hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

February, 2006

the Business of Caring

Changes to Illinois' Workers' Compensation Act

Maximize and Accelerate Your Reimbursement

BY NEIL J. GREENE

INSIDE:

Highlights and Recap First Illinois Chapter Events

A review of the October 2005 Revenue Cycle and November 2005 IT Programs

Founders Merit Award Recipients 2005

Recent changes to Illinois' Workers' Compensation Act (WCA) means an end to business as usual for providers. From prohibitions against balance billing patients to the imposition of a reimbursement fee schedule there are opportunities and pitfalls for providers who render services to patients who have incurred injuries in the scope of their employment. This article is designed to help providers understand and navigate these changes.

Inside This Issue

The Fee Schedule

For services rendered on or after February 1, 2006, providers will receive payment for Workers' Compensation services at the lesser of charges or a fee schedule which has now been posted at www.iwcc.il.gov. The schedule is primarily based on DRGs with reimbursement designed to occur at 90% of the 80th percentile. Geographic modifications occur based on zip code.

For trauma services (level I and II), emergency room visits, outpatient procedures, freestanding ambulatory surgical centers and other limited exceptions, bills will be paid at 76% of charges. Similarly, for high cost (outlier) services when charges exceed twice the new schedule's proposed DRG reimbursement, the provider, after receiving the DRG rate will also be paid 76% of all charges that exceed the DRG rate.

The exception to all reimbursement at the 76% rate is any portion of those bills involving prosthetics, implants, orthotics, ambulance, drugs with detailed coding and investigational devices. Such items are classified as "pass through charges" and will be paid first at a rate of 65% of charges. For purposes of calculating whether outlier rates apply and for other services paid at 76% all pass through items are first paid and deducted.

Keep the Patient Involved

While the new act prohibits balance billing, it is important for the providerto maintain communication with the patient. By placing limits on a provider's right to bill a patient for job-related injuries (technically injuries 'incurred in the scope of employment',)the Illinois legislature

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President's Message

Strength in Numbers

Growing up in suburban Chicago I was the second oldest of six children, three girls and three boys. Finding my role in our large family was never a problem for me. Not so, however, for everyone else. Today with all siblings married, and each with children of their own, we are an immediate family of near thirty.

First Illinois Chapter leadership, like a family, does so much for the benefit of the chapter and each other, often times we forget to be grateful for how much work gets done. Thank you to each and every Officer, Board Member, Committee Chairperson, and Committee Member for going above the call of duty in all that you do to manage and grow our chapter.

Chapter activities have been numerous and exciting these last few months. In late October, our chapter launched our redesigned website. In addition to its new look and feel, the site now includes our strategic plan , on-line registration, event brochures, photos, and president's messages to name a few of the changes. Check it out at www.firstillinoishfma.org, then let me know your impressions of what the committee created. With your input we will continue to improve the sites functionality.

The morning of November 17th, forty-five members and twenty-three non-members attended a half-day education program put together by our IT committee. This informative event was co-sponsored with CHEF, HIMSS, and IHA. Later that same day, the certification committee held an information open house at RSM McGladrey's Schaumburg office. Fifteen members attended that event and we anticipate at least twenty-five people will sit for the certification exam by April 30th.

December 8th; Chicago experienced its worst snow storm of the season – this also happened to be the date of a chapter Board meeting as well our chapter holiday party. Tim Herberts, HFMA Region Seven Executive, special guest for the event, thankfully had arrived early the day prior to the snowstorm. Unfortunately, of the fifty-eight RSVPs for the holiday party, only fourteen were able to make it.

The First Illinois Chapter is the fourth largest of seventy HMFA chapters. Such a large membership base allows our chapter to provide quality education and social events. This year we continue to promote the membership campaign – HFMA Member-Get-A-Member! Those who sponsor a new member, or get a member to reinstate their membership will receive BONUS rewards from National. Additionally those who join between now and April 30th can do so at a reduced, prorated membership rate.

As a member, already you are in the best possible position to directly and positively impact HFMA's continuing growth. Participation in HFMA contributes to the quality of life and economic well-being of millions of Americans; improves standards of industry leadership and practice; and offers education, networking, community-building and more. Please call me or one of our Chapter Officers if you have any questions about how you can impact our "Strength in Numbers". The strongest recruiting tool for new and former members is your own personal endorsement.

By now, we all know that our Chicago White Sox won the World Baseball Series (actually we knew this before the previous issue of First Health Speaks went to print and was distributed to our members). We were optimistic that the next playoff bound team, the Chicago Bears, might follow in their footsteps and reach the Superbowl – alas, the familiar refrain "wait until next year." An optimistic attitude will always get better results!!!

Sincerely,
Jim Heinking, FHFMA
President
First Illinois Chapter HFMA

the Business of Caring

First Illinois Chapter News, Upcoming Chapter Events & Committee Updates

Upcoming Chapter Events –

Accounting and Reimbursement Committee:

The 2006 Accounting and Reimbursement Committee presented its annul program – "Winning Strategies in 2006 – Will You Be There?" on Thursday, January 19th, 2006. More than 95 participants were in attendance with a variety of legal, reimbursement and legislative updates discussed. A more detailed program summary will be included in the April edition of *First Illinois Speaks*.

Managed Care Committee:

SAVE THE DATE!

"Managed Care 2006 – Send Lawyers, New Computers and Money!! Emerging Managed Care Issues and Trends Facing Providers" will be held on **Thursday, March 16th, 2006** at the William Tell Inn in Countryside. Starting the day's program will be an updated discussion on key legislative initiatives in Springfield, followed by updates in Workers Compensation, Provider Exposure under ERISA regulations, as well as a joint presentation with IPAM on improving the bottom line. The program will conclude with a discussion of Pay for Performance Trends. Registration forms will be in the mail soon! Or, register at www.firstillinois.org under the Events Calendar Section. Call or fax Gail Walker for more information: 219-874-4684.

Golf Committee:

Plans are underway for the annual HFMA Golf Outing, to be held on Friday, May 26th, 2006. This is the 30th anniversary of the event, which always guarantees a good time, good golf and ability to meet with your fellow HFMA colleagues. The event will continue its tradition of offering a scramble format at St. Andrews and a regulation format at Klein Creek. Both novice and veteran golfers are invited!

Founders Merit Awards for 2005

BY BRIAN SINCLAIR, VICE PRESIDENT, HEALTHCARE FINANCIAL RESOURCES, INC. AND CHAIRPERSON, AWARDS COMMITTEE.

Congratulations are in order for the recipients of the 2005 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 are part of a merit plan, which assigns a range of point values to specific chapter activities, such as committee participation, educational presentations, newsletter articles and service as a chapter officer. The Follmer Bronze Award is earned when a member has accrued 25 points, the Reeves Silver Award is earned after an additional 25 points are accumulated, and the Muncie Gold Award is presented after a final 25 points are earned. A fourth award, the Founders Medal of Honor, is conferred by nomination of the Chapter Board of Directors to qualifying members. This award recognizes significant continuous service after completing the medal program.

THE 2005 AWARD RECIPIENTS ARE:

Follmer Bronze Award

Jack Chrencik
David A. Hammond, CHFP
Ronald J. Hennings
Michelle A. Holtzman
Mary Ann Klis
Lawrence S. Kloc, CPA
Robert F. Maziarka, CHFP, CPA, FHFMA
Cathy L. Pastorek
Kevin P. Shaughnessy

Reeves Silver Award

Rebecca S. Busch, FHFMA
James F. Heinking, FHFMA, CHFP
Dominic J. Nakis, CPA
Richard J. Stewart, CPA

Muncie Gold Award

Suzanne K. Lestina, CHFP, CPC
Lawrence A. Manson
Vincent E. Pryor, FHFMA, CPA
Alan Staidl

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

Please refer to your Chapter Membership Directory for more information regarding the awards series, scoring details and a listing of all former recipients. If you have any questions regarding the awards or your current point status, please call Brian Sinclair, Chairperson, Awards Committee, at 847-273-2196

Chapter Events

New Member Breakfast

On Thursday, October 20th, 2005, the First Illinois Chapter hosted a new member breakfast for those HFMA members having recently joined the chapter. Approximately 30 members participated in the morning's session, which preceded the October Education Program.

Among the officers, board member and chairpersons representing the First Illinois Chapter were James Heinking, President; James Watson, Secretary; Guy Alton, Treasurer; Board members Sylvia Sorgel and Liz Simpkin; Janet Blue, Education Co-Chair; Brian Sinclair, Education Co-Chair and Awards Chair; Al Staidl, Membership Chair and Golf Co-Chair; and Paula Dillon, Newsletter Co-Chair

Jim Heinking kicked off the morning's program by introducing the chapter representatives, after which the new members had the opportunity to introduce themselves to their fellow members. Chapter leadership took the opportunity to present a brief overview of HFMA, the First Illinois Chapter, its current goals and accomplishments and future plans. Members also had the chance to learn about the variety of chapter activities offered as well as volunteer opportunities; the meeting concluded on a positive note as members engaged in general networking and socializing with other new members.

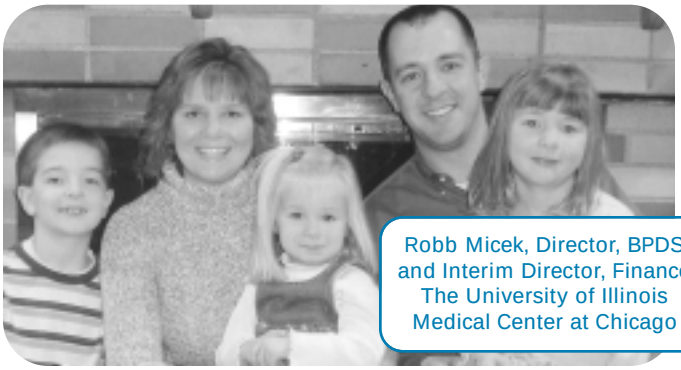
The First Illinois Chapter routinely holds new member breakfasts as an informal way to introduce new members to the chapter and its variety of opportunities. As additional breakfasts are scheduled in the future, First Illinois will continue to reach out to the new membership.

Chapter leaders Brian Sinclair, Liz Simpkin and James Ventrone meet with new members of the First Illinois Illinois Chapter.

Q: Tell Me Again Why We are Doing This? A: We Are Professionals

BY HOLLY SOVA

Karin Podolski
Director of Patient Access
Delnor Community Hospital



Robb Micek, Director, BPDS and Interim Director, Finance
The University of Illinois Medical Center at Chicago

Karin Podolski: She's not quiet. She's not timid. Nor is she one to allow the prevailing mindset to limit her staff's self-image and the expectations they set for themselves. As Director of Patient Access, Karin Podolski is intent on proving the worth of her department's work. She is a professional and positive leader making the area of Patient Access an attractive career path for new-comers. She and her team are earning needed resources and respect from hospital leadership. "Access is where its at!" Karin says. "If we get patients in the door with accurate information, the hospital need not waste time in collections."

Six years ago Karin used her energy and vision to begin study toward two masters degrees while working full-time as Manager of Same-day Surgery at Delnor Hospital. She had started at Delonor three years prior, fresh out of nursing school. By 2002 she had redesigned her department's intake process and graduated from Northern Illinois University with a Masters in Nursing and a Masters in Public Health.

Karin evaluated her career options, was asked to step up to her current Director role and decided to stay at Delnor. She's been in hospital finance for three years now and has built a team which delivers a better patient experience and improved revenue cycle results. Key to her success has been her ability to weave her clinical background into the finance side. She has strengthened relations between clinical & patient accounts and driven an array of process improvements; improvements that stick and continue to evolve with changing reimbursement trends, legal issues and technology choices.

This Elgin-native who spends her free time with her 2-year old daughter, Schuyler, became an HMFA member for the resources. Karin understood that someone new to the finance side may not recognize when being given faulty information or bad advice. She really appreciates access to a variety of seminars, to HFM magazine and perhaps most importantly the networking. She sees HFMA as an efficient way of finding folks who know industry best practices.

When our chapter challenged local organizations to engage in a friendly competition around CHFP certification, Karin was definitely interested. Suzanne Lestina, chair of First Illinois' certification committee, describes the challenge as a reminder to local executives that encouraging employees to pursue certification is a win-win all around.

First Illinois Chapter will reward the organization with the highest proportion of employees achieving certification this year. In turn, organization's like Delnor Community and University of Illinois Medical Center are supporting and rewarding their employees who are willing to study for and sit through the series of two two-hour exams.

Karin is coordinating study for five Delnor professionals who plan to take their exams by March 31st. Finding time to study together during lunch & otherwise are the hospital's CFO, Controller, Director of Managed Care, Director of Patient Accounts and Karin. The best parts about the group effort: definitely the camaraderie, the chance to learn more about their own organization by asking about each other's respective specialties, and the relatively politics-free forum to challenge the way things have always been done. All five Delnor candidates are a little nervous about taking the test, but all are definitely excited.

Karin has been driving her team toward strict business results. Now she's asking for extra-curricular effort above and beyond the work day. What would Karin's co-workers say about her? "They'd probably say that I have an infectious laugh and can be heard coming from way down the hall." Her boss, if asked to recommend her for a TV reality show, Karin imagines would say that Karin will try anything. "Except eating bugs!" she protests. "I won't eat bugs!"

At the University of Illinois Medical Center at Chicago, Robb Micek is coordinating a study group of 15 coworkers preparing for HFMA certification exams. "It's like going on a diet or working out at a gym – togetherness makes it less painful," Robb says. Many in the U of I group had been meaning for awhile now to get certified, but life just gets in the way. The group agreed

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We Are Professionals (continued from page 4)

there's never a good time, so they might as well just buckle down and do it. The sense of camaraderie and competition helped.

At least two U of I representatives are planning to take each of the five specialty certification exams. As Robb puts it: "I'm most excited about (the) diversity of this group". Robb, who has been in the healthcare industry for only three years, sees the certification experience as a way of "rounding out my understanding of this industry and my understanding of what those around me are supposed to be doing." Like Karin, Robb predicts his organization will benefit as study partners develop a collaborative relationship, come to see the nuances of each other's work, understand how the overall process fits together and are moved to practical application of what they are learning. In short, the experience is bound to raise the caliber of the individuals & the organization.

Robb feels that CHFP certification certainly makes people more marketable. He compared it to achieving his CPA: "One nice thing about any sort of certification; employers immediately assume a certain level of expertise. It demonstrates a person is serious about making this a career."

The fundamental prerequisite for squeezing in hours of study and testing: "It's a matter of being driven by a personal sense of achievement." It's highly questionable that Robb Micek needs to worry about personal achievement.

This former CPA and consulting firm partner earned his BBA in Accounting from Notre Dame. After four years as an auditor for then PriceWaterhouse, Robb wanted something more out of his career so he picked up an MBA from the University of Michigan.

A job offer brought him to Chicago where he worked in various consulting roles for "Fortune 100 companies and in nearly every industry under the sun other than higher education and healthcare". Ironically, he really wanted to be in precisely those fields (he comes from a family of academics). "Health care is the most dynamic, complex and challenging industry that I can think of."

Robb admits his background is atypical for his position, but he sees this as beneficial. Apparently so does the U of I Medical Center, which recruited Robb for his expertise in strategic consultancy and large-scale change management around e-business and technology. After overseeing a successful implementation of the Banner ERP system, Robb was asked to lead a new department, Business Planning & Decision Support (BPDS). The organization wanted this department to help leadership identify and flesh out new business opportunities and make more data-driven decisions.

Robb may lead complex executive support analytics, but he actually feels that any individual in any finance position can impact organizational change. Every finance professional has a unity opportunity to educate internal customers about how the organization works, and about how any one role ultimately impacts financials. Robb recommends finance professionals go beyond waiting for things to come to them, but rather to proactively help the operations side take a collaborative look at how to eliminate non-value added activities. This past summer Mr. Micek assumed the position of Interim Director of Finance.

Robb's "free-time" is full. He coaches his children's sports teams, leads a bible study, and together with his wife Traci, a speech pathologist, supports the National Organization Caring for Kids (NOCK). NOCK provides communication and mobility devices for kids whose families are just above the poverty line. The Miceks are very committed to supporting NOCK and are happy to get the word out about this excellent organization.

Robb attended high school with Traci, but the two did not start dating until they lived twelve hours apart, while attending different colleges. So after that why has Traci put up with Robb for all these years? "I am extremely lucky. You'd have to ask her that question."

Karin Podolski is a First Illinois HFMA member and can be reached at Karin.Podolski@delnor.com or 630-762-6401.

Robb Micek is a First Illinois HFMA member and can be reached at RMicek@uic.edu.

To learn more about how to get involved in the chapter's certification challenge, contact Suzanne Lestina at sklrunner@hotmail.com or 708-492-3395.

October 20, 2005 – Managing the Best Patient (Financial Experience) ... It Can Be Done

Over 90 First Illinois chapter members attended the annual Revenue Cycle Education program "Managing the Best Patient (Financial Experience…..It Can Be Done" this fall. The program topics reflected the diversity of challenges faced by organizations in the revenue cycle process.

At the start of the program, Thomas Matthews from TransUnion highlighted several areas of growing concern and the importance of financial triage tied to improved front end technology improvements – among the statistics cited by Mr. Matthews included the growing number uninsured (60 million by 2010), the financial impact of HDHPs/HSAs and the fact that the largest growing number of uninsured are arising in the $50,000 and up income bracket. Several strategies were highlighted as a means by which providers could address some of the revenue stream challenges: increasing utilization of credit reports to determine payment capabilities, flexibility in shifting FTEs from front-end to back-end and improved communication of payment policies. Mr. Matthews concluded his comments by focusing on the challenges faced in the future: determining appropriate benefit plan logic, setting realistic expectations for payers and patients, addressing medical necessity denials and the ongoing efforts for training and reeducation.

Dan Furhman of CORE Business Technologies presented an overview of the future wave in office design – "The On-Line Business Office". The future of business office functions appears to focus on innovation, simplicity of procedures and how technology enhances the efforts of the business office. Mr. Furhman focused on several key techniques – centralization of information, supportive technology, more defined workflows and increased outreach to the patients.

That final topic provided a smooth transition for the next speaker – Elise Lauer from Northwestern Memorial Hospital – who illustrated how improvement in customer service can have a wide-reaching impact, based upon specific tactics employed within her organization. Best practices can include setting a clear vision, a focused billing unit with defined goals and appropriate resource allocation. UB Martinez of MedAssist provided additional focus on how organizations strive to balance their revenue stream with a social mission, particularly in dealing with the growing number of underinsured, as well as uninsured populations. Many of the principles recommend correlated to other presentations during the day, specifically related to communications and improved business workflows.

Shana Jones of Shriner's Childrens emphasized the value of electronic medical record technology and the critical steps to organizational buy-in, successful implementation, and ongoing monitoring and improvements. Joni Dion and Richard LeBoutillier of Bearing Point focused their presentation around how organizations must be better prepared to balance revenue expectations against established chargemasters and the need for improved document across an organization. Pam Waymack concluded the day's events outlining the current issues related to effective denial management and the importance of improvements in all phases of an organization – clinical documentation, upfront screening and authorization, timeliness of billing and follow up and documented performance standards.

Congratulations to Chairperson Michelle Holtzman for a timely and cohesive program!!

Michelle Holtzman, Revenue Cycle Chairperson

Pamela Waymack, Phoenix

Richard Leboutillier & Joni Dion, Bearingpoint

UB Martinez, MedAssist

Shana Jones, Shiners Children's Hospital

November 17th, 2005 – Achieving Bottom Line Results Through IT

Approximately 60 members of the First Illinois Chapter of HMFA participated in the I.T. Educational program entitled "Achieving Bottom Line Results through IT. The theme of the program was to hear insight into how the goal of squeezing and measuring value from the investment in healthcare information technology is still a critical, albeit an elusive one. Additionally, hospitals represented at the program were asked to illustrate how they are successfully using IT to improve their bottom line. Topics presented for the day ranged from using IT enhancements for improved cash flow to effective project and portfolio management.

Alden Solovy

Alden Solovy, Executive Editor of Hospital & Health Networks and Associate Publisher for Health Forum, kicked off the day's program by presenting his findings from the Most Wired Hospital survey as well as highlighting trends in technologically savvy hospitals. Critical to full adoption of technology industry-wide are three critical elements of the research phase: 1) creating benchmark groups; 2) conducting mortality analysis; and 3) evaluating the differences amongst hospitals based upon the array of IT tools used for quality and safety measures. Trends to watch in the future include more advanced bar code technology as well as the rise in consumerism – requiring additional focus around quality measures.

Jim Gallagher and Vince Gallagher of Alexian Brothers Medical Center combined efforts to present how IT systems within their healthcare organization have translated into improved financial projection and reimbursement models. Information Technology continues to play a crucial role in evaluating underpayments, however, compatibility between systems is also integral for providing the most updated financial projections. Audrius Polikatitis from the University of Illinois Medical Center focused his comments around the need for more proactive planning when creating a long-term capital needs plan that requires both portfolio and program management. A coordinated effort must take into account clinical, supply chain, web option, electronic medical records, among other elements, and requires a very disciplined approach in scoping out the capital needs.

Jim & Vince Gallagher

After a brief video narrative, Doug Colburn of the Nebraska Heart Institute presented a live demo on system technology used within their organization – as the premier cardiac institute for a significant geographic region, Nebraska Heart Institute consists of both a ambulatory care clinic as well as a specialty hospital. Several key features were noted during his presentation – single sign on capability; EMRs available in all computers organization wide and admitting conducted through wireless computers, thus decreasing patient wait times. This presentation pointed out the key need for more centralized technology as a differentiator.

The day's program concluded with a panel discussion moderated by IT Co-Chair Eric Tate and featured a distinguished panel of participants: Doug Colburn, Nebraska Heart Hospital; Jim Doyle, Elmhurst Memorial Hospital; Rose Ann Laureto, University of Illinois Medical Center at Chicago; Barb Mills, Sherman Hospital; Frank Scafidi, Elmhurst Hospital; Hugh Rose, Palos Community Hospital; and Alden Solovy, Executive Editor of Hospital & Health Networks and Associate Publisher for Health Forum. The panel, which consisted of CIO's and CFOs shared their experience in grappling with IT capital allocations, measuring value and developing strong working partnerships.

Congratulations to Co-Chairs Eric Tate and John Roquena for a very illustrative program!!

I.T. Panel Members

I.T. Co Chairs, John Roquena & Eric Tate

Engaged Physicians Critical to Organization's Survival

BY JOHN BISAHA

Recent studies by The Gallup Organization showed that only 10% of U.S. physicians are fully engaged with a hospital while 42 % are actively disengaged. Think it doesn't matter? Hospitals scoring in the top quartile for physician loyalty had earnings per adjusted admission that were on average $320 more than those of bottom-quartile hospitals. More significantly, earnings per adjusted patient day were about $80 more compared to bottom quartile hospitals.

Many healthcare facilities spend quite a bit to improve customer satisfaction among patients. Whether or not success on that front is even possible, and if so would translate into fiscal benefits is not a straightforward issue. Across industries, annual surveys conducted by the University of Michigan reveal that customer satisfaction has been flat to declining since the survey began in 1994. Similarly, annual Gallup surveys found that only about 1 in 20 US companies (5%) saw their customer scores improve in any consistent way over a seven-year period.

Real return on customer satisfaction

One area of customer satisfaction which clearly impacts the bottom line is that of physicians. Yet most healthcare administrators do not track or even know how healthy their relationships with medical staff are.

Physicians are among a healthcare organization's most important customers. True, they do not directly pay for a hospital's services, but they do make careful choices about where they send their patients and prefer to practice. Physician referrals drive hospital revenue. Facilities must regard them as critical customers, and partners in the organization's future success.

Case studies demonstrate a clear linkage between physician engagement and referral patterns. A recent Gallup study of a large community hospital identified that 17% of physicians who are actively disengaged with this hospital anticipate decreasing referrals to the hospital in the next year. The hospital's "poor management of customer relationships" was the reason most frequently given. Meanwhile, engaged physicians at this hospital anticipated increasing their referrals.

Similar research has shown that an engaged medical staff impacts financial survival. Four levels of physician engagement have been identified:

Fully Engaged physicians are the most valuable to a hospital. They have a strong emotional bond with the organization and have a loyal attitude.

Engaged physicians have an emotional bond that is less strong and feel less loyalty toward the organization than do their fully engaged counterparts.

Not Engaged physicians are emotionally and attitudinally neutral. They have no positive association with the organization.

Actively Disengaged physicians have an active emotional detachment form the organization and are antagonistic toward it.

New generation demands new relationship

Healthcare leaders need a different kind of thinking and a different kind of relationship to engage the hearts and minds of younger physicians. MDs entering the healthcare industry today are less engaged with their profession and with individual healthcare organizations than previous generations. Consider that for every one fully-engaged physician over 55-years old, two of his cohorts are actively disengaged. Among physicians under 45, it's much harder to find emotional commitment to a facility; for every one who is fully-engaged, six are actively disengaged.

Physicians are emotional beings. As with any person, their thought processes are driven by two distinct patterns—Rational and Emotional. Physicians use rational thoughts all the time to interpret test results, diagnose and develop treatment plans. It has been assumed, since they have had years of training and expertise in analytical hypothesis testing and rational science, that the best way to engage physicians would be to address their rational needs. Based, however, on years studying physician engagement, and on my own personal experiences, I have discovered that physicians' decision-making is more emotional that one would think.

Through extensive research and development, Gallup developed a set of rating scales that reliably represent the strength of emotional connection a physician has toward a healthcare organization. Gallup can then compare individual physicians on a hospital's medical staff to our national data base. This crucially important data indicates that attachment develops in a

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Engages Physicians Critical to Organizations Survival

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cumulative way. Confidence is the foundation and Passion is the pinnacle. The hierarchy of physician engagement is as follows:

Confidence: Belief that the hospital can be trusted to consistently deliver on its promises.

Integrity: Belief that the hospital consistently treats them fairly and will satisfactorily resolve any problems that might occur.

Pride: Good feelings about using the hospital and about how that affiliation reflects upon them.

Passion: View of the hospital as irreplaceable and as an integral part of their practice of medicine and hence of their lives.

How to achieve good vibrations (& the revenue that follows)

Emotional attachment to the organization's values and a high level of confidence in its key leaders are two factors strongly influencing doctors' engagement to a particular hospital. Doctors want to align themselves with leaders who are truthful and candid, share common ethics, respect their input, and focus attention on what helps them as a doctor. In essence, physicians choose to work closely with leaders who make them feel good about practicing medicine in their hospital. Healthcare leaders must realize the extent to which physicians are emotionally driven, and must and build strong relationships with their medical staff based on trust, integrity, and personal values.

Stronger relationships require individualized solutions and attention. General "free food in the lounge" programs are superficial and do not work. The leadership of top performing hospitals consistently build physician engagement by:

- Meeting one-on-one with each physician at least once each year to ask questions like these: Are we, as leaders and employees, meeting your expectations and those of your patients? Do you have any concerns with our values and/or goals? How can we help you provide higher quality care to your patients?
- Hosting retreats for executive management and physician leaders as a way to solicit doctors' input on the strategic plans and operations of the hospital.
- Requiring managers and leaders to participate in medical staff committees to listen for potential concerns and conflicts to resolve these issues before they become a problem.
- Facilitating effective communication between doctors, nurses, and key department managers to ensure they are working as a team and share mutual trust.
- Including physicians in recognition activities and acknowledging their efforts to improve quality and efficiency or achieve strategic goals.

Today only 15% of U.S. physicians believe that hospitals provide fair resolutions to problems. What physicians are looking for are hospitals that treat them well and reinforce their self-image. They want to be proud to tell others where they practice medicine. As markets become more and more competitive, healthcare leaders must create, strong, emotionally-based relationships with their medical staff to build a powerful network of engaged physicians.

John Bisaha is a member of HFMA and can be reached at 312-601-9129, John_Bisaha@Gallup.Com

10 Strategic Planning Resolutions You Can't Afford to Break

BY AARON DEBOER

The New Year may have come and gone, but it's not too late to make a few more resolutions. Here are ten that your management team can make to ensure a smooth, successful, strategic planning process.

1) Establish a strong analytical foundation for your strategic plan

A strategic plan is only as good as the foundation upon which it is built. A good strategic plan can propel your organization forward once your leadership team has a common understanding of your current position, future trends, and key uncertainties. On the other hand, a strategic plan based on an insufficient understanding of the internal and external environment can, at minimum, lead to poor acceptance of the plan and, at worse, sub-par decisions.

2) Focus the environmental assessment

When developing an environmental assessment as part of your analytical foundation, it is important to select only those elements that will address the organization's future challenges and resulting array of strategic opportunities. An efficient way to focus your environmental assessment is to develop and test a set of planning hypotheses centered on major market forces. With hypotheses formed, the organization can focus its analysis efforts on building a common understanding of the environment.

However, performing a focused environmental assessment is not an end in itself. If the data does not convey a message and support the decision making process, it is simply data, not "information."

To mitigate this risk:

- Identify what information is most important to make decisions.
- Effectively transform the data into actionable information.
- Understand that there will never be perfect information.

3) Explicitly consider key uncertainties

Addressing key uncertainties can help build a sense of charting your own course, albeit in turbulent waters. Tools like scenario planning, game theory, and decision tree analysis can all aid in understanding the risks associated with pursuing a particular approach/direction. Strategies that reduce the identified risks can then be incorporated into the strategic plan.

4) Keep your strategic plan focused on strategy, not operations

All organizations have extensive opportunities to improve their efficiency and effectiveness in the areas of customer service, cost, and quality. An internally-focused strategic plan often seems successful because of the substantial operational improvements that can be made. However, it does not take long for organizations that are too operationally focused to grow out of touch with their markets. True strategic initiatives on the other hand, frequently have higher risk, are more disruptive to the organization, and may have longer implementation times and payoff returns. While operational initiatives are necessary to

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Figure 1: Strategic Planning Metrics

	STRATEGIC METRICS		MANAGEMENT METRICS
	Vision Level	**Goal Level**	**Strategy/Tactic Level**
Definition	Metrics that indicate broad success, usually across multiple goals.	Metrics that indicate progress along a specific goal.	Metrics that indicate progress along a strategy or action
Characteristics			
• Number	3±	15±	100±
• Accountability	Board/Senior Leadership	Senior Leadership	Middle Management
• Review Cycle	Annually	Semi-Annually /Annually	Weekly/Monthly/Quarterly
• Organized Around	Vision/Desired Future State	Core Goals	Strategy/Tactic
• Applicability	Entity	Entity	Entity/Programs/Units
Example (Financial)	Desired bond rating	Operating margin Days cash on hand Cash-to-debt	Personnel costs as a percent of net patient service revenue Supply cost per adjusted discharge

10 Strategic Planning Resolutions

(continued from page 10)

keep you in the game, strategic initiatives address competitive advantage. Too many operational initiatives in your strategic plan will weaken it and detract from its value, so keep your strategic plan strategic.

5) Avoid the use of "me too" strategies

Many organizations take comfort in adopting the same strategies that other organizations have deployed. Once a strategy has been proven successful by one organization, it is often ubiquitously adopted by competitors, diluting the impact of the strategy. Strategic success begins with articulating what differentiates the organization from its key competitors. That is, how will we choose to compete (e.g., on price, quality, service)? In what ways will we create value for consumers? How will we respond to other organizations' strategies?

6) Minimize least common denominator strategies

Decision-making in health care organizations is often compromised when leaders wait for unanimous stakeholder agreement. Not only will this stall the process, but it will weaken the boldness of the strategy. After all, you will only be able to progress as fast and as far as the least ready person will allow. Remember, broad based input is desired, but effective leadership is ultimately about making tough decisions.

7) Align strategies with financial capabilities

Even the most brilliant strategy is reduced to mere speculation if the health care organization does not have the financial means to implement it. Every organization must ensure that their strategic plan is congruent with their financial capability.

A strategic-financial plan should:

- Include a full financial capability assessment
- Address the allocation of scarce resources
- Maximize the financial viability of the organization

8) Communicate early, often, and clearly when bringing your strategic plan to life

A plan must be well known by key physicians and employees to be successful. The strategic intent for the organization should be communicated frequently, clearly, and concisely to ensure that the momentum created during the planning process is carried forward in the implementation. Make a resolution to communicate the strategic plan consistently throughout the year.

9) Add metrics to your strategic plan

In stable environments, one has the luxury of making a few mistakes and course corrections. In an unstable environment, those course corrections must come sooner. Metrics are one possible tool to monitor the organization's progress towards achievement of goals, strategies, and/or tactics. Metrics are the combination of a measure and a target. Measures are what we want to achieve, while the target is the quantified value of the measure. Figure 1 outlines some of the different metrics an organization can adopt.

The value of this resolution can be summed up by the old adage "what you measure is what you get." If you want results, identify what you want to achieve, assign responsibility, and create appropriate timetables.

10) Have fun and inspire your team!

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Does Your Hospital Need a Check-Up?

BY TERI LEWAND AND VINCE CUSHING

Over 60% of America's hospitals were built before 1980. Obsolete infrastructure is a wide-spread industry challenge. The combination of an aging population and an aging hospital infrastructure result in hospital administrators needing to address both issues concurrently.

Can your facility accommodate the growing needs of the baby boomer population? Do you know what can be done to expedite renovations, therefore more quickly see returns on expanded medical procedures and services? What can you do to moderate soaring energy costs? These are a few questions hospitals across the nation are grappling with. Three timely insights on this subject follow.

INSIGHT # 1:

Improving the Healing Environment

Facilities, if not properly taken care of, can have performance issues just like people. Often where resources are stretched thin, building infrastructure doesn't receive the attention needed until something fails. As hospitals age, their environmental systems, that which provide basic prerequisites making healthcare delivery possible, become increasingly costly to maintain and operate. Aging buildings also mean additional risk as air quality diminishes to the point of affecting patient wellness and facility accreditation. To reduce these risks, it's important to invest in physical plant assets that help, not hinder the healing process. This priority will be emphasized in future health care standards.

INSIGHT # 2:

A Quicker Return on Investment

Accommodating the latest technology can be an expensive and disruptive proposition. This is especially true when renovating areas needed for patient care. Getting new revenue-generating services up and running quickly is critical to financial goals . A design/build approach can provide the expertise necessary to perform renovations quickly and efficiently. This process allows decision-making as the project is proceeding, providing a more expedient installation and quicker return on investment.
Construction and remodeling in a healthcare environment requires special considerations for patients and staff -choosing the right firm is important to the success of any such project.

A design/build firm that has experience working with hospitals will have a better understanding of these requirements.

INSIGHT # 3:

Managing Energy Costs

The dramatic run-up in energy prices over the last year is reminiscent of the 1970's oil embargo. The challenge of providing top-notch, affordable healthcare is made even more difficult as a result. More than ever, hospitals must make sure every dollar is well spent. Inefficient and outdated facilities increase costs and decrease patient and staff morale. What can be done when revenue-generating investments monopolize capital dollars? The answer is simple…let the facility improvements pay for themselves. Many healthcare executives may not be aware that facility investments can help, not hinder their position in the marketplace.

A structured approach to energy decisions and budgets is critical to remaining competitive in a fee-driven market. A formal energy plan documents investment and operating decisions, and helps ensure that anticipated savings are realized.

- Technology for building systems has advanced, improving comfort and costing less to operate. The Energy Policy Act of 2005 helps by providing financial incentives for energy efficiency investments.
- The reward for reducing and shifting energy use is greater than ever, especially if anticipated and matched with the right energy supply arrangement.
- A risk management plan can avert the financial losses possible in the face of volatile energy prices.

Professional engineers can formulate a custom energy plan informed by their expertise in identifying savings opportunities and choosing among many potential solutions. An energy program can bring lower costs, improved productivity and an enhanced healthcare environment. An energy plan formulated with the help of experts will optimize these benefits,

In summary, treat your infrastructure as an asset. Like people, buildings need regular "check-ups" to assess performance levels and catch problems before they grow Facility investments help hospitals deliver better patient care and retain the best staff. There are many innovative ways to fund the improvements

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Changes to Illinois' Workers' Comp Law (continued from page 1)

included a number of conditions which alternately allow and prohibit pursuit of the patient. Failure to adhere to those regulations will result in both violation of the statute and a lost opportunity to pursue payment.

First, balance billing prohibitions do not take effect unless the provider is notified that the admission is due toto a job-related injury If the provider is notified of a work injury and of the identity of the employer, the patient may not be billed. A claim should be sent to the employer. Within 60 days the employer (or their insurer) should tender payment of a clean claim, unless they disput liability., Employers failing to pay within 60 days become subject to an interest penalty after 60 days of 1% per month.

While the claim is pending, the provider may and should mail the patient reminders that the bill is outstanding. The statement should indicate that payment is not due. Most importantly, the statement should include a request for status of the claim. If the patient fails to provide a status update within 90 days, the provider can resume billing the patient for full charges. The statement requesting status should include a warning of personal liability for failure to respond.

The provider may also pursue a patient who, after having received an award, fails to tender payment to the provider. Unfortunately, despite many amendments to the Act, there is no mechanism to file a lien nor secure payment directly from the payor. A patient who receives direct payment is liable for the payment (at either the lesser of the fee schedule or actual charges) plus the 1% per month interest. If the patient loses the workers' compensation claim, then the provider may bill the patient for full charges.

Finally, please note that if an employer denies liability and the provider does not receive information that a disputed claim has been filed, then the patient can be billed. There is a provision mandating resolution of disputed claims within 180 days. During the time a dispute is pending, the statute of limitations for pursuing the patient is tolled, or paused.

Utilization Review

With the intent of helping Illinois business owners contain costs, the bill contains a provision for utilization review of proposed or provided medical services. All utilization review programs must register with the state and comply with Utilization Review Accreditation Commission (URAC) standards. Determinations regarding medical necessity are limited to health care professionals.

It is important to note that a denial by a URAC program will be accepted as correct by the industrial commission. Providers must be on guard for adverse URAC reviews and be prepared to contest unfavorable determinations.

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Does Your Hospital Need A Check-Up? (continued from page 12)

needed to maximize asset performance with minimal interruption to revenue-generating medical services. Consult with a professional contracting engineer to find out more.

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Non-Acute Facility Ownership – If Not You, Who?

BY J MICHAEL DAVIS

Third Party Development Makes Sense

Hospitals and health care systems have embraced third party ownership and management of existing medical office buildings (MOBs). Third party developers willing to *build* and own new projects are now being called upon by hospitals and integrated systems. Far less public attention is paid to *new* third-party development than to the selling of existing real estate assets like MOBs. Yet third-party development is likely to have a more profound impact on capital and operational decisions for hospitals and health systems.

Increased institutional demand for medical real estate has made third-party ownership very competitive relative to the direct cost of capital many hospitals face. MOB developers may employ capital structures that take advantage of relatively attractive financial leverage. They can also capture tax benefits associated with real estate investments in ways that tax-exempt hospitals cannot. Such lease arrangements provide a viable alternative to a hospital's traditional cash or debt alternatives.

These changes have allowed hospitals to move away from a balance sheet approach. CFOs are asking how they can capture the financial benefits of using someone else's money to create value for their own economic or mission-driven purposes.

Financing considerations are not the only benefits to this approach. Properly structured, newly-built MOBs developed and owned by investors result in market-competitive rents to physicians. They also eliminate many of the relationship conflicts and legal exposure inherent when hospitals serve as landlord to physician tenants.

Managing the Developer Selection Process

The economics and market capabilities around financing and developing real estate is something hospitals face relatively infrequently. Even a hospital which develops projects itself may not have a thorough grasp of the factors that differentiate developers in the medical real estate market. In brief these factors are:

- Experience
- Capital Sources
- Geographic Focus
- Investment Strategy/Time Horizon
- Type of Projects

Imagine yourself a hospital or system seeking a developer/owner for a new MOB. Without a doubt, your quest should start with a competitive and transparent request-for-proposal process to solicit input from a broad group of qualified developers. Evaluate those proposals against structured criteria and a comprehensive approach that explores both developer qualifications and project parameters. This allows a complete look at several options and the information needed to select the best alternative within your circumstances. While it is relatively easy to identify what issues would differentiate one proposal from another, the art is in effectively quantifying and evaluating the relative strengths and weaknesses of each proposal and each developer.

The process typically involves a balance among: obtaining the best possible facility at a competitive cost; an acceptable return for the developer; lease rates that will work for expected tenants; overall risk of the transaction; and suitable control provisions for the hospital.

Project Cost

Cost is obviously critical. Lease rates need to be low enough to fill the building with targeted tenants, and high enough to generate the required return.

To start, pose two questions: What are the design criteria for the building? What will it take to build? Break the costs into line items that can be readily compared. Although specifics will depend on particular circumstances, the line items of a typical development budget will include:

Soft Costs

Development Fees
Construction Interest
Fitup Design Allowance
Building Shell Design
Leasing Fees
Other Fees
Contingencies and Miscellaneous

Hard Costs

Site Development
Building Shell
Tenant Build-out Allowances

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Non-Acute Facility Ownership (continued from page 14)

A skilled developer can offer value-engineering expertise. This is especially important when the design as originally costed, would require lease rates higher than the market would support. It's usually worth consulting such specialists for design modification suggestions that woul d lower costs but wouldn't compromise the function or quality of the building nor of tenant operations.

Cost of capital

The best developer is the one who can not only deliver the project at the right cost, but also has a low cost of capital. To asses this aspect, a Request for Proposal should ask for planned lease rates, the project's estimated cost and the developer's expected return. As the project scope is refined and project costs change, locking in the developer's return with clarity up front is another key to successfully managing the developer selection and implementation process.

It is often important to understand the issues underlying cost of capital expectations among developers. Expectations by the firm's equity investors, leverage strategies employed, overall approaches to the development, and other factors can influence the cost of debt and equity that lead to a developer's overall cost of capital. Understanding what drives those differences may identify important risk characteristics that you will want to consider in the selection process.

Risk profile

Developers seek compensation for the risk they believe they are taking. Developers who understand that medical property construction & ownership, properly managed, can produce stable, long-term returns, are likely to accept a lower cost of capital.

A developer's risk management often involves requiring that a certain threshold percentage of space be pre-leased before breaking ground. By comparing both pre-lease and lease term requirements among proposals, you can identify a developer's risk tolerance. Developers striving to minimize ownership risk generally focus on assuring a stable long-term cash flow in which case lease terms of ten years or longer and pre-lease commitments ranging from 60% to 75 % would not be unusual.

Meeting Operational Objectives

Hospitals historically have been reluctant to forfeit direct ownership of non-acute facilities. Their concern is loss of control over factors necessary for effective patient care. Deal structures have changed - increased market competition has meant that, investors have become sophisticated and the issue of hospital controls is less of a concern. By retaining ownership of the ground underneath the project buildings and by negotiating control provisions in the ground lease, hospitals now routinely achieve many of the control objectives they identify as vital. Hospitals can find a developer who will be flexible in negotiating control provisions.

Conclusion

As medical real estate moves from a niche to a dynamic mainstream market, providers have an attractive alternative to hospital-owned and hospital-financed outpatient facilities and medical office buildings. Options for new development and ownership have expanded greatly in the past few years and are likely to continue to evolve.. New sources of institutional capital have led to a competitive market for capital partners in medical real estate. With a selection process that is itself competitive, hospitals can identify developer/owners that will meet financial and operational needs.

J. Michael Davis is a First Illinois HFMA member and can be reached at mdavis@cainbrothers.com

The Pendulum has Swung

BY CARL PELLETTIERI

Responding to a three-year litigation onslaught, hospitals are making drastic shifts in charity policies and in some cases nearly abandoning traditional collection efforts. For years, hospitals offered charity care — as a well-kept secret. Recently, however, hospitals have re-examined and often reversed previous practices.

Today all patients are enthusiastically notified of charity policies through signage, brochures and the like. Eligibility criteria are more liberal now, sometimes up to 400% of the national poverty level. Simplified procedures make it easier to get approved as a charity care patient. Many organizations simply qualify all uninsured patients for some discount, without filing out any forms or producing any documents for review Much of the public is saying that it's about time.

Among provider finance professionals however, many should ask whether now is time for the pendulum to swing back. As things are now, fear has caused some hospitals to pull back so far that they are leaving quite a lot of money on the table.

Hospitals Ask: Why Me?

Healthcare providers delivered 41 billion dollars in uncompensated care to 46 million uninsured Americans in 2004. Meanwhile, federal outlays for hospitals, clinics, and health centers increased only slightly more than 1% after adjusting for inflation.

Is it fair to ask the insurance industry what their role should be in helping to solve this problem? So far, neither attorneys nor consumer groups have targeted insurance companies in the way they've pounded hospitals Expanding the role of private payers in funding care to underinsured and/or uninsured would lessen the current financial burden on hospitals.

Can you pay? Will you pay?

May a hospital view indigent patients differently from those who can afford to pay but simply do not? The CDHP trend has shifted a large percent of provider revenue from managed care to self-pay. Patients often trade lower premiums for lower benefits and end up with sometimes unfathomably high co-payments and deductibles. Many patients refuse to provide financial information; sometimes simply out of pride and an unwillingness to accept charity. Some refuse to disclose in hopes of taking advantage of charity care policies that discount without verification. Not pursuing patients who can afford to pay but refuse to do so, is unfair to those that do pay. Communities should understand that and support providers' rights to collect from those who can pay.

Self-pay Collections: Options and Consequences

The risk of being perceived as, or of actually engaging in, collection activities that are discriminatory, brutal and inhumane, aggressive or price gouging of uninsured patients has hospitals closely analyzing their internal and external collection activities. Although collections is clearly outside a hospital's core business, many are expanding their internal resources to deal with patient self-pay balances because they fear that loss of control could lead to legal and PR headaches.

Point of service collections are becoming more common in hospitals. It's challenging and expensive to determine in what category a patient belongs. Software tools used at the point of access help verify patient demographics and their ability to pay. The credit reporting industry allows healthcare providers to do a "soft hit" into consumer information and that can help determine a patient's ability to pay. Charity care and Medicaid eligibility forms can be populated and printed during the registration process. Taking the indigent population out of the collection cycle as soon as possible makes sense for everyone,

The business of collections, however, is very sophisticated, and requires substantial investment in time, expertise, technology and training. Outsourcing those functions is often a valid choice. The main thing is to continually guard against any disconnect between the hospital CFO and their collection agencies and attorneys in regards to methods and policies, especially in the use of liens and lawsuits.

Risk Reward Proposition: Is it enough to matter?

The determination of which collection tools and services to use should include a broadly-defined cost benefit analysis. Is the amount of money at stake worth the public perception and general outcry a hospital risks by asking the uninsured or underinsured for payment? Fair or not, perception is everything. Litigation, legislation and negative publicity, whether actual or threatened, has caused the industry to nearly abandon traditional collection efforts. Meanwhile, charity care grows and bad debt recoveries fall. On the other hand, no court decisions have ruled that any hospital pricing or charity care policies violate any state or federal laws. It may be time for the pendulum to start to swing back.

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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.

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Publication Scheduling

Publication Date	Articles Received by
April 2006	March 10, 2006

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Vein Clinics of America, Inc.

Michel Agriopoulos
Medsynergies, Inc.

Janis Ellen Anfossi
Rush University Medical Center

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A Newsletter from HFMA's First Illinois Chapter

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2006 Calendar

March 16, 2006

Managed Care, Full Day, William Tell Inn, Countryside

May 5, 2006

CFO Meeting and Golf Outing, Full Day, Calumet Country Club

May 26, 2006

Annual Golf Outing, Full Day, St. Andrews & Klein Creek

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