First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
April 2016

GO BEYOND

Highlights and Recap
First Illinois Chapter Events
begin on page 12

News, Events & Updates

In This Issue

9 Best Practices to Improve Your Month-End Close

BY ALAN NEWBERG AND JAY SUTTON, CROWE HORWATH LLP

An efficient month-end close process increases discipline and structure, improves controls, and reduces risk. Streamlining this process also puts accurate financial information into leadership's hands sooner—facilitating timely analyses and smarter decision-making.

Following are nine best practices for improving your month-end close.

1. **Set your goal for a three-day close.** The norm for a hospital system to close its financial records is eight business days. Best-in-class systems typically take three to five days. Set interim goals to shave a day off the process each month or two and foster an expectation of continuous improvement.
2. **Immediately convene a five-person close-improvement team.** Select five individuals based on their role in the close process to be permanent close-improvement team members. Communicate the creation of a formal close-improvement program to the entire accounting team, including those in payroll, accounts payable, and revenue accounting. Invite representatives from nonaccounting departments to provide relevant information. Build a project charter to describe your vision for an improved close process, delineate your final and interim goals, and designate all staff involved in close activities as program participants and ad hoc team members. Invite all team members to a "kickoff" event—a real event that is not merely a meeting summarizing the program but one that educates the participants in improvement objectives and techniques. For a case study during the kickoff event, find a small problem and improve upon it. Communicate progress and planned improvements on a quarterly basis.
3. **Conduct pre- and post-close team meetings.** In pre-close meetings, discuss the close schedule and timeline, changes being implemented and issues to consider, and follow-up items from the previous month's post-close meeting. In post-close meetings, review what worked and troubleshoot

(continued on page 2)

what did not, including actual versus scheduled journal entry (JE) completion dates and times. Review the status of assignments given to team members during the month. Discuss data and characteristics gathered during the process, including any nonvalue-added steps, risks, controls, and abnormalities from previous months.

4. **Create a Gantt chart of journal entries.** The close process consists of numerous JEs. Some take very little time to prepare; others take days. Some data is available at the start of month-end close; other data is not available until the end.

   Ask each accountant to select 10 JEs that require more time than the others, or JEs not completed until the last day or for which data arrives late. If someone has more than 10 problem entries, document them all. The point is to focus on all time-consuming and end-of-process entries. Have each accountant create a Gantt chart of his or her selected JEs, with a starting point (when data is received) and an end point (when the JE is booked). Then combine the individual Gantt charts into a single chart. Shortening the close process involves reducing the time required to prepare entries, analyzing the results, and obtaining needed data sooner (preferably, on day one). The master Gantt chart will help reveal which entries should be focused on first.

5. **Prepare a detailed close schedule.** Detailed schedules add discipline and structure to the close process. Build a schedule identifying the day of completion for each JE. Start with daily increments (for example, end of day one or end of day three). Update the schedule each month to address the changes implemented. After a few months, adjust the schedule into half-day increments (a.m. or p.m.). Finally, adjust the schedule into hourly increments. Record actual completion days and times, analyze variances, and discuss results in post-close meetings.

6. **Measure close characteristics.** In addition to creating a Gantt chart, collect measures of process performance. Create two bar graphs: one reporting when JEs were posted to the general ledger (day one, day two, etc.), the other reporting the number of entries by each team member. Collect total lines posted, and sort this data by accountant. Add intelligence to JE numbers—for example, 100 series for cash, 200 series for fixed assets, 300 series for reclassifying entries. This will allow you to report the number of entries by type and when they are posted.

   Create statistics according to JE dollar value, and summarize by number of entries under $1,000; $1,000 to $10,000; $10,000 to $100,000; and greater than $100,000.

   Measures will be added and dropped as the improvement program progresses. For example, a company might have a problem with accrued payable as the last entry booked each month because the accountant takes two days to review invoices and book their accrual. By measuring the number of accrued invoices by dollar value, the company might discover that more than half of the review time is spent on invoices less than $100. By changing policy, the company could shave a day off month-end close.

7. **Focus on journal entries.** As a general rule of thumb, focus first on improving the last posted entries—working from the back forward. Begin with entries posted on the last day. Look at the steps performed and when the data is received. Have your team list root causes for the delay. Does the team member not have time to start the entry until later even though the data is present, or does the data arrive late? Is the process inefficient? Ask "Why?" five times to help identify root causes. Then, when all of the last-day JEs are completed earlier in the close, move to the next day, and so on.

8. **Conduct a monthly improvement day.** Formal methods to improve processes such as lean manufacturing might prompt the team to spend a week qualifying and quantifying a problem, identifying solutions, and implementing improvements. A modified, daylong version of this process one or two days after close, in which the team discusses the target JEs, maps JE subprocesses, reviews data, discusses potential root causes, and brainstorms solutions, can be helpful. The associated accountant(s) then should make the necessary changes, implement solutions, and apply the new processes in the next month's cycle.

(continued on page 3)

9 Best Practices to Improve Your Month-End Close

(continued from page 2)

9. **Implement other improvement ideas.** As a general process improvement rule, eliminate tasks or JEs where possible. When this is not feasible, consider automating, simplifying, or load balancing to reduce the time it takes to prepare JEs. For example:

   - Monitor, review, and analyze transactions throughout the month to reduce time spent reviewing these transactions at month-end. Checking for large-balance patient accounts receivable accounts three or four days before month-end can save time recording revenue adjustments. Also, reconciling cash weekly accelerates an accountant's ability to record cash at month-end.
   - Raise the dollar limit for booking expense reclassification JEs to reduce time spent reviewing and recording immaterial transactions. A large number of hospitals do not have a policy for reclassifying JEs. Some will book a $5 or $10 reclassification from one cost center to another. Establishing a policy of no expense reclassifications under $250 or $500 can eliminate many immaterial JEs.
   - Implement early cutoffs for specific systems to save time during the close. A good example is an early cutoff of fixed assets (the 29th of each month). This allows a head start on recording fixed asset changes; most months throughout the year still have 30 or 31 days of activity, and at year-end, cutoff can be extended to the actual last day of the year.

Contact Information

Alan Newberg is with Crowe Horwath LLP and can be reached at +1-317-706-2754 or alan.newburg@crowehorwath.com.

Jay Sutton is a director at Crowe and can be reached at +1-317-706-2738 or jay.sutton@crowehorwath.com.

President's Message

Made in Chicago!

My son who is five has a habit of reading the tags on his toys and clothing. In our house, he announces that his new shirt or art supplies are "made in China." I'm assuming the tag or sticker is accurate but I'm also aware that not everything has a label. Take, for example, the First Illinois Chapter of HFMA. This is without a doubt a "made in Chicago" offering.

So what have we made this year as a chapter? Let me summarize our effort into three areas: 1) education, 2) membership, and 3) leadership training.

1. Education: We will finish the year delivering 16,500 hours locally. In addition, we've significantly grown the number of certified members, which has historically been a challenging area for us. Today, 7.7% of our members are now certified compared to a goal of 6.7%.

2. Membership: We've made a concerted effort to engage with our members by individually reaching out by phone and personalized emails. We developed an approach to systemically contact over 800 members about our in-person programs.

3. Leadership training: We've seen the HFMA secret of engaging volunteers and watching as they become local leaders. This precedes our year and will continue into the future.

As we approach the chapter's fiscal year end, it appears we may have a chance to unveil the "Mission Accomplished" banner.

Humility

I know by this point you are asking, "Adam, what does this have to do with you?" Being president of a volunteer organization with a scorecard to judge accomplishments is unique. I wanted to keep the momentum going from our recent successes. #BigMo.

At the same time, we had to make changes to planning, strategy and execution to remain successful. Incidentally, given our size it was apparent that no single person could accomplish our goals without a lot of help.

In retrospect, the commitment of so many is remarkable. During the past fiscal year I've learned humility from my experience as president. In this role you are seeking people that are extremely capable to share in your vision for the chapter.

The Institution of HFMA

No question our chapter is fortunate to have so many capable members and for this reason we have even better days ahead. The First Illinois chapter as an institution predates all of us in healthcare; here's to many more years.

Let me conclude my final president's message with two comments: 1) thank you and 2) long live the First Illinois Chapter of HFMA!

Adam Lynch
2015 – 2016 First Illinois,
HFMA Chapter President

CAREER Corner

BY VICKIE AUSTIN

Mary Treacy Shiff

*This issue of "Career Corner" focuses on **Mary Treacy Shiff,** vice president of finance and support services, Advocate Health Care-Good Samaritan Hospital in Downers Grove. Mary is also president-elect of the First Illinois HFMA Chapter. Our interview was conducted during one of the breaks at the FIFHMA Spring Summit.*

Q: What was your first job?

A: My first job was working at a McDonald's for $3.25 an hour. I got a 10-cent raise and thought I was rich! And I was, compared to the $1 an hour I was getting for babysitting. I learned so much at McDonald's… I trained for different positions, learned all the stations and did everything from window-washing to hosting the kids' parties. They also "promoted" me to being a hostess and I would fill up the coffee cups of the regulars. That job was a great lesson in cross-training and learning as much as I could about every aspect of the business.

Q: Who were some of your early influences and role models?

A: I grew up in Hebron in McHenry County. My father was a volunteer fireman and an EMT, and I remember hearing him respond to emergencies at all hours of the night. It was an all-volunteer fire department but he treated it like a job. He inspired me with his commitment to service.

Also, I've had some great mentors. The CEO of our hospital, Dave Fox, is a great example of leadership—you heard him talk about his philosophy of leadership in this morning's session. And M.E. Cleary, who is CFO of Chicago Market Tenet Healthcare, was a mentor to me, too. Mary had that "Be-Do-Have" that Dave talked about this morning. She embodied that spirit and demonstrated kindness. She always had my back.

Q: What had you choose healthcare as a career?

A: When I was 12 years old, I was out with a friend and her family. We had just been to the racetrack and as we were piling back into the car to go home, my friend's father collapsed from a heart attack. The mom rushed off to get help and my friend went with her, leaving me alone with him. I didn't know CPR and felt so helpless. He later died. I didn't blame myself but that experience really changed me. I decided that I wanted to become a nurse.

I trained as a certified nursing assistant (CNA) to put myself through school, studying nursing at Marquette. Then I got married and we moved to San Diego. I worked in a nursing home where the nurse-patient ratio was just crazy—15 patients for every nurse. I decided to change my focus to business and I finished my degree at San Diego State University with a degree in accounting. My first job out of school was with KPMG—they really appreciated my healthcare background.

In every job since, my mission is to make sure the patients are taken care of. Yes, we have to meet the bottom line, but we have to take care of our patients first—and the people who care for them.

Q: What key lessons about career management have you learned along the way?

A: We're here to serve. It's just like what David Tomlinson was talking about this morning [in his presentation at the summit, "Four Golden Leadership Nuggets to Live By"], we have to adopt a servant leader attitude.

Q: What role has HFMA played in your career development?

A: HFMA is all about connecting with people. Dan Yunker is the one who inspired me to get involved with HFMA. To get value [from membership], it's important to become involved, whether it's on a committee or coming to an event like this two-day summit. Also, we are mentoring the next generation of healthcare leaders.

Q: What are you reading?

*A: **Fast and Furious: Observatinos on Healthcare's Transformation** by Kenneth Kaufman of Kaufman Hall.*

Q: What advice would you have for someone just starting out in the healthcare financial management profession?

A: Take it all in! Learn all you can. Use that "McDonald's mentality," and learn everything you can, from making the french fries to doing breakfasts. Get as much experience as you can and remember, we are here to be of service.

Vickie Austin

Vickie Austin is a business and career coach and founder of CHOICES Worldwide. She's a frequent speaker at HFMA chapters around the country. You can connect with her at vaustin@choicesworldwide.com, 312-213-1795. Follow her blog at http://vickieaustin.com and connect via Twitter @Vickie_Austin and via LinkedIn, www.linkedin.com/in/vickieaustin.

The Costs of Clinical Risk

BY BRAG GRANGER, VP OPERATIONAL AND CLINICAL UNDERWRITING FOR LANCASTER POLLARD

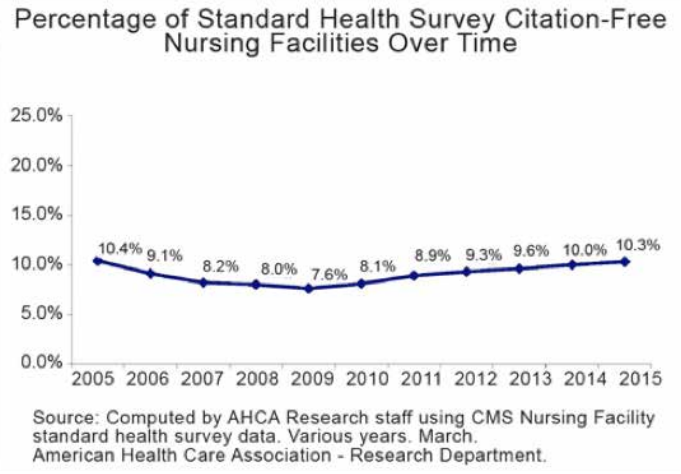
The nursing home industry has often been described as one of the most regulated industries in the country. This is not surprising, as nursing homes care for the most fragile individuals within the health care spectrum and are predominately reimbursed through government programs. The financial instability that can arise as a result of clinical and operational risk can affect refinancing efforts in various ways, which explains why risk management is a major area of focus for nursing home providers.

The high cost of risk is easily demonstrated by a quick glance at recent legal actions brought against nursing homes around the world:

- A nursing home in Tennessee was fined $1.2 million following 35 deficiencies for medication errors, dirty bathrooms and neglect of residents.
- Thirty-six nursing homes in Pennsylvania were sued by the state's attorney general's office for alleged understaffing and depriving residents of their basic needs.
- Two of the largest nursing home chains were accused of routinely billing for therapy services that were either unnecessary or not medically reasonable.

As seen in the chart in the next column, only 10.3% of nursing facilities were citation-free in 2015. Although that number has steadily been improving since 2009, there clearly remains ample room for improvement when it comes to risk management at nursing homes nationwide.

The financial cost of risk not only involves expenditures related to risk remediation, as seen in the last two examples, but can require increased facility staffing or reduced service delivery which can directly decrease a facility's cash flow and ability to borrow. These are just a few examples of actual, unforeseen expenses that can devastate the game plan of predictable results and financial stability for an operator.



When lawsuits against nursing homes occur, even if a civil judgment is found in favor of the nursing home, the fines associated with Centers for Medicare and Medicaid Services (CMS) citations and disputing the allegations can be detrimental to a facility's financial stability. Costs of risk include the sum total of self-insured losses, civil monetary penalties (CMPs), denials of payment on new admissions (DPNAs), lost admissions, additional staffing and legal/consulting fees as well as reputational risk through media or word-of-mouth. A proactive approach to minimizing risk should include establishing achievable goals measured by industry ratings such as the Nursing Home Compare 5-Star system, onsite reviews and third party databases. In doing so, operators should recognize, measure and monitor the areas of greatest exposure. Steps to success include:

- **Check information in the public domain.** Validate that publicly reported information for the facility is accurate.

(continued on page 6)

- **Be prepared.** Identify trends and conditions that lead to costly compliance and regulatory risk as well as potential litigation.
- **Understand the risk and revenue spiral.** Anticipate a facility's reputational risk and the sponsor's ability to attract the most desirable patient mix including Accountable Care Organization (ACO) referrals.
- **Link risk to financing long-term care (LTC) assets.** The total cost of risk is an ongoing predictive aspect and includes determining how it affects cost availability of debt.

Check Information in the Public Domain

By using public data sources such as Medicare.gov, investors, sponsors and principals can identify patients with high-risk conditions (such as a high likelihood to fall or develop pressure ulcers) so that appropriate care planning can take place and provide insight to assist in managing family expectations. The source document to capture this patient health information for government reimbursement purposes and acuity statistics is the Minimum Data Set (MDS) record. This is also factored into the 5-Star rating and determines the acuity and staffing ratings for their state. Despite the various critics of the 5-Star system, it is still considered the industry benchmark and providers as well as lenders would do well to understand how the scores are calculated in order to place the numbers in context. After all, these data sources are used by consumers, insurers, plaintiff attorneys and regulatory agencies for the purpose of sizing up nursing home providers.

In health care organizations, reputation is directly and positively correlated with financial success. Health care reform has increased the amount of information available to the public, and requirements for transparency will provide more insight into an organization's capital structure. As ACOs are launched, reputation and results will drive referrals, and facilities that don't perform will lose revenue opportunities. Not surprisingly, prospective patients and their family members are reluctant to select a health care provider with below average performance or a high number of complaints, making it critical to manage risk and mitigate non-compliance. Furthermore, referral sources, such as physicians and hospital discharge planners, have access to public information (along with word-of-mouth) for the purpose of making good placement choices for their rehabilitation patients.

Be Prepared

The time and cost of preparing for the CMS-directed State Department of Health Inspection process (approximately every 12 months) can be extensive for most facilities. The initial cost is in management and staff time, but if the survey does not go well, added costs will come from responding to citations, revising care processes, and covering consulting or legal expenses. Surely the greatest cost, although more difficult to quantify, is the business lost or reputation damaged by deficiencies. Bad health inspections can strain relationships with the referring hospital, resulting in physicians that no longer feel comfortable referring new patients to a particular nursing home.

Tools are available today that enable a facility to benchmark its performance against others in its survey district or state and anticipate the next likely citation. The most popular is the Nursing Home Compare 5-Star report. It is important to dig below the surface, however, to understand what is driving the scores in the areas of health inspections, staffing and quality measures in order to put the report in context and to understand if the facility is improving or declining. Realistically, many events can be anticipated and avoided with a deliberate Quality Assurance Performance Improvement (QAPI) program to manage risk.

By utilizing public and private databases, information such as occupancy, payer mix, staffing, survey citations and quality measures can be combined with loss history to provide a quantitative model for measuring risk. Once benchmarks are established for the potentially modifiable risk factors, risk management prescriptions are developed to focus on those areas that can have significant, adverse impact on the overall risk of the facility. Should an adverse event occur, remediation efforts to correct non-compliance issues can impact cash flow, causing the facility to forego other important expenditures and ultimately perpetuating more risk.

Understand the Risk and Revenue Spiral

When risk-related adverse events occur and they are communicated to referral sources, a disruption in referral flow with a reduction in revenue can occur. The direct effect of any severe citations can be devastating to an operator's revenue stream, not to mention be a public relations nightmare. Therefore, a damaged reputation from survey deficiencies, resident complaints and poor-quality measures, whether valid or not, can have a negative impact on the cost of risk and trigger a downward spiral that can be difficult to stop. Lost revenue equates to lower investment in quality improvement programs, less money available for staff improvement, and a reduction in cash flow and the capitalization rate required to meet a lender's conditions.

Since staffing is the largest line item in an LTC facility's budget, this is where the axe most often falls. Some facility administrators respond to diminishing revenues by adjusting the staffing matrix from registered nurses (RNs) to less expensive licensed practical nurses (LPNs) or reducing certified nursing assistants (CNAs). Over the long term, however, these shifts will not deliver the expected savings. When facilities fail to properly staff to meet patients' needs, risk increases. It takes one claim or one citation to cancel out any expected savings from using a lower-cost staffing matrix. Inappropriate staffing also leads to turnover, which results in utilization of contract workers and discontinuity of resident care. Each of these impacts quality of care and can result in more unanticipated costs and increased risk.

Quality of Care

With nearly two million licensed beds in the U.S. and an increased national focus on the quality of long-term care, nursing homes must be diligent in assessing and improving their facilities by closely monitoring their areas of risk and greatest exposure. The total cost of risk is ongoing and includes determining how predictable trends affect future profitability. When adverse events occur, they result in fines, expenditures to regain compliance, defense costs (internal and external) and harm to the nursing home's reputation. Ultimately, when a facility gets a reputation as a provider of poor patient care, it is difficult to regain the trust of the community and maintain a consistent referral flow.

2016 Medicare Physician Fee Schedule – Final Rule

BY NICOLE CHANNELL, HEALTHCARE CONSULTANT, PBC ADVISORS

The Centers for Medicare and Medicaid Services (CMS) has released the revised 2016 final Physician Fee Schedule. When Congress repealed the sustainable growth rate (SGR) formula, it called for an annual raise of .5% from 2016 through 2019 as a part of a transition to value-based reimbursement. This has evolved into a .3% pay cut in the final rule this year.

CMS lowered the conversation factor (CF) by .02% to reflect an RVU budget neutrality adjustment. There was also an additional .77% decrease from CMS to meet cost-savings targets. CMS only corrected enough misvalued codes for a savings of .23%. Because it fell short of the 1% mark, CMS is obligated to reduce total fee-for-service spending on physicians by .77% to make up the difference.

The Final Rule also contains policy updates on the following programs that are either already present and/or coming in the near term:

- Physician value-based payment modifier
- Advanced Care planning reimbursement
- Stark Law changes and clarifications
- Medicare shared savings program

We will review the above items in future newsletters.

Impact of Final Rule by Specialty

Here is a snapshot of the combined estimated impact (work, MP and PE RVU changes) for select specialties from CMS. The impact illustrated here only reflects the change in RVUs. It does not include the conversion factor (CF) calculation for 2016.

Specialty	Combined Impact	Specialty	Combined Impact
Cardiac Surgery	0%	Ophthalmology	-1%
Clinical Psychologist	0%	Orthopedic Surgery	0%
Dermatology	-1%	Otolaryngology	0%
Diagnostic Testing Facility	0%	Pathology	8%
Emergency Medicine	0%	Plastic Surgery	1%
Gastroenterology	-4%	Psychiatry	0%
Hematology/Oncology	0%	PT/OT	0%
Independent Laboratory	9%	Radiation Oncology	-2%
Interventional Pain Management	0%	Radiology	0%
Interventional Radiology	1%	Rheumatology	0%
Nurse Anes/Anes Asst	0%	Urology	0%
OBGYN	0%	Vascular Surgery	-1%

Here is a comparison of reimbursement for select codes:

CPT	Mod	Description	2015 Medicare Loc 16	2016 Medicare Loc 16	% Difference
11000		Debridement up to 10% body surface	$58.40	$58.49	0.2%
27447		Arthroplasty, Knee	$1,580.73	$1,579.64	-0.1%
43239		Endoscopy	$436.42	$428.90	-1.7%
45378		Colonoscopy	$426.97	$414.23	-3.0%
59400		Normal Vaginal Delivery	$2,513.16	$2,483.42	-1.2%
59510		Cesarean Section	$2,783.56	$2,774.06	-0.3%
70450	26	CT-Head	$45.63	$46.42	1.7%
71010	26	Chest X-ray	$9.86	$9.87	0.1%
88305		Surgical Path - Level IV	$75.78	$77.35	2.1%
99213		Office Visit - Established Patient	$77.02	$77.85	1.1%
99232		Subsequent Hospital Visit	$77.75	$77.49	-0.3%
G0202	26	Screening Mammogram	$37.59	$37.64	0.1%

MACRA: The Evolution of the Medicare Physician Payment System Continues

BY CHAD MULVANY, FHFMA, TECHNICAL DIRECTOR, REIMBURSEMENT AND REGULATORY ISSUES, HFMA, WASHINGTON, D.C.

LEGISLATION REPEALING THE SUSTAINABLE GROWTH RATE (SGR) CONSOLIDATES PHYSICIAN QUALITY REPORTING PROGRAMS AND INCREASES INCENTIVES FOR PHYSICIAN GROUP PRACTICES TO PARTICIPATE IN WHAT THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) REFERS TO AS ALTERNATIVE PAYMENT MODELS (APMS).

On April 16, 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) into law. Beyond creating some predictability in payment updates for the physician fee schedule, MACRA attempts to consolidate the myriad physician incentive programs into one pay-for-performance program. It also encourages physicians and other eligible professionals to participate in APMs that would hold these participants accountable for cost and the quality of care.a

The incentives to participate in APMs could be transformational, but CMS has yet to resolve a number of questions that will determine the extent to which physicians will be willing to engage in these models. Physicians will need to follow the regulatory process closely. As new APMs are developed, organizations should quickly evaluate whether participating in them would be in keeping with their capabilities and strategic and financial interests.

Stable Payments

MACRA should bring some predictability to physician fee schedule updates for the foreseeable future. It repealed the SGR, with its ritual "patching," thereby preventing significant cuts to Medicare physician payments. Instead, physicians will receive annual updates of 0.5% from 2016 through 2019, with no update from 2020 through 2025. After 2025, a physician's payment updates will be determined by the payment model the physician chooses. Physicians who choose the pay-for-performance Merit-Based Incentive Payment System (MIPS) will receive updates of 0.25% in 2026 and thereafter, while those who choose a qualifying APM will receive updates of 0.75%.

MIPS participation. Starting in 2019, the MIPS program will consolidate the current patchwork of physician pay-for-reporting and pay-for-performance programs—i.e., the electronic health record (EHR) meaningful use penalty, the Physician Quality Reporting System, and the Value-Based Payment Modifier—into one composite system.

Merit-Based Incentive Payment System Components

MERIT-BASED INCENTIVE PAYMENT SYSTEM COMPONENTS

Component	Weight	Description
Quality*	30%	Includes measures used under CMS's Physician Quality Reporting System, Value-Based Payment Modifier, and EHR Incentive Program, as well as new measures approved by the secretary of HHS. Measures developed for other payment systems (e.g., Hospital Inpatient Quality Reporting) also may be used, as appropriate.
Resource Use†	30%	Measures resources used to furnish care. Examples include current measures from the Value-Based Payment Modifier, such as the following: › Total per capita costs for all attributed beneficiaries › Total per capita costs associated with specific conditions (e.g., diabetes, coronary artery disease, chronic obstructive pulmonary disease, heart failure) › Medicare spending per beneficiary
Meaningful Use	25%	Considers whether the physician or physician practice meets the current regulatory requirements (as of the time that use level is measured) to be considered a "meaningful user."
Clinical Practice Improvement	15%	Involves performance activities that improve clinical practice or care delivery, resulting in improved outcomes. Such activities include patient access expansion, population health management, care coordination, beneficiary engagement, patient safety improvement, practice assessment, and participation in an alternative payment model.

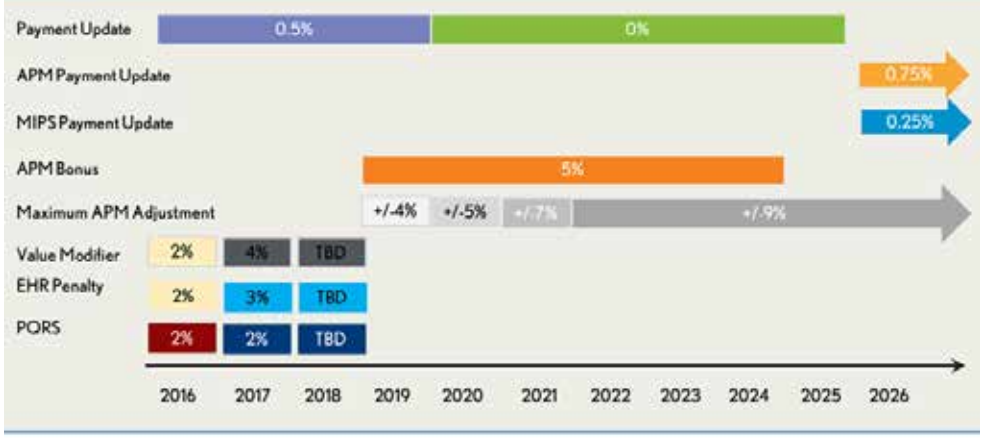
*Quality could be weighted as much as 50 percent in year one and 45 percent in year two, depending on the weight CMS assigns to the resource use category.
†Resource use will not account for more than 10 percent in year one and 15 percent in year two.

Published in hfm magazine, February 2016 (hfma.org/hfm)

The MIPS program initially will apply to the payments of all physicians and physician extenders who are not full participants in a qualifying APM.b Payment adjustments under the program are on a sliding scale based on a physician practice's performance relative to its peers across four categories described in the exhibit above. As shown in the exhibit below, the maximum amount of Medicare physician payment that depends on outcomes in the MIPS program grows over time. Although only 4% of a physician's Medicare revenue is exposed in 2019, in 2022 and subsequent years that figure grows to 9%.

Physician Value-Based Payment Implementation Timeline

PHYSICIAN VALUE-BASED PAYMENT IMPLEMENTATION TIMELINE



APM = alternative payment model; MIPS = Merit-Based Incentive Payment System; EHR=electronic health record; PQRS=Physician Quality Reporting System

Published in hfm magazine, February 2016 (hfma.org/hfm)

(continued on page 9)

 (continued from page 8)

Unlike the approach it uses under the current value-modifier program, CMS will communicate the MIPS target thresholds in advance. Practices that are at or above the threshold will receive no payment adjustment or an increase; those below the performance threshold will receive a negative payment adjustment, with the maximum negative adjustment imposed on practices for which the score is 25% or less of the performance threshold. The adjustments will be applied on a budget-neutral basis. However, CMS has discretion to apply a scaling factor to ensure that the increase in charges for eligible professionals who are above the threshold is equal to the decrease for those below.

APMs. Through MACRA, Congress offers two financial incentives for qualifying professionals to participate in APMs. In addition to the 0.5% annual update differential that begins in 2026, qualifying providers participating in an eligible APM will receive a 5% annual bonus payment from 2019 through 2024. The bonus payment will be calculated based on the prior year's eligible billing.

Qualifying APMs are limited to models developed by the Center for Medicare and Medicaid Innovation (CMMI), the Medicare Shared Savings Program, or other demonstrations. Further, qualifying models must:

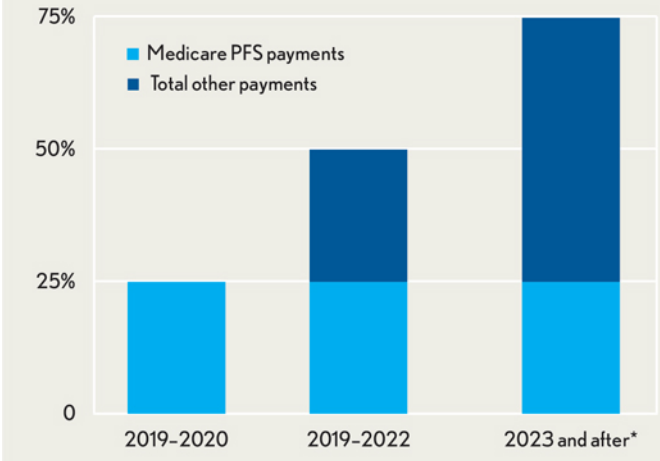
- Require the use of certified EHR technology
- Link payment to quality measures similar to those in the MIPS category
- Require participants in the APM to bear "more than nominal financial risk" if actual expenditures exceed expected expenditures or to be a medical home expanded under a CMMI program

Beyond merely participating in an APM, physicians must meet volume criteria to qualify for the financial incentives. As shown in the exhibit below, in 2019 and 2020, 25% of a practice's Medicare physician fee schedule revenue must be attributed to services provided under an APM.c After 2020, MACRA will allow total patient revenue to be included in the calculation, thereby helping practices meet the legislation's aggressive goal for transitioning payments from fee-for-service to APMs.

Alternative Payment Model Qualifying Payment/Volume Criteria

MACRA's incorporation of revenue from Medicaid and commercial health plans to determine eligibility for APM participation incentives aligns with the January 2015 announcement by the U.S. Department of Health and Human Services that it plans to collaborate with other healthcare purchasers in the development of APMs.d The legislation specifically directs CMMI to consider models that are aligned with private payers, Medicaid, and other state-based initiatives. Also in recognition that many of the current qualifying APMs may not be a good fit for all specialties or allow participation by smaller groups (15 professionals or less), MACRA encourages development of models targeted to these groups. To better solicit ideas for APMs from stakeholders, the legislation creates an 11-member technical advisory committee to review proposals for new physician-focused models. As a result, providers can anticipate a proliferation of models similar to the Oncology Care Model, which will start in 2016.e

ALTERNATIVE PAYMENT MODEL QUALIFYING PAYMENT/VOLUME CRITERIA



*Medicare physician fee schedule (PFS) payments or patient volume must be at least 25 percent, but can be more.
Note: The percentages on the vertical axis refer to the share of revenue that must be in APMs.
Published in *hfm* magazine, February 2016 (hfma.org/hfm).

MACRA Implications

CMS has made it clear it would like to aggressively move more providers into payment models bearing downside risk in the future. MACRA provides the legislative framework to do just that. The phrase "the Secretary shall" appears more than 100 times in MACRA, leaving providers with a number of uncertainties and affording the agency significant discretion in how the law is implemented. In this environment, providers should take the following steps.

Monitor the regulatory process related to MACRA closely. It will be important to follow CMMI's development of qualifying APMs closely to understand how such models will shift risk to physicians and attempt to align with other payers. This information can inform a practice's development of similar models with Medicaid and private payers so it can have sufficient revenue flowing through an APM to qualify for the incentives, should it elect to pursue that option.

Beyond the design of various models, some basic questions need to be clarified. For example, where the MACRA legislation states "… such payments are made under arrangements in which…the eligible professional participates in an entity that bears more than nominal risk… ," the way CMS defines participates could affect alignment opportunities for physicians and health systems. Regardless of how this question is resolved, health systems will need to continue to assess options for improving physician engagement and alignment.

Develop a strategic and financial framework for evaluating whether to default to the MIPS program or immediately seek to participate in an eligible APM. Although CMMI doesn't have a long track record of offering APMs, experience to date has shown that the decision-making window afforded providers is relatively narrow. That may be acceptable for models that involve a relatively small portion of a provider's overall revenue. However, pursuing the APM incentives likely commits

(continued on page 10)

physicians to exposing a material percentage of their revenue to downside risk in a matter of years.

As part of this work, physicians will need to understand the gaps in their longitudinal care management capabilities (and the up-front and ongoing costs related to filling those gaps), the potential impact on revenue from all payers, and the longitudinal cost of providing care for episodes or populations for which they will likely take risk. With those key pieces of information available, management teams will be better able to quickly assess whether participating in a proposed APM model fits with the practice's strategic plan and capabilities and meets financial targets.

Begin or continue experimenting with payments that transfer some degree of risk to providers. If a physician practice opts to pursue the APM incentives, the experience gained managing risk will help identify missing capabilities. It will provide invaluable experience with modeling and managing the financial results. Should the practice decide not to pursue the APM incentives, partially qualifying for an APM is scored favorably under the "Clinical Practice Improvement" component of the MIPS program under MACRA.

Footnotes:

a. Hereafter "physicians" includes all other eligible professionals unless otherwise noted.

b. *Physician extenders* include physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists. CMS may expand the MIPS to other professionals in 2021.

c. CMS allows for an alternative calculation that is based on the volume of patients and requires providers to meet the same thresholds.

d. HHS, "Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value," news release, Jan. 26, 2015.

e. See Mulvany, C., "CMMI's Oncology Care Model: New Model, New Twist," Eye on Washington, *hfm*, June 2015.

This article is republished, with permission, from the February 2016 issue of *hfm magazine.*

Treatment of Minors without Parental Consent

BY VANESSA MULNIX, RN, BSN, CPHRM, CPHQ, PROASSURANCE SENIOR RISK RESOURCE ADVISOR, AND JEREMY A. WALE, JD, PROASSURANCE RISK RESOURCE ADVISOR.

What are you bound by law to do when a minor presents for healthcare without a parent or legal guardian? Related laws are largely state-specific; however, there are instances for which a majority of states have similar laws.

One example is the provision of prenatal care to minors. Florida, for example, allows "an unwed pregnant minor [to] consent to the performance of medical or surgical care or services relating to her pregnancy—and such consent is valid and binding as if she had achieved majority.[1]"

Another example is Virginia law, which states that a minor is "deemed an adult for the purpose of consenting to medical or health services required in case of birth control, pregnancy or family planning except for the purpose of sexual sterilization.[2]" If your facility provides prenatal services or labor and delivery services, it is helpful to ensure familiarity with your state's laws regarding these instances of care.

You also may be asked to provide alcohol and/or drug abuse treatment for minors. Much like prenatal care, many states allow healthcare providers to provide services to minors for alcohol and/or drug abuse treatment without parental consent. For example, Missouri law states a minor may consent "for himself [sic] in case of pregnancy, but excluding abortions; venereal disease; and drug or substance abuse.[3]"

Caring for minors is part of many facilities' services. Applying related state (and federal) law is an important element of your treatment.

[1] Fla. Stat. § 743.065.

[2] Va. Code Ann. § 54.1-2969(E)(2).

[3] Mo. Rev. Stat. § 431.061(4).

First Illinois Healthcare Financial Management & Chicago Executive Forum's Managed Care Conference - 2016

BY ROEY MORAN, ECG MANAGEMENT CONSULTANTS

HFMA's and CHEF's annual Managed Care Conference was a great success, bringing together about 200 attendees for a day of educational sessions and a social hour. The February event, taking place at the neo-gothic University Club in Chicago, benefited from an impressive lineup of speakers, and from meticulous planning and preparation on behalf of FIHFMA's Managed Care Committee, headed by Cathy Peterson.

The day started with a keynote address by Andrew Ziskind, MD, managing director at Huron Consulting Group. Dr. Ziskind's presentation, A Structured Approach to an Uncertain Future, addressed the means by which providers and payers can prepare themselves for an era of significant changes in payment models.

The speech was followed by a presentation by Robert Mendonsa, deputy administrator for Care Coordination Rate and Finance for Illinois Department of Healthcare and Family Services. Mr. Mendonsa reviewed recent changes and developments in the State's Medicaid strategy, emphasizing tight monitoring of quality, results and care standards across Illinois' Medicaid-based health plans.

Mitch Santiago, senior VP with Aon Hewitt's Health and Benefits Practice, presented the challenges faced by employers, as well as opportunities to exploit, as companies seek to provide healthcare benefits to their employees in an age of care integration and changes in managed care.

Terri Welter, principal, and Roey Moran, senior manager, both from ECG Management Consultants, presented on the major trends providers are likely to face in 2016, among them a greater push toward regional integration and the need to update technology capabilities.

Concluding the presentation portion of the day was Bryan Becker, MD, VP Clinical Integration and Network Development, at the University of Chicago Medicine. Dr. Becker reviewed various modes of clinical integration, among them Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs), and spoke about his own experience in driving such integration efforts from the perspective of both an executive and a physician.

The final educational session provided an opportunity to engage with leading Medicaid payers. The 2016 Medical Payer Panel was honored to host Larry Kissner, president, Aetna Better Health,

Robert Currie, president, Community Care Alliance of Illinois, Karen Brach, vice president, Medicaid, Blue Cross and Blue Shield of Illinois, and Jeff Joy, president, IlliniCare Health. These senior executives reviewed their challenges and plans to increase access to healthcare in communities, as well as mechanisms to boost quality and track results in an effort to minimize preventable inpatient and emergency care, and to maximize community well-being.

A big "thank you" to all the speakers and organizers! We are looking forward to seeing everybody again at next year's event.

Founders Merit Awards for 2015

BY BRIAN SINCLAIR, CHAIRPERSON, AWARDS COMMITTEE

Congratulations are in order for the recipients of the 2015 Founders Merit Awards. National HFMA recognizes that its strength lies in the volunteers who contribute their time, ideas and energy to serve the healthcare industry and their local chapter. The Founders Merit Award program was established to acknowledge the contributions made by individual HFMA members.

The awards program is a merit plan, which assigns a range of point values to specific chapter activities, such as committee participation, educational presentations, and serving as a chapter officer. The Follmer Bronze Award is awarded when a member has accrued 25 points, the Reeves Silver Award is earned after an additional 25 points are accumulated, and the Munice Gold Award is presented after a final 50 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the Chapter Board of Directors to qualifying members. This award recognizes significant continuous service after completing the medal program.

The 2015 award recipients are:

Follmer Bronze Award
Craig Standen
Mary Treacy Shiff
Karen Wagner
Peter J. Leenhouts

Reeves Silver Award
Richard A. Franco
Adam D. Lynch

Each of these award recipients will receive a personalized, inscribed plaque from HFMA to officially recognize their achievements. The First Illinois Chapter officers and directors also extend their congratulations and appreciation for the support and participation of the award recipients.

If you have any questions regarding the awards or your current point status, please contact Brian Sinclair, chairperson, Awards Committee, at 630-207-7308 or bsinclair9@aol.com.

Rich Franco, Chief Financial Officer, Northwestern Medical Group, FIHFMA Treasurer, Mary Treacy-Schiff, VP of Finance, Advocate Good Samaritan Hospital & FIFHFMA President Elect

Leaders Share Stories and Strategies at FIHFMA Spring Summit

BY VICKIE AUSTIN, CHOICES WORLDWIDE

This year's First Illinois HFMA Spring Summit was rich with opportunities to learn, to hear from great speakers and to connect with colleagues, friends and new acquaintances. Here are some highlights from the "Effective Leadership" track on day one of the summit.

Tom Walter received his title of "Chief Culture Officer" from a young woman in the marketing department at Tasty Catering, the company Tom created with his brothers Larry and Kevin. She advised Tom that his most important role was to maintain the culture that they all had worked so hard to achieve, a culture that has earned Tasty Catering recognition in *Forbes, Inc. Magazine* and the book *It's My Company, Too!* that Tom co-authored.

In "The Most Essential Work of a Leader: Create More Leaders," Tom shared from such diverse sources as Jim Collins' book, *Good to Great*, author Brené Brown's work on vulnerability, and the philosopher Emmanuel Kant. Tom told stories of how his company achieved record-breaking sales results by listening to their people.

Tom grew up as the second of 11 children with a father who had served in the military. He said their home (which only had one bathroom) was run with the kind of precision made famous by the book, "Cheaper by the Dozen." However, Tom knew that our future leaders, the Millennials, won't accept the "command and control" style of leadership experienced by the Baby Boomer generation.

"What's the one thing any employee needs to know in order to be engaged in the workplace?" Tom asked the audience. "Here's what they want to know," he said. "My leaders care about me."

From a Naked Leader

C. Richard (Rich) Panico shared his own company values in his presentation, "Naked Leadership: Leading to Win Hearts and Minds." Rich once made a rash promise to someone he thought had little chance of getting a promotion—he said he would "run naked through the building" on the unlikely day that employee received a promotion. The employee took on Rich's challenge and did, indeed, get promoted. Modestly covered by a barrel with straps, Rich made good on his promise.

"Naked leaders are authentic," he said, adding that a leader's role is to embody the values of the organization. Rich, who is founder and CEO of Integrated Project Management Company, Inc., shared some Naked Leadership Characteristics, including:

- Business is personal
- A leader has heartfelt concern for others' well-being
- Treat everyone with dignity and respect
- A leader is comfortable expressing emotions and displaying vulnerability

Rich puts his money where his mouth is by investing in his own team, bringing them together from their seven offices four times a year to communicate face-to-face. The cost of doing so is significant, but Rich said he knows it's worth the money to bring his 150 employees together.

From a Winner of the Malcolm Baldrige Award

Dave Fox, president of Advocate Health Care-Good Samaritan Hospital in Downers Grove, presented "Creating a Different Future through the Pursuit of Performance Excellence." He shared about his organization's commitment to culture, a story that led to the hospital receiving the Malcolm Baldrige National Quality Award in 2010.

Dave set the stage by quoting from Jim Collin's book, *Great by Choice:* "Instability is chronic, uncertainty is permanent… and we can neither predict nor govern events." He added another famous quote from Collins: "Good is the enemy of great." And a "good" hospital is just what Dave inherited when he stepped into the role of CEO in 2003. His vision, however, was bigger. "There's a big difference between change and transformation," Dave said, adding that change is about **doing;** transformation is about being.

The "G2G" (Good to Great) campaign Dave and his team launched at Good Sam set the stage for some staggering statistics. Outpatient satisfaction went from 7% in 2004 to 90% in 2006. Intensive care unit cases of ventilator-assisted patients who developed pneumonia went from 5.48 per 1,000 days to **zero.** Central blood stream infections in ICU dipped from 2.70 per 1,000 days to .85. Those are just a few of the results he shared that demonstrate how culture shapes quality.

According to Dave, the key steps in Good Samaritan's transformation included:

1. Establish an inspiring vision and enroll leaders–create ownership
2. Create alignment, ownership and transparency to drive improvement focus
3. Deploy evidence-based practices
4. Foster a process honoring culture
5. Fully deploy a performance improvement approach
6. Build Loyal Relationships–the foundation to accomplishment

The best secret of all, Dave said, is to love what we do. "This [work] is too damn hard to do if you don't really love it," he said.

From the Son of a Farmer

David Tomlinson, executive vice president, chief financial officer and chief information officer at Centegra Health System, provided his own insights as well as an interactive exercise that helped participants walk away with a new perspective of time. Having grown up on an apple orchard, David said he drew much of his leadership experience

(continued on page 15)

Leaders Share Stories and Strategies at FIHFMA Spring Summit (continued from page 14)

Mary Treacy Shiff, FIHFMA president-elect, shares a moment with speaker David Tomlinson

from the wisdom of his father and the challenges of farming.

In "4 Golden Nuggets to Live By," David offered these recommendations:

1. Live by the 5 "Ps"—"Proper preparation prevents poor performance."
2. Become a Servant Leader (a phrase coined by Robert Greenleaf).
3. Master the 168. We all have 168 hours in a week: how do you spend those hours? David sent everyone off with the assignment of doing a "time audit," then comparing that time audit to the list of valued activities we wrote on 3 X 5 cards. "Do they match?" he challenged us.
4. Maintain a high "Do/Say" ratio. "Are you doing what you say you're going to do?" he asked.

Whether monitoring performance by measuring our "Do/Say" ratios or working the checklist for the Malcolm Baldrige National Quality Award application, healthcare leaders have an opportunity—and a responsibility—to touch the lives of patients, families, physicians and the teams they lead. Based on the wisdom of these leaders, the job begins with keeping our word, investing in our people and aiming for our own true north. With time and faith, they told us, the results will follow.

Effective Leadership speakers Rich Panico and Tom Walter join Greg Kain, program chair

Women in Healthcare Panel Creates Vision for the Future

BY VICKIE AUSTIN, CHOICES WORLDWIDE

Panelists for the Women in Healthcare panel are (L to R) Pat Currie, Nancy Martin, Cherilyn Murer, Fawn Lopez, Sasha Demos, Laura Zumdahl and Rebecca Caires.

Day two of the FIHFMA Spring Summit included a morning panel, **"New Roles, New Partners, New Strategies and New Competencies,"** expertly moderated by **Cherilyn Murer,** president and chief executive officer of Murer Consultants. Each of the panelists brought a unique point of view covering a breadth of healthcare issues, from the effects of mergers and acquisitions on large tertiary hospitals and clinics to the need for "boots on the ground" services in underserved urban areas and developing countries.

Panelists and their topics included:

- **Rebecca Caires,** director of oncology for Northwestern Medicine and Lurie Comprehensive Cancer Center. Rebecca shared her own story of helping her mom from 1,000 miles away when her mother was diagnosed with cancer. The biggest issue for patients from Rebecca's point of view is **access.**
- **Pat Currie,** president of Central Texas Operations for Baylor Scott and White Health. Pat described the merger of two large systems that now include 40 hospitals, 600 clinics and 40,000 employees with $8 billion in revenue. She highlighted the need for a **digital ecosystem.**
- **Sasha Murer Demos,** MD, PhD, chairman of the anesthesiology department at Edward Medical. Sasha, who is also Cherilyn's daughter, described the need for **better coordination between physicians and administration.** She also shared about the frustration of inadequate and uneven access to pharmaceuticals for patients.
- **Fawn Lopez,** VP and publisher of *Modern Healthcare magazine,* said the goal of the magazine is to provide complete, accurate and objective news for healthcare leaders. She gauges her organization's success by the number of corrections required and the visits and letters she receives from readers each week. Fawn invited ongoing *input, feedback and engagement* about the magazine's coverage from the audience.
- **Nancy Martin,** MPP, founder and CEO of Fortify—Food for Global Health, described the mission of her company: to tackle the problem of iron deficiency anemia throughout the world, specifically targeting West Africa. Nancy described this $2 billion problem that kills two million women and children each year and she shared how results can be improved by **nominal investments in nutrition.**
- **Laura Zumdahl,** PhD, president and CEO of New Moms, Inc., presented an overview of her program, which provides support for young moms in the Chicago area, many of whom are victims of physical or sexual abuse. Laura's organization provides services to short-circuit the cycle of inappropriate use of the healthcare system. She called for a **holistic approach to community health.**

Cherilyn moderated the second half of the morning with questions from the audience. The panel represented an impressive range of women in leadership who shape the top tier of the healthcare delivery system, the brightest of clinicians, media moguls and the grass-roots organizers who are out to shape a better world for women and their families.

HFMA Upcoming Event

Vegas Baby!! 2016 HFMA Annual National Institute (ANI) to be held June 26-29 in Las Vegas

BY HFMA EDITORIAL STAFF

Join your peers at ANI 2016 and think out of the box to drive success where it matters most:

- Meet the challenges of consumerism—from first contact to final payment
- Manage costs while delivering quality
- Capture more revenue, whatever the payment or delivery model
- Leverage analytics to make smarter decisions in an uncertain environment

ANI 2016 keynote presentations include:

- Julie Williamson, PhD, Co-author of *Matter: Move Beyond the Competition, Create More Value, and Become the Obvious Choice*
- Finding Your Edge of Disruption: Learn how innovative, "generative organizations" are able to continuously create more impact on their customers, employees, and communities
- Eric Topol, MD, Cardiologist and author of *The Patient Will See You Now: The Future of Medicine Is in Your Hands*
- The Future of Medicine Is in Your Hands: Hear insights on the future of medicine—as well as innovations that will be required to drive health solutions aimed at improving outcomes
- Healthcare Innovation Panel
- A discussion around the possibilities of using hospitals and clinics as learning laboratories to commercialize innovation, moderated by Joe Fifer, President and CEO, HFMA

You'll also hear from ANI featured speakers—leading innovators at the forefront of collaboration and change including:

- Mark Chassin, MD, Joint Commission Center for Transforming Healthcare
- Getting to High Reliability Healthcare While Generating Positive ROI
- David Johnson, CEO & Founder, 4Sight Health
- Competition, Consumerism, and Choice: Building a Better Healthcare Market
- Vivian Lee, PhD, MD, MBA, Sr. VP for Health Sciences, University of Utah
- Finding a Better Way Toward Patient-Centered Medicine
- Thomas Lee, MD, CMO, Press Ganey
- What Drives Patient Loyalty? Analyses from Inpatient, Outpatient, and Emergency Department Patients
- Paul Keckley, PhD, Navigant
- Provider-Sponsored Health Plan Analysis of Competitive Landscape
- Sachin Jain, MD, CareMore
- Enabling Physicians to Deliver Value-Based Care
- Martin Arrick, Managing Director, Standard & Poor's
- Industry Trends and Credit Issues

At ANI, you'll have the opportunity to lay out your action plan—find out "how to" with Innovation Lab specifics. Try out new tools and takeaways. Check out 400+ products and services. Earn up to 25.5 CPEs. And, with ANI to Go, access ANI sessions until October 7, 2016. To register and for full session details, go to www.hfma.org/ani.

Welcome New Members

Elena Buckley

Paul R Zuradzki
Consulting Analyst
1992

Percy Moss
Director of Financial
Statistics & Analysis
Cook County Health &
Hospital System

Bob Hozian
Consultant

Dorothy M Loving
Controller
Cook County Health and
Hospitals System

Barry C Holcomb
Senior Financial Analyst

Cory Gusland
Milliman

Tamas Ban

Kevin Burrows
Director, Financial
Performance & Physician
Compensation
Northwestern Medical Group

Jeff M Simnick
Financial Analyst
Juniper Advisory

Mark Stortz
Manager Transaction
Advisory Services Healthcare
Ernst & Young, LLP

Joel Berger
Executive Managing Director
Bradford Allen Medical

Michael E Garcia

Magdalena Kenworthy
Manager, Coding &
Compliance
Advocate Dreyer Medical
Clinic

Phil Zeni
Editor/Publisher
TheChicagoDoctor.com
Newspaper & Website

Santhosh Nandhan

Michele Le
Senior Consultant
ECG Management
Consultants

Beth Gordon
Senior Associate Executive
Search
TalentRISE LLC

Michael Biegel
Manager
Huron Consulting group

Mark Euckert
Vice President Practice
Development
Foundation Radiology Group

Jefrey Stoga
Director, Business
Development
Cardinal Health

Dan A Dopp
VP of Business Devleopment
Integrify

Katy Dettman
Principal
Plante Moran

Chuck Vronch
Managed Care Analyst
Rockford Health Systems

Emily Stalec
Manager, Financial
Performance & Physician
Compensation
Northwestern Medicine

Kevin Mehta
Director, Management
Consulting
KPMG LLP

Jeanette D. McQuarter-Butler
Director
NorthShore University
Health System

Kimberly C. Hartsfield
Senior Manager
ECG Management
Consultants

Sandra Young
Senior Manager
University of Illinois
at Chicago

Timothy Long
Healthcare Consultant

Louis Tinajero
Director, Fiscal Services
Norwegian American
Hospital

Nick T Donnelly
Director of Business
Development Midwest/
Northeast
Xtend Healthcare

Derek Foster
Chief Executive Officer
Etyon, Inc.

Ella Birman
Revenue Liaison
Northwestern Memorial
HealthCare

Cory Ryan
Director
RedRidge Finance Group

Theresa Hearn
Associate Director
RedRidge Finance Group

Doris I. Alfaro

Daniel P Herrmann
VP, Business Development
Healthware Systems

Ashley Allen
Director, Enterprise Solutions
ZirMed

Shashank Karnik

Dipak Patel
Pamplona Capital
Management

Ben Dohner

Javier Lopez

Welcome New Members Cont'd

(continued from page 18)

Mohamed Elnoory
Revenue Cycle, Financial Analyst
Northwestern Memorial Hospital

Carissa Panek

Taylor R. Hilderbrand
Revenue Cycle Financial Analyst
Northwestern Medicine

Tangela Johnson
Financial Analyst II
Advocate Health Care

Natalia Glubisz
Manager of Research Operations
University of Illinois at Chicago

Kimberly Keehan
Revenue Cycle Liaison
Northwestern Memorial Healthcare

Robert M. Adduci

Jacqueline Glanton
Manager, Practice Management
The College of American Pathologists

Jenean Abedalrahman

Michael Levy

Radhey Raval

Brittany D Turner
Project Manager
Cardon Outreach

Derrick Yang
Planning Manager

Khalid J Yousuf
LCMH

Lisa Bower
Director, Healthbox

Atit Patel
Pharmacist

Tom Derrick
SVP Co-Founder, OpenMarkets

Liliana Caicedo

New Member Profile

Van Dawson

Director of Decision Support,
Northwest Community Hospital

Questions:

What was your first job?

I began as a budget and cost analyst at Northwest Community Hospital back in 1998. I came back to NCH in 2013 as director of decision support.

Do you have any early influences?

One of my early influences was a professor at NIU for my healthcare finance class. His teaching style made it very interesting, which helped guide my decisions that led to my career path.

Why did you decide to get into healthcare financial management as a career?

I wanted a career that made a difference in the community and was always interested in the business side of healthcare.

What are you hoping to get from your HFMA membership?

I joined HFMA to expand my knowledge within healthcare finance and have the opportunity to network with others who might run into some of the same challenges we face.

Any tips for young professionals thinking about a career choice, or to those HC financial professionals as they begin their careers?

For those young professionals… just because school is over doesn't mean you can stop learning. Healthcare is constantly changing and in order to stay on top, you need to continue to increase your knowledge in the industry.

Are you involved in any other activities (e.g., coaching) or volunteer organizations?

Yes—I coach my kids' teams. They play soccer and basketball.

The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2015-2016 chapter year. Thank you for all your generous support of the chapter and its activities.

Gold Sponsors

Besler Consulting
Plante & Moran, PLLC
Crowe Horwath LLP
PBC Advisors, LLC
Harris & Harris, LTD
JP Morgan Chase
EnableComp
Calliduscloud
OST

Silver Sponsors

Horizon Financial
Hollis Cobb Associates
Triage Consulting
Powers & Moon, LLC
Parallon
ClearBalance
RSM
Passport Healthcare
PNC Bank

Bronze Sponsors

Conifer
Pro Assurance
Medical Business Associates
Ernst & Young LLP
Avadyne Health
Pavillion Group
State Collection Services
OnPlan
Lubaway Masten
Healthcare Payment Specialists, LLC
PARO Decision Support
The SSI Group
Bank of America Merrill Lynch
Cirius Group
Tatum

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

Publication Information

Editor 2015-2016
Shane Ramsey..... 312-515-7854 Shane@imagemovermd.com
Jim Watson..... 630-928-5233 jim_watson@pbcgroup.com

Official Chapter Photographer
Randy Gelb ..... 847-227-4770 rgelb@mbb.net

Sponsorship
Chad Preston .....615-414-1025 cpreston@avectushealth.com

Design
DesignSpring Group, Kathy Bussert kbussert@designspringinc.com

HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 4 times per year. Newsletter articles are written by professionals in the healthcare industry, typically chapter members, for professionals in the healthcare industry. We encourage members and other interested parties to submit materials for publication. The Editor reserves the right to edit material for content and length and also reserves the right to reject any contribution. Articles published elsewhere may on occasion be reprinted, with permission, in *First Illinois Speaks*. Requests for permission to reprint an article in another publication should be directed to the Editor. Please send all correspondence and material to the editor listed above.

The statements and opinions appearing in articles are those of the authors and not necessarily those of the First Illinois Chapter HFMA. The staff believes that the contents of *First Illinois Speaks* are interesting and thought-provoking but the staff has no authority to speak for the Officers or Board of Directors of the First Illinois Chapter HFMA. Readers are invited to comment on the opinions the authors express. Letters to the editor are invited, subject to condensation and editing. *First Illinois Speaks* does not promote commercial services, products, or organizations in its editorial content. Materials submitted for consideration should not mention or promote specific commercial services, proprietary products or organizations.

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 2016	June 10, 2016
October 2016	September 10, 2016
January 2017	December 10, 2017
April 2017	March 10, 2017