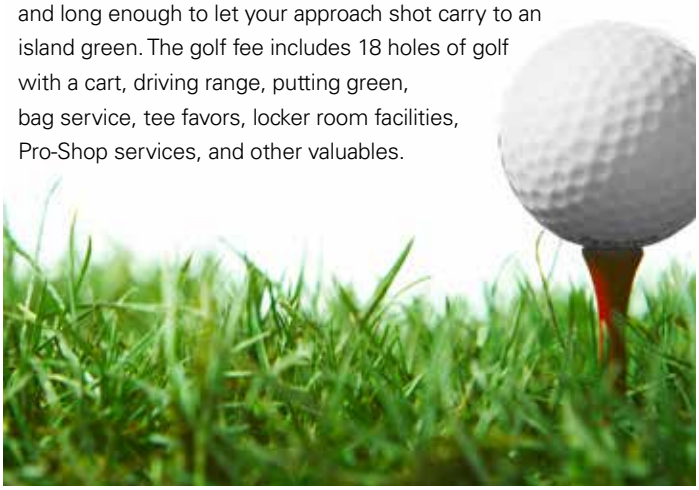


SAVE the DATE!

The "Invitation Only" 21st Annual Educational Symposium and Executive Golf Outing

Monday, June 29, 2015

Eagle Brook Country Club is a private country club in Geneva, Illinois, with nearly 300 members, containing golf courses designed by Roger Packard and Andy North, swimming and tennis facilities and a wonderful clubhouse. As one of the best finishing holes in the Chicago area, hole 18 presents players with a challenging tee shot. It must be straight enough to avoid the water on the left and long enough to let your approach shot carry to an island green. The golf fee includes 18 holes of golf with a cart, driving range, putting green, bag service, tee favors, locker room facilities, Pro-Shop services, and other valuables.

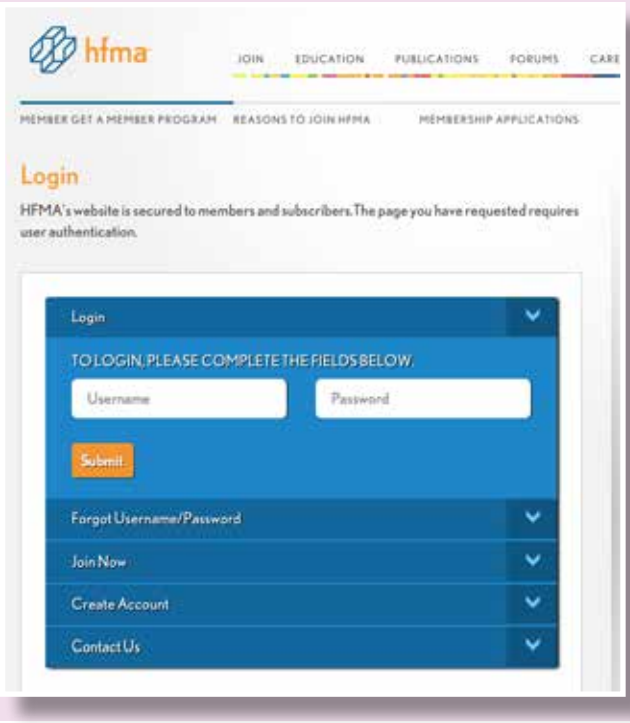


DID YOU KNOW???
HFMA's Online Membership Directory

Have you visited HFMA's Online Membership Directory lately? Log in at **www.hfma.org/login/index.cfm.** When you select "HFMA Directory," not only can you search for members of your chapter, you can also search for all your HFMA colleagues by name, company, and location, regardless of chapter! Using an online directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA's Online Membership Directory, you can view your current contact information and make edits to your profile. You can also see products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It's vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you'll ensure that HFMA continues to provide you with valuable information and insights that further your success.



Welcome New Members

Steve Wang
Director of Strategic Financial Analysis
Advocate Good Samaritan Hospital

Pam Cassidy
Regional Director PFS & Pre-Access
Adventist Midwest Health

Kimberly Hart
Assistant Regional Director
Adventist Midwest Health

David R. King
CTO
OnPlan Health

Nidhie Singh
Senior Consultant
Deloitte & Touche

Brandon R. Hofmann
Senior Reimbursment/ Financial Analyst
KishHealth System

Brian Main
IDS

Regina Meyer
Marketing Manager
Citi Retail Services

Scott C. Straz
Operations Coordinator, Patient Accounting
Northwestern Medicine

Karen M. Giocondi
Operations Coordinator
Northwestern Medical Group

Christopher Barlett
OPS, Advocate Good Samaritan Hospital

Russell B. Cox
Director, Patient Accounting Physician Services
Northwestern Memorial Healthcare

Laura Ingratta
Market Development Executive
Accretive Health

Wyoneenah Jones
Manager, Advocate Good Samaritan Hospital

Cindy Monahan
Revenue Compliance Auditors
Good Samaritan Hospital

Vikram Patel
Director
Advocate Health Care

Ismet Saric
Manager of Emergency Patient Access
Advocate Health Care

Erika Slick, CRCR
Revenue Compliance Auditor
Advocate Good Samaritan Hospital

Karen Walling
Manager Out Patient Registration
Advocate Good Samaritan Hospital

Christie Zajac, CRCR
Manager Revenue Cycle Compliance
Advocate Good Samaritan Hospital

Leonard Oteyza
Manager of Patient Access
Northwestern Memorial Hospital

Paal B. Braathen
Director of Finance
Northwestern Memorial HealthCare

Maryann Czarnota
Consultant
The Abrix Group, LP

Iftikhar Bhuiyan
Medical Graduate

Jay Dainas
Vice President
BMO Harris Bank

Terry Flanagan
Principal
A Third View Medical LLC

Evan J. Fry
Consultant
The Claro Group

Aditya Govil
Director, Business Development
Strata Decision Technology

Krista Gronow
Consultant Lubaway, Masten & Co.

Sonny Lam
Senior, McGladrey LLP

Millicent Lawson
VP - Treasury Management
Fifth Third Bank

Dwaynlee Lee
Controller Gateway Foundation, Inc.

Michael Londo
VP of Administration
Veragae

Hemal Mehta, CRCR
Supervisor, Health Care Consulting
McGladrey LLP

Taylor Miggins
Associate
McGladrey LLP

Darryl Palmer
CTO, Janus Choice

Katherine Peters
Director
Erie Family Health Center

Rachel Wessling
RN, Provena Saint Joseph Medical Center

Elizabeth Wiseman Chase
Consultant

John A. Bracha
Senior Financial Analyst
Northwestern Memorial HealthCare

Suzanne Davis-Bilbo
Accounts Payable Manager
Northwestern Memorial HealthCare

Paul J. Zaleski
Director Expense Reduction Analysts

Carolyn Adamek
Assitant Controller
Alexian Brothers Medical Center

Beth Benson
Assitant Controller
Alexian Brothers Medical Center

Laura Bianchi
Director Of Patient Access
Saint Alexius Medical Center

Kimberly J. Huffman
Alexian Brothers Health System

Andrew Stieve
Sr. Project Manager
Ascension Health

Karissa Hartman
Account Executive, Immunology
AbbVie

Vanessa A. Griggley-Owens
Sr. Director, Product Strategy
MedeAnalytics, Inc.

Caitlin Patrick

Satanya Turner
Medicaid Manager
Great Lakes Medicaid

Matt A. Farmer
Associate Cressey & Company

Matthew A. Curren
Vice President
Falcon Consulting Group

Debra Barger
Reimbursement Specialist
Abbott Molecular

Ayaz Karwa
Consultant
McGladrey

Anthony Mingone
PNC

(continued on page 28)

Welcome New Members

(continued from page 27)

Susan O'Brien
Manager Registration Services
Advocate Christ Medical Center & Children's Hospital

Adam Zepeda
TransUnion Healthcare

Carl J. Gustafson
Director Supply Chain
Centegra Health System

Bridget Morehouse
ATI Physical Therapy

Yijin Zhou, CHFP
Sr. Financial Analyst
Advocate Health Care

Amanda Hayes
Regional Director, Patient Access South
Suburban Presence Health

Bill Case
VP Finance
Presence Healthcare

Jonathan Rosa

Jason Brown
Vice President
Valence Health

Jimmy Bolanos
Finance Manager
Adventist GlenOaks Hospital

Thomas Duffy Littel
Consultant, The Claro Group

William J. Ennis
Chief section wound healing
University of Illinois Hospital and Heatlh Sciences Center

Arun Arora
Business Administrative Associate
University of IL At Chicago

Donna Bonds
Resource & Policy Analyst
UIC - MSP

Kelly Gallagher
Resource & Policy Analyst
University of IL At Chicago

Timothy Granato
Resource & Policy Analyst
University of IL At Chicago

Silvia Jacomee
Resource & Policy Analyst
University of IL At Chicago

Pongchai Kasemcharoenwong
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UIC - MSP

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Business Administrative Associate
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Kevin D. Ray
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Centegra Health System

Bipin Thomas
Director, CURO

Rachael A. Spiotto
Manager, AR Services
Adreima

"Life is 10% what happens to me and 90% of how I react to it."

~ Charles Swindoll

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The First Illinois Chapter wishes to recognize and thank our sponsors for the 2014-2015 chapter year. Thank you for all your generous support of the chapter and its activities.

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First Illinois *Speaks*
HFMA's First Illinois Chapter Newsletter

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Style

Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

Founders Points

In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

Publication Scheduling

Publication Date	Articles Received By
July 2015	June 10, 2015
October 2015	September 10, 2015
January 2016	December 10, 2016
April 2016	March 10, 2016