First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
January 2012

Believe to Achieve

Highlights and Recap First Illinois Chapter Events begins on page 17

Captured Events & Updates

In This Issue

Health Care Connectivity: Will it be taken for granted as ATM connectivity is today?

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

It is hard to believe that another year has passed and that 2012 is upon us. Like many years past, 2011 didn't fall short in regards to industry change and additional pressures on the health care system. As we begin the New Year, we find ourselves facing more challenges, including rising health care costs that already account for almost 18 percent of the U.S. gross domestic product (GDP). Americans spent $2.5 trillion on health care in 2009 (latest data available) — more than $8,000 per person. Health spending grew by 4 percent in 2009, a reasonably average increase until you consider that the U.S. GDP shrank that year by 2.6 percent.

Health care spending in the U.S. is outpacing our overall economic growth. At a time when budgets are already tight, this inequity is forcing consumers to allocate more of their money toward health care costs, resulting in less money for other priorities and some tough choices. However, some economists believe that rising health care costs are representative of increased access to care and new, more expensive treatments and technologies. And as health care costs grow, so will employment in the health care sector. Here in the Chicago region, hospitals employ more than 407,000 people directly and indirectly, generating a payroll of almost $43 billion annually. During the economic recession, health care has consistently been one of the lone job-creating sectors.

As leaders in health care finance, we have an opportunity to influence an industry that cares for people when they are most in need and is also a significant economic engine. As leaders, we have an opportunity (and some would say an obligation) to lead change, not resist it. The changes we implement will have a significant impact on the cost and accessibility of health care in our market. We are in the midst of a significant transformation of the delivery system that will require us to deliver more with less. It is disruptive, especially in this market, where we are experiencing a shift from a stand-alone-dominated market to a system-dominated market. There are more physicians aligned with and employed by hospitals today than ever before and the consumer is becoming more engaged in their health care decisions. The industry is expected to increase quality and reduce cost at a time when our aging baby boomer population is expected to flood the delivery system. Additionally, and as a result of health care reform, we will likely experience a surge in demand from a segment of the population

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Health Care Connectivity: Will it be taken for granted as ATM connectivity is today?

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who will be newly insured and seeking care that they had previously foregone.

How are we going to move forward? I recently met with an area hospital's executive team and we had an engaging dialogue about health care connectivity. When we think about health care reform's implications we can identify those that are being resisted, those that impact reimbursement and others that are moving the industry forward. I see connectivity in the latter category. Health care connectivity is moving fast and I believe it will be taken for granted in a short time frame, as ATMs are in the banking industry today. Consumers will demand connectivity and in non-emergency situations will choose to seek services from those who are connected.

Health care connectivity is physical, technical, and strategic and has the consumer in mind. A physical example could be viewed as the systems being formed to offer consumers a broader, clinically-integrated network providing continuum of care. Technical connectivity could be the investments being made in electronic health records (EHR) and networking of these EHRs across the continuum via health information exchange (HIE) and these exchanges networking between providers throughout the, state and nation. Strategic will be how we use the physical and technical connectivity to impact how we do business and deliver world class care. It will impact how payment models are agreed upon, how consumers are engaged, how care and prevention are delivered, and most importantly, it will drive operational innovation in ways that we can't even imagine today.

I am fortunate in my role to interact with so many great leaders in this market and to hear firsthand about the inventive changes being implemented, the strategic directions and visions being executed and the investments being made in clinical integration and connectivity. Our push for all-encompassing connectivity is nothing short of impressive. As we begin 2012, take a moment to recognize the momentous innovations we have applied and the impact they will have on health care in our region. The work we are doing to achieve connectivity in order to improve care and reduce health care costs is vital to our communities and the future of health care in our country.

Dan Yunker
VP & CFO, Metropolitan Chicago Healthcare Council

Editor's Letter

Dear First Illinois Chapter Members:

Happy New Year!

I hope everyone enjoyed the holidays and had a chance to step back and spend some quality time with family and friends. For me, this was the first time that my wife and I had the opportunity to "host" my family for the holidays; we had a number of relatives from both the east and west coast spend the week with us – good times!

Speaking of family, I hope you had the opportunity take advantage of your HFMA "family" last year by participating in networking and educational opportunities – both at the local and national level; and, I hope you take advantage of the opportunities "on tap" this year. Please see the upcoming events listed in the newsletter or at our chapter website.

I would like to welcome Andrew Digate – extended "family" from the local Illinois MGMA chapter; in collaboration with the IL MGMA chapter, Andrew will be providing a quarterly legislative update. In times like this, networking within and between organizations is a great way to help each other navigate the "complexities" of the current environment, and the rapid pace of change.

And, unfortunately, this new "pace" will be the norm for the next several years. I don't think we will be given too many opportunities to catch our breath; case in point, everyone raced to the finish line in 2011 to "attest" for Meaningful Use, and for those that did, now they must meet MU for the next 365 days! Sometimes it's a sprint, sometimes it's a marathon, and, most of the time, it will feel like an Ironman – the analogy only works if we see a finish line, though.

Stay warm.

Sincerely,

Tim Manning, Co-Chair together with
Jim Watson, Co-Chair/Editor

Legislation Connection

BY ANDREW DIGATE, HEALTHCARE CONSULTANT, PBC INC.

First Illinois HFMA Chapter welcomes a new columnist to *First Illinois Speaks*. Andrew Digate serves as Chair: Legislative Affairs for the Illinois chapter of the Medical Group Management Association (MGMA) and will be updating First Illinois members with his legislative column. He has served in his present role with the ILMGMA since 2010 and has volunteered extensively in the past in local, state, and national political campaigns. Andrew is a Healthcare Consultant at Professional Business Consultants (PBC, Inc.) and can be reached at 630-928-5228 or andrew_digate@pbcgroup.com. He welcomes your questions or comments about any legislative matters.

Who Has the Answers in DC?

The most pressing issue in Washington is SGR and the impending 29.5% Medicare cut. Republicans and Democrats are feeling the heat from constituents and special interest groups to stop the pending cuts. Most everyone agrees that the cuts will be stalled as a result. The questions to which no one has any answers right now are: (A) For how long will the cuts be stalled? (B) If there are no cuts now, how will it be paid. This is also known as, "What's the cost for kicking the can down the road?" and (C) If there are cuts, will it be say 20% instead of 29.5%? We can hear elected officials say, "Gee, we saved you 10%!"

We are seeing policymakers increasingly turn to one group for answers. The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. MedPac's recommendations in the past were given consideration within all of the rhetoric of Washington, but not anymore in the age of healthcare reform. A chief of staff from one congressman's office told us, "Everyone agrees that we need to depoliticize Medicare decisions. No one here is an expert in the provision of healthcare so it should be left to experts. More and more people will rely on MedPac for recommendations."

One area that is getting significant overview from MedPac is hospital acquisition of private practices. The basis of their concern centers on what they say is a "shifting of patients to sites of care where Medicare pays higher rates." As one MedPac Commissioner put it, "Since hospitals are reimbursed at an overall higher rate than a private practice, a hospital acquires a practice and starts billing for the services as if the practice is an outpatient department…it's possible that care does not change at all, but Medicare prices could increase substantially."

MedPac has discussed the leveling of Medicare payments, regardless of site of service, as a means to pay for the continued Medicare shortfalls. This was echoed by RUSH COO and MedPac Commissioner Peter Butler who was a speaker on a webinar sponsored by ILMGMA. A recent proposal to stop the January cuts from House Speaker John Boehner had similar language as a means to pay for the delay of the cuts. This is an area that will not see decreased discussion and debate. Stay tuned for more information but in the meantime, members need to consider the ramifications if such a decision takes place.

Who is In/Who is Out?

Last year, the Governor passed a new law that dealt with out of network providers who treat at in-network hospitals. HB 5085 would amend the insurance code for out of network physicians who provide services at an in-network hospital or ASC. The bill would allow insurers to pay the physicians at an out of network rate marginally higher than the in-network amount, prohibit balance billing the patient and require the physician to initiate arbitration to collect fair payment from the insurer.

While this may be a "non issue" for some, it may have an impact for some hospital based physician groups, which were defined in the law as Anesthesiology, Emergency Medicine, Neonatology, Pathology and Radiology. If providers decide to arbitrate, they need to have a coordinated effort with their hospital and billing department or outside billing partner if used.

Legislators in Springfield told us that they would get calls all the time from constituents who had these "astronomical" bills from a provider who they thought was in-network. These constituents got a sympathetic ear from many legislators who personally "felt their pain." Lobbying efforts against the legislation from impacted organizations and its members like ILMGMA, ISMS, and the Illinois Society of Anesthesiologists fell on deaf ears.

There is a painful learning lesson from this new law. The business of healthcare is complex and difficult to explain in the era of sound bites and tweets. When dealing with a legislator, always speak in terms they understand, even presenting the position within the context of another industry.

Accountable Care Organization Model:
The Mystery of the Missing Business Case

BY C. RICHARD PANICO, FOUNDER, PRESIDENT AND CEO OF INTEGRATED PROJECT MANAGEMENT COMPANY, INC.

The jury is still out. There is still a significant amount of controversy pertaining to the Accountable Care Organization (ACO) model and whether it will be the "cure" for a multitude of issues concerning healthcare. While the intentions driving the movement to ACOs are good, there are still many questions as to whether the model is the right one, and for good reasons. There is a limited amount of credible data to support the financial viability of the model. A recent study by *The New England Journal of Medicine* noted, "The limited data suggests that most organizations will lose money in the first three years under the ACO model." However, a closer look will indicate that this payback period assumes implementation costs of approximately $740k, which one can easily debate is at the overly optimistic end of the implementation cost spectrum (see graph below). [1] A closer review of the graph reveals that the payback assumes an aggressive and probably unrealistic margin.

Most of the information available in the form of case studies I have reviewed pale in comparison to case studies developed in other industries to justify a major change in a business model. For one thing, while case studies seem to focus on the cost, effort, and time required to transform an organization(s) to an ACO, there is an obvious omission of financial justification for the investment, not to mention the direct financial impact to those who are essential to its success, that is, the doctors and other clinical personnel. These case studies are loaded with assumptions that may or may not be valid, and proof of the ultimate financial viability of ACOs seems to continually elude many who are trying to understand whether the model is financially sustainable. It is rather remarkable that the approach to determining whether ACOs are the best, a good, or inadequate alternative to addressing our healthcare challenges is so much different than is the approach applied across most other industries. The supposed goals of the ACO model include increasing quality and efficiency, increasing accountability, improving patient outcomes, satisfaction and overall health, and paying for performance. In business terms, the base goal is to optimize healthcare providers' performance, thereby improving the benefits to patients while simultaneously lowering costs and generating a profit. Any model that does not generate sufficient revenue to cover costs, reward those who are critical to delivering service, and reinvest in continually improving services will not be sustainable. These organizations will be forced to compromise service delivery, which usually translates to reduced capabilities and capacity, and quality erosion. This has been proven continually in other industries. Notwithstanding, there are plenty of profitable models within healthcare that support the correlation and direct relationship between strong profitability, quality outcomes, and high patient satisfaction. It

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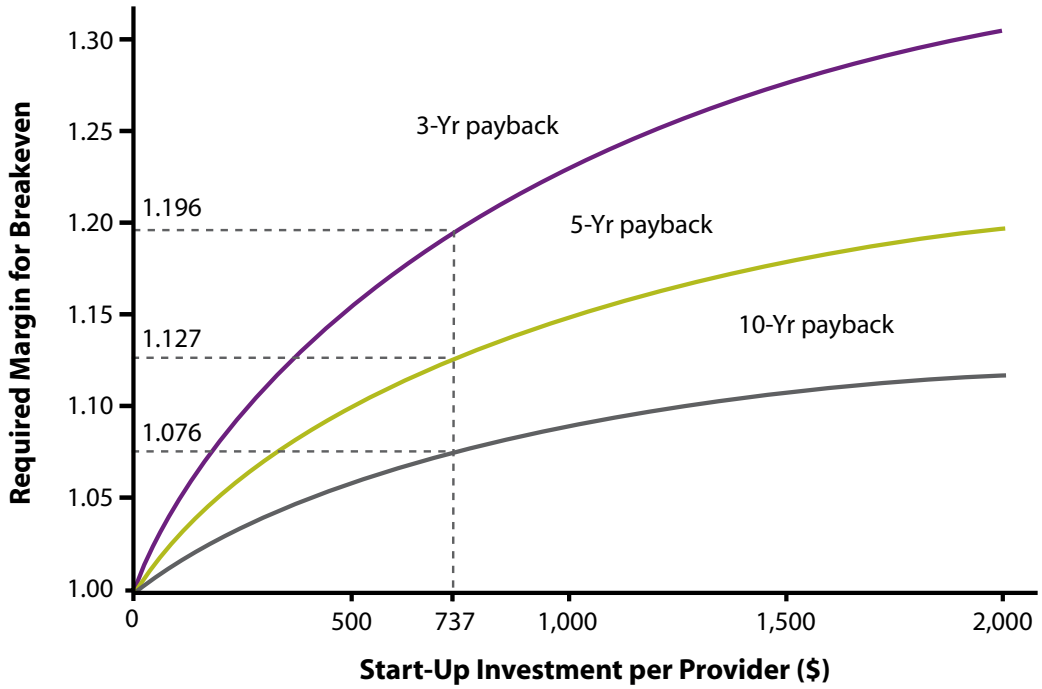

Required Operating Margin Needed for an ACO to Recover the Start-Up Investment.

is hard to fathom why the healthcare industry has not fully exploited the opportunity to develop scenarios and corresponding simulations that measure the true business justification and long-term business viability of ACOs. Any business analysis begins with clearly defining the objectives the enterprise is trying to achieve. Healthcare's goal is to provide high quality, regulatory compliant and reasonably priced patient care in a highly efficient manner that results in a positive profit margin (after competitively compensating those stakeholders who are critical in delivering the service).

The current challenges facing healthcare are unprecedented, and so are the opportunities. Savvy business people will take this opportunity to create and analyze scenarios to achieve the objectives stated above. You can be assured that profitability motives will generate models that are unencumbered by debilitating mindsets and paradigms that reject or struggle with the concept that high quality care, reasonable cost, highly regulated, and profitable are realistic and achievable. The ACO model, or whatever variations thereof best address the healthcare challenges and opportunities of the future will be, first and foremost, innovative business models that are profitable and driven by competition to continually improve and remain profitable.

[1] "The ACO Model – A Three Year Financial Loss?", Haywood, Trent T., M.D., J.D., and Kosel, Keith C., Ph.D., M.B.A., M.H.S.A, The New England Journal of Medicine, April 7, 2011

About the Author

C. Richard Panico, is the founder, president, and CEO of Integrated Project Management Company, Inc. (IPM) which is a project management consulting firm specializing in the healthcare, life sciences, ag-science and nutrition, consumer goods, and industrial products sectors. Through disciplined on-site leadership, IPM completes complex projects in often highly regulated industries. Since 1988, IPM has served over 250 clients across 3,500 projects, delivering measurable results. The company has regional offices in Chicago, San Francisco, St. Louis and Boston. For further information, visit www.ipmcinc.com or call 630-789-8600

Capturing Every Dollar: Tips for Overcoming Denial

BY CAITLIN ZULLA, VICE PRESIDENT OF MANAGED CARE SERVICES, MEDASSETS REVENUE CYCLE DIVISION

In the current healthcare environment, hospitals need to capture every dollar from their payers, and as quickly as possible.

The retrospective war against denials is often a losing proposition for hospitals because the burden of proof is on the provider, and once the payer finally agrees to pay what they should have in the first place, cash collection is often significantly delayed. As a result, providers must become more aggressive in preventing and reducing denials moving forward, and rely less on retrospective appeals.

Denials can be separated into two categories, administrative and clinical, and the best way to handle them is through proactive measures. Below are key tips for providers to win the battle on denials.

Overhaul patient access processes. Technical or administrative denials are difficult and cumbersome to handle. The good news is that providers can put a process in place to prevent them from occurring at all. This entails identifying weaknesses in the system, fine-tuning processes – or overhauling them if necessary – and ensuring that patient access staff understand and play their important role in the organization's financial success.

Hospitals should focus on obtaining all authorizations and referrals up front in order to avoid issues later. Patient access staff should be educated about required authorizations and how to make sure obtained authorizations match the services physicians are providing. If there are additional services to consider or if the authorization is significantly different from the service performed, there should be a process in place that allows staff to go back and obtain the necessary approval before or immediately after the procedure.

Evaluate and revamp patient satisfaction policies. Hospitals need to consider the financial consequences of their actions, particularly in the area of patient satisfaction. In many cases, providers avoid patient dissatisfaction at all costs. As a result, they often accept patients that come into their facility with the wrong authorization in order to avoid losing that patient to another provider or extend patient wait time as the correct authorization is obtained.

Although patient satisfaction is extremely important, the financial risks of this type of narrow policy can far outweigh the benefits as it often results in the accumulation of outpatient denials. Providers need to take a hard look at how much money they are losing due to technical denials and then work strategically to come up with processes that save money and do not drastically reduce patient satisfaction.

Focus on physician education and compliance. Clinical denials are based around proof that the patient is sick and if the care given is medically necessary. At the end of the day, battling clinical denials comes down to physician compliance Physicians must move the patient through the most efficient process of care, use the correct

location of care and, most importantly, carefully document all of these details. It must be made very clear to the utilization management or UM agents (on both the provider and payment sides) exactly how sick the patient is.

Many physicians are not aware of how significantly clinical denials can affect a hospital's revenue stream, underscoring the need for education on this topic. Providers should share the denial rate and net dollar impact with physicians to get their buy-in and then spend time educating them on the importance of documentation and compliance.

Think beyond recapturing revenue. Perhaps more important than recovering lost revenue from existing denials is determining the root cause of the problem and changing processes to prevent and reduce further denial volume. Hospitals can identify holes in processes and pinpoint delays among revenue cycle staff through business intelligence data and act accordingly.

The right business intelligence solutions allow one to obtain reports of denial activity by payer, physician, diagnosis-related group (DRG) or CPT code and registrar to assist with denial prevention. For example, by arming oneself with a list of administrative denials by outpatient service area, one can more easily understand which registrars and physicians are struggling with authorization requirements and focus on mentoring those individuals.

About the Author

Caitlin Zulla is vice president of managed care services for MedAssets' Revenue Cycle Services division. She is responsible for overseeing the operations of the silent PPO, underpayment, retrospective appeal and lost charge recovery services. She also worked as a decision support analyst in the managed care office of the Atlantic Health System.

Interview with the C-Suite: Pam Williams, CEO Adventist Midwest Management Services and Adventist Health Partners

BY TIM MANNING

Questions:

Please give us a little background on your organization and the role you play.

AMMS (Adventist Midwest Management Services) was created in 1993. Our goal at that time was to create a management organization to allow for employment of primary care physicians in a time when capitation was expected to overtake healthcare, and the only defense was to hire primary care physicians. I started at GlenOaks Hospital while a similar organization existed at Hinsdale, the only two hospitals in our system at that time. We justified purchasing a billing system, +Medic (later Mysis) by gaining agreement from the hospital based physicians to use our billing services – radiology, pathology, anesthesiology and emergency physicians.

My role and title has changed throughout the years, but, in the beginning, I was the initial administrative person asked to create the management company. After a few years our organization was asked to move to Hinsdale to provide these services for both GlenOaks and Hinsdale, then later La Grange, when that hospital was purchased in 1998. I became CEO of AMMS in 2001. I also later spearheaded the creation of Adventist Health Network, one of the early and few clinically integrated PHOs in the Chicago area, for the benefit of the general medical staff. I have been executive director of that organization through now.

Where do you see health care reform taking us?

The changes today seem both necessary and unavoidable. A focus on quality, communication between providers and a reduction in duplicative and unnecessary care is hard to argue with. Never before has there been this level of transparency within healthcare. I still remember when physicians viewed their paper charts as their property – rather than the patient's, and rather than a document that was open to all care providers for the good of the patient. To have a contiguous record, accessible to all providers in every part of the care continuum, is critical to excellent care.

I don't know that I believe bundled payments will be a common reality any time soon, but I know that access to quality and other data on physicians and hospitals is here to stay, and the need for broad access to patient records is the foundation for great care.

The incentives at every level of healthcare can be perverse – payment for doing more, not for doing what's necessarily "right." The focus on the patient centered medical home has great potential; providing coordinated care that focuses on the relationship between the patient and the PCP can work if well orchestrated.

What do you think organizations need to do to be successful moving forward under the new "reform"?

Data is key. Incomplete, inaccurate data sometimes has been used to justify actions – erroneously. How the data is collected, the ability to compare and contrast, and the ability to report is very limited in most settings. Only "clean" data can tell us what is going on within a hospital, physician's office, or healthcare system. We need to be completely transparent with physicians and ourselves in order to understand how we need to improve. Many are fearful of this transparency, but only through transparent comparisons can we know where we need to focus, where the issues are, who the outliers are. Data that is not aggregated and analyzed properly can be misleading; data that is good can lead to a wealth of opportunity for improvement in systems.

The other significant need is healthcare leadership that is not "hospital centric." Individuals with the orientation to manage the entire continuum of care and to work well with physicians are needed. Only by working in an aligned way can we continue to improve care.

As a CEO within a health system, what would you say are the major barriers to improving patient care?

Management of the complete continuum of care. Too often, each element is in its silo, sending patients off to the next one with little coordination or recognition of the complexity that patients and their family's face. Again, leadership with a focus on the entire care continuum and assistance for patients and families to navigate the care continuum properly is key. And, improving the sense of urgency amongst health care providers

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Interview with the C-Suite... (continued from page 8)

to do the right thing, as absolutely quickly as possible, for every patient, every time – very important. We need to put a face behind every "error," recognize how we would want to be treated and have our own families treated, and saturate everything we do with that recognition and level of awareness.

There have been a lot of mergers, acquisitions and consolidation in the healthcare market; in particular, there has been a "flurry" of activity in the Chicago market, including the suburbs. What impact is this having on your organization and how has this impacted your overall strategy for growth?

Pam Williams
CEO Adventist Midwest Management Services and Adventist Health Partners

It is imperative that we participate in thoughtful alignment with quality physicians and facilities. It is not the time to look at quantity over quality – aggregating physicians just for the sake of "more" will fail. It needs to be the right physicians with the right motivations and the right qualities. We need to continue to focus on the kind of physicians we would be willing to seek for our care. I take the "mom" test very seriously: Who would I trust with her care? It is easy to lose sight of this. Our strategy is to grow and expand, but only with physicians who pass that test.

The View from Healthcare's Front Lines:
An Oliver Wyman CEO Survey

BY TOM MAIN AND RICK WEIL

After decades of false alarms, healthcare providers are agreed: Their industry is about to go through transformative change. Why is this time different? We met with 40 top leaders of healthcare organizations to find out how they planned to respond. Here is what they had to say.

In principle, health system and physician executives know what they need to do over the next decade or so. The Patient Protection and Affordable Care Act (PPACA) contains a fairly clear itinerary: Depart without delay from the familiar territory of fee-for-service and travel to the as yet undefined new world of value-based care—a world in which care delivery companies will compete on value, producing better outcomes more cost effectively year after year, and once and for all taming medical trend. The stakes have never been bigger. The private healthcare system itself hangs in the balance.

An itinerary is not a roadmap, though. At this stage, value-based care is still mostly hypothetical. The rules are not yet written; only a handful of market participants have practical experience with value-based models; and there are few examples to learn from. And the change required is transformational. Under the fee-for-service model, every patient touch produces revenue; under fee-for-value, every touch generates costs. The basic economic unit will shift from visits or days to episodes or diseases, while improved margin performance will be a matter of effectively managing the cost of care while producing exceptional outcomes. New leadership, competencies, culture, and systems will be essential.

To find out how leading organizations are preparing for fee-for-value, Oliver Wyman conducted in-depth interviews with 40 healthcare executives. It should come as no surprise their local market strategies were as varied as the participants themselves, but we also heard strong shared themes that transcend geographies and organizational types. In this paper, we summarize four of these themes, as well as Oliver Wyman's perspectives on the key unresolved issues.

#1 This one is for real

The most striking feature of our interviews was that executives are now virtually unanimous in believing that the system is on the verge of a shift from a volume-based to a value-based model over the next decade. This is hardly the first time that healthcare executives have heard the rumblings of imminent revolution. From the boom and gradual demise of HMOs to the rise and fall of provider risk sharing arrangements in the early 90s, new ideas have come and gone, with limited impact on how healthcare is actually delivered—and making no more than a tiny dent in medical trend. "Usually chatter fails to transpire into real change," we were told by Tom Priselac, president and CEO of the Cedars Sinai Health System in Los Angeles. "But this time it's different." Our interview subjects cited several reasons:

- The **current transactional fee-for-service model** for healthcare is a low-value formula that produces high costs with highly variable

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outcomes—and is gradually bankrupting America. Art Nichols, CEO of Cheshire Medical Center–Dartmouth Hitchcock Clinic, agrees: "I truly believe that fee-for-service is unsustainable," he says. "We're seeing it in the erosion of health insurance. And doctors are on such a treadmill."

- **Medicare and Medicaid funding shortfalls** will inevitably lead to regulated price controls under PPACA. "The healthcare reform bill is a disaster," says the CEO of one of the largest group practices in the country. "The bill has no regard for funding sources. It dumps people into Medicaid and state budgets that are already constrained." The worst cuts are still several years off, but hospitals are already feeling the pinch.

- The **slow-growth, high-unemployment economy** makes a bad situation worse—driving down the tax base, weakening labor markets, increasing the uninsured population, and cutting into families' discretionary income.

Without a strong labor market and a bigger tax base, there is no silver bullet for healthcare; the industry must either transform the system from fee-for-service to fee-for-value or prepare for price controls and rationing.

#2 Up or down, the same or different?

The market is not just stressed, but increasingly hard to predict. "Take the question of capacity," says Warren Green, president and CEO of LifeBridge Health, a regional healthcare organization based in Baltimore. "One model shows a surge in admissions based on an aging population. Another model shows reduced need based on accountable care organizations [ACOs]. Nobody knows if we will need more beds or less."

On the one hand, the signs all indicate that volume will rise. The population is aging, and average health status is declining. The government is about to spend $900 billion over ten years to bring the previously uninsured into the market. New medical technology is abundant. That all sounds like good news for the industry. On the other hand, margins seem poised to plunge. Funding sources across the board are approaching insolvency and can no longer support rate increases that outpace the growth of the economy. Until recently, the U.S. government was able to tap into public debt markets to fund its growing healthcare liabilities. No more. As a result, Medicare and Medicaid are trying to balance their budgets by ratcheting down reimbursements. Commercial payers, already following their lead, will step up the pace as they are hit by PPACA's restrictions on medical loss ratios. Thus, even though Congress has delayed the 24.9 percent Medicare reimbursement cut scheduled for January 2011, providers will still feel the squeeze.

#3 My ocean liner has to become a what and by when?

Almost all the physician and health system leaders we interviewed saw substantial opportunities in the health system to eliminate excess spending while improving overall value. But the key to seizing these opportunities is new care models that integrate care across the care continuum, and our interview participants were unclear on what care models should look like, how to deploy them without eroding the fee-for-service cash engine, and where their organizations stand on value today. "If you asked me to draw a value-based cardio model, I couldn't," confessed Ed Brown, CEO of the Iowa Clinic. "I really don't know where I'm currently at from a value standpoint, and I really don't know all of our total costs that well."

Many executives believe physician integration and leadership will be essential. As Jim Skogsbergh, president and CEO of Advocate Health Care, Illinois' largest healthcare system, told us, "We are betting the farm on physician integration." And most CEOs we interviewed estimated hospital-based physician employment will increase from 10 percent today to more than 50 percent by 2015.

Hospital-centric integrated models are likely to compete directly with large multi-specialist practices that contract for hospital services. A number of large multispecialty groups we talked to have already realized they can preempt the hospitals. "If [physicians] organize together, we can turn the hospital into a cost center," the head of one of these practices told us.

Hospital executives know this all too well based on their own experiences. We have talked with CEOs who worry that they could destroy their organizations if they move to a more effective care model too rapidly. One described the launch of an integrated care model so successful that it cost the hospital thousands of admissions in the course of a year—without a reimbursement scheme that would have allowed

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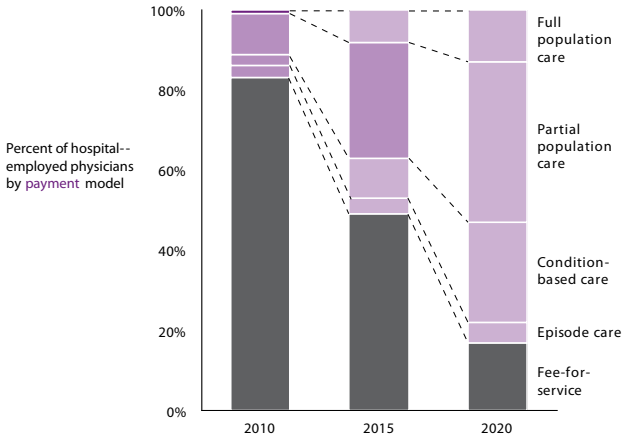
it to share in the savings it produced for payers. He posed the trillion-dollar question: "How do we transform ourselves with the right tempo to not cannibalize our business and to keep up with the curve?"

Based on our interviews, the healthcare system forecast is clear and cloudy—clear on the need for change and the shift to fee-for-value (see The Migration to Fee-for-Value, below) and cloudy on the pathway, the pace, and the design of new care models. Ed Brown captures the cloudy part of the forecast well: "People are unclear about what the value-based world looks like, and they're unsettled on what clinical integration really means. And nobody has really made it work." In the meantime the ocean liner has to stay on course.

The Migration to Fee-for-Value

Today, more than 80 percent of hospital-employed physicians work under the fee-for-service model. Oliver Wyman estimates that by 2020 that figure will be less than 20 percent, with the bulk of physicians working under a variety of fee-for-value models.



Sources: AHD Acute Data; SK&A, NEJM; RWJ Foundation; HIMMS; Commonwealth Fund; Oliver Wyman Analysis

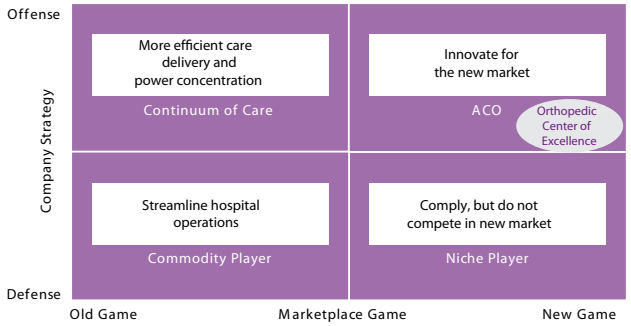
#4 Work in the boiler room or learn to fly?

Executives we talked to recognize that the shift to a value-based strategy will have enormous economic and clinical consequences. Most executives consider it an irreversible step. Understandably, roughly 60 percent of the leaders we talked to are looking for a greater level of certainty around value based reimbursement changes before they pull the transformation trigger. Many are starting in the boiler room and taking out costs before grappling with how to fly a plane. "We will adopt ACOs if it makes business sense," explained Bruce Moore, president of Outpatient Services for HCA. "But if we swing for the fences [on value] too early, we could do some real damage to our organization."

Despite market uncertainties, 40 percent of CEOs have already begun to transform their organizations. In plotting their course, most see a spectrum of choices that vary across geography and care model rather than a systemwide bet one way or the other. One such CEO is Dr. Richard Afable, of Hoag Memorial Hospital Presbyterian, in Newport Beach, California. Like many hospital system CEOs we talked to, Dr. Afable realizes that though each hospital is managed as a single P&L, hospitals are actually aggregations of care models (such as transactional outpatient services and complex surgical episodes of care), and that the care model level is where fee-for-value migration strategies must be worked out. He shared with us the strategy framework his organization is using to shift the system from fee-for-service to fee-for-value over the next decade (see Plotting a Course, below). The framework helped Hoag to select the first care model in its shift to value: an orthopedic center of excellence.

Plotting a Course

A hospital may be a single P&L, but it contains multiple care models, and the care model is the level where value-migration strategies need to be worked out. Here is the framework used by Hoag Memorial Hospital Presbyterian in selecting an orthopedic center of excellence as the starting point for its shift to fee-for-value.



Source: Hoag Memorial Hospital Presbyterian

Oliver Wyman Observations

It is hard to turn an ocean liner, an analogy that certainly holds true for the $2.5 trillion U.S. healthcare system. A whole range of factors keep that vessel on course: well-established leadership models, information systems, cultures, profit engines, and organizational models and competencies. But those same factors tend to stifle significant change as well. Accordingly, industry leadership often rotates away from the incumbent company to the innovator when industries go through transformational change. After all, the innovators have much to gain, little to lose, and are not held hostage by the economics of prevailing business models.

Who will the innovators be? Oliver Wyman expects to see an unprecedented number of partnerships, as payers, providers, health information companies, and Web 2.0 companies work together to invent new value-based care models. The trend is already well under way: McKesson recently acquired U.S. Oncology; United Health Group and Aetna have been rolling up a series of health information management companies; Ascension is piloting Web 2.0 models with Cisco and American Well; Walmart is rolling out on-site clinics with integrated pharmacy offerings; and large, integrated multispecialty groups are positioning themselves to redefine their roles and the basis of competition in their markets.

How do organizations move forward in the face of uncertainty? Many leadership teams have used scenario planning in combination with strategic hedging to create a path forward and prevent the loss of precious time. The concept is straightforward: Identify initiatives that will make the cut whichever way the wind blows, bet on the relative certainties of the future market, and hedge against large, high-impact

(continued on page 13)

uncertainties. Most importantly this time around, CEOs, working with their boards and leadership teams, must understand the nature of the uncertainties they face and their potential impact on the business. They also need to clear away organizational impediments to change, because change is certainly coming.

What types of physician integration make sense? When bringing physicians into a health system, it is important to ask: Do they advance our long-term clinical strategy and bring us closer to the value-based model we have chosen—or have we selected them just to drive fee-for-service volume in the short run? For the best results, the basis of alignment should be as specific as possible. For example, if the health system aims to become a risk-bearing population health management company or ACO, the focus in integration should be on patient-centered medical homes, chronic care management models, hospitalists, and home care programs.

What competencies will be needed in the value-based marketplace? The shift to value-based care will require health systems and physician organizations to invest heavily in new competencies, including:

- clinical risk management
- care model management for episodes, diseases, and populations
- population management
- predictive modeling
- retail and Web 2.0 capabilities
- the use of integrated multidisciplinary teams for complex patient care and patient engagement.

The good news is that the new world of healthcare will reward disruptive innovators that improve the quality and lower the cost of care. Leaders will grow market share and margin as they learn how to compete on value. Though the barriers to change are numerous and high, there is massive opportunity in the current system to improve access, quality, and affordability. As one health system CEO put it; "We have the opportunity to do the right thing."

About Olivery Wyman

Oliver Wyman is an international management consulting firm whose Health & Life Science's practice serves clients in the pharmaceutical, biotechnology, medical devices, provider, and payer sectors with strategic, operational, and organizational advice. To contact the authors, please email: kathryn.weismantel@oliverwyman.com

Workin' the Room:
How to Make the Most of Conferences and Conventions

With today's financial pressures and restricted budgets, your participation in professional conferences may be somewhat limited. That's why it's so important to make sure that if you *do* attend an event—anything from a large conference like HFMA's ANI to a chapter meeting—you get the biggest return on investment of your time and money. Here are some tips for maximizing your participation in any professional event:

Have a plan. "You probably don't gain as much [from a conference] if you don't have a plan," said Paula Wilke, administrative director for patient financial services at Edward Hospital in Naperville, Illinois, and a past HFMA First Illinois Chapter president. "You want to create a list of which classes you'll want to attend and who you'll want to meet," she advised.

Prior to boarding that airplane or jumping into your car, take some time to map out your conference strategy. Review the brochure or website, study the programs or tracks and, if possible, find out who will be attending. Write down your intention for the event. Are you there to pick up some technical skills? Are you hoping to meet some peers who are experiencing some of the same issues you are? Is there a notable speaker you'd like to meet? Perhaps you're just building relationships you already have. Whatever your mission, there's tremendous power in writing out your intention.

It's about the people! Not just the topics. Liz Simpkin, senior vice president of consulting services for Valence Health, emphasized that conferences aren't just about the sessions. Liz recommends asking yourself: "What kind of members do I want to find and network with?"

"Is it someone in a similar position?" she asked. "A different market? Maybe it's someone in a position you aspire to. You may want to meet people who can help you and talk to you about your career goals. Comb the attendee list and find those people—and don't be afraid to introduce yourself," she encouraged. Liz agreed that "you have to have a strategy so you can find the people you'd like to meet versus meeting by accident."

Conferences are so much more than training opportunities. Professional meetings give us the ideal opportunity to sustain and grow our networks. Of course we want and expect quality programming, but a large part of the value of any association meeting is connecting with others in your field. The topics are important, but making connections *in person* with people in your industry is just as critical to your career as the educational content.

Be present. In our fast-paced, multi-tasking, Blackberry®-texting, attention deficit world, being present to people is one of the hardest things to master, especially if you're in a huge convention hall with lots of background noise. If you're in a conversation with someone, give them your full attention. If it's impossible to talk over the noise, step out into a hallway to have a private conversation. Listen—really listen—to what that person has to say.

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Workin' the Room: How to Make the Most of Conferences and Conventions

(continued from page 4)

Go for quality, not quantity. Tabari Woodson, project manager for Rush University Medical Center, shared his experience with user group meetings, another type of conference. "When I've given a presentation, folks come up and talk, exchange business cards… it's a great networking opportunity." But it can be overwhelming, he said. "Sometimes I leave with two dozen cards. It's not just about accruing the most numbers or contacts," he cautioned. "Try not to overdo it. Jot down a note to remember the person. Think quality versus quantity."

Look for connections you can build on versus superficial volume. This is where having a plan in place *before* you go to your conference can be helpful. If you can, set up some of those appointments to connect with people prior to the conference so your "dance card" is filled before you arrive.

Build in some room for "serendipity." Yes, have a plan, but when you're at a conference, allow for the magic of serendipity. The dictionary defines serendipity as "an aptitude for making desirable discoveries by accident." Your timing is perfect and without any effort on your part, you connect with someone or some information you've been seeking to enhance your career. Maybe that's running into someone you want to know in the buffet line or waiting for a cab. Be open for those opportunities to connect.

Follow up. Following up is critical to cementing those new relationships and sustaining old ones. Whether it's with a quick email, an invitation to connect via LinkedIn or a written note, it's imperative to let that person know how much you enjoyed getting to meet him or her. Ask for permission to stay in touch and put that person's name in your "tickler" file to follow up with again.

Relationships worth fostering take time and attention. You'll want to "seed, weed and feed" your contact list—your "Golden Rolodex"—throughout your career, and conferences are a great way to do just that.

Vickie Austin, founder of CHOICES Worldwide, is a business and career coach and a professional speaker based in Wheaton, Illinois. She is honored to be a contributing writer for First Illinois Speaks, HFMA's First Illinois Chapter's newsletter. You can contact her at 630-510-1900 or vaustin@choicesworldwide.com.

HFMA Captured Events

HFMA Treasury Program: December 15, 2011

HFMA 2011 Treasury: Adam Lynch, Jerry Berg, Kevin Fitch

HFMA 2011: Treasury: Andrew Stefo, Martin Arrick, Rachel Cortez, Jim LeBuhn

HFMA 2011 Treasury: Co-chairs Kim McMahon, Tony Kazwell

HFMA 2011 Treasury: Tom Fahey, Mark Deaton

Upcoming CFO Programs

CFO Capital Decisions

When: Thursday, January 19, 2012, 8:00am – 4:30pm

Where: 55 E. Monroe Street, Chicago, IL 60603

Networking and cocktail reception to follow. Questions and more information contact Rosalyn Ryan at 630.475.3884 (r.ryan@ccgled.com) or John Masini at 847.445.0874 (john.masini@na.firstsource.com)

Compliance Education Program and CFO Breakfast

When: Thursday, January 26, 2012, 7:30am – 5:30pm

Where: Katten Muchin Rosenman LLP
525 W. Monroe Street, Chicago, IL 60661-3693

Compliance in a changing environment. Save the date for the First Illinois HFMA's second Compliance Program. This full day program was developed for Senior Financial Executives, Chief Compliance Officers, Chief Internal Audit Officers and members of Hospital Audit Committees responsible for compliance within their health organization. Our program offers a practical source of information to educate yourself and your organization. Our expert speakers will provide the latest developments on complex healthcare compliance issues.

HFMA Event Promotions

What's Happening in 2012

2012 First Illinois HFMA Scholarship

It's Not Too Late to Apply!!!

The deadline for First Illinois Chapter of HFMA's ("the chapter") 6th annual scholarship applications for its members and their children seeking higher education is fast approaching. Don't miss your opportunity to apply.

Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter.

The chapter is pleased to award up to four scholarships of $4,000, $2,500, $2,000 and $1,500. The First Illinois HFMA application cycle is as follows:

- First Illinois HFMA applications can be downloaded from the First Illinois Chapter website – www.firstillinoishfma.org.
- All applications must be **postmarked by February 10, 2012.**
- **All applications should be mailed to:** Vincent Pryor, Edward Hospital, 801 South Washington, Naperville, IL 60540.
- All scholarships will be awarded no later than May 1, 2012.

The eligibility requirements for applicants for the 2012-2013 academic year are as follows:

- Applicants must attend or plan to attend an accredited college, university or proprietary/trade school.
- High school seniors and undergraduate students are eligible to apply.
- Only one scholarship per student will be awarded during their lifetime.
- First Illinois Chapter HFMA members and their children are eligible for scholarships.
- Applicants must be U.S. citizens.

Click Here to access the application. The application consists of six parts: the application, a letter of recommendation from a faculty member, two letters of reference, an essay/testimonial, academic transcripts and an interview with the Selection Committee.

Please note: Scholarship recipients and their parents will be recognized at the annual installation dinner and awards ceremony the evening of July 19, 2012.

Please direct any questions to Vince Pryor at vpryor@edward.org or (630) 527-3035.

Save the Dates

Revenue Cycle Education Program

When: Thursday, February 9, 2012

Dinner and Play - Social Event

When: Thursday, February 23, 2012
8:00am – 4:30pm

Where: TBD, Downtown Chicago

Managed Care Education Program

When: Thursday, March 8, 2012

IT Education Program

When: Thursday, April 19, 2012

Join us for ANI 2012

Mark your calendar now for next year's ANI: The Healthcare Finance Conference at the Mandalay Bay Resort and Convention Center in Las Vegas. ANI will take place June 24-27, 2012.

the numbers

4 jam-packed days

29 priceless CPEs

85 in-depth, expert-led sessions

2 ways to save

the issues

REFORM

Reform Implementation Understand the implications of government and private-sector actions implementing health reform

MARGIN

Margin Pressure Manage operating costs, reengineer services, and rethink cost structure to reduce margin pressure

REVENUE

Revenue Cycle Use metrics, technology, process improvement, and training to improve your revenue cycle

VALUE

Value Focus on quality, efficiency, transparency, patient outcomes, and accountable care models

CARE

Transformation of Care Delivery Improve costs and outcomes of care through collaboration, business intelligence, and risk management

the lineup

KEYNOTE SPEAKERS

Carl Lewis, the nine-time Olympic gold medalist and world record holder, tells what it takes to overcome the odds and achieve your goals.

Going the Distance

Chesley B. (Sully) Sullenberger III, the heroic pilot who landed his plane on the Hudson, talks about his lifelong commitment to excellence and safety and offers lessons for the work we do in health care.

Passion for Excellence

David Walker, former U.S. Comptroller General, spells out how America's budget challenges affect healthcare finance and discuss solutions to restore fiscal sustainability.

Comeback America: Turning the Country Around and Restoring Fiscal Responsibility

Kevin & Jackie Freiberg, bestselling authors of *Nanovation*, share proven strategies for collaborating, thinking creatively, turning liabilities into assets, and finding ideas from beyond health care.

Leading Innovation in an Era of Uncertainty

FEATURED SPEAKERS

George Halvorson
Chairman and CEO, Kaiser Permanente

Innovations in Providing High-Quality, Cost-Effective Health Care

Brent James, MD
Chief Quality Officer, Intermountain Healthcare

Clinical Transformation and Increasing Value

Simon Stevens
Executive Vice President, UnitedHealth Group

Delivery System Reform and Payment Policy

James LeBuhn
Senior Director, Fitch Ratings

Capital Market View of the Healthcare Industry

Gregory Meier, CPA
Executive Director of Finance, Mercy
Dottie Bringle, RN
COO and Chief Nursing Officer
Mercy St. John's Regional Medical Center

Tragedy in Joplin: A Hospital's Response to a Deadly Tornado

hfma national institute

NETWORKING OPPORTUNITIES

Attend the opening reception, shop solutions with more than 400 companies in the exhibit hall, visit the HFMA Product Showcase to see products and services in action, and enter the Exhibit Hall Raffle to win great prizes.

Firt Illinois HFMA is Proud to Announce Its 2011 Scholarship Recipients

Zach Richmond

$1,000.00 – Illinois State Scholar, Eagle Scout, PSAE All-Star, Youth Minister at United Methodist Church; will be attending Carleton College in Minnesota.

Kathleen O'Brien

$1,000.00 – National Honor Society, Rotary Youth Leadership Award, Academic All-State. While being editor-in-chief of her school newspaper, co-captain of the varsity soccer team and secretary of the Student Council Executive Board, Kathleen found time to work part-time at Old Navy! She wants to be an attorney, and she will be attending Notre Dame.

Cassandra Lynne Levitske

$1,500.00 – Pom and Dance Team (Varsity), National Dance Association. 2009 Fed-Ex Orange Bowl pre-game show participant, National Honor Society, Illinois State Scholar, Church Lector and Eucharistic Minister. The English Department Chairperson at Nazareth describes Cassie as "an intellectual powerhouse with an unstoppable work ethic in the classroom and a vivacious actor, dancer and singer whose concern for others is always apparent. She will be attending the University of Illinois at Champaign.

Allison Perlin

$2,500.00 – Junior AP English Achievement Award, Outstanding Dance Student Award, Outstanding Junior Science Award in Chemistry, Honor Roll all 4 years, Social Studies Outstanding Artisan Award, Freshman Mentor, Dance Teacher of Special Needs Activity Program, 300 club (hours of community service by graduation), Model United Nations, Protecting and Advocating for Animals in the World Member and Education Director. Allison wants to combine international relations with her passion for dance. Melissa Mack, her English Instructor at Stevenson High School, stated, "What I find truly compelling about Allison is her sincerity, humility and genuine concern for others," Allison will be attending the University of Wisconsin, Madison.

Visit our New Website!

If you have not done so already, please check out our new website at **www.firstillinoishfma.org**. And, once again, a very special THANK YOU to Peter Leenhouts for making this happen!

New First Illinois HFMA Chapter Website Home Page

Welcome New Members

Joanna Biestek
Consultant

Carolyn J Ogrey
Business Development

Justin Dearborn
President and Chief Financial Officer
Merge Healthcare

Lee M Karlin
Director Finance
ARAMARK Healthcare

Margaret LaFleur

Kathy Fox
Manager, Regulatory Integrity
Advocate Health Care

Katie Nuszloch
Sr. Accountant, External Reporting
Rush University Medical Center

Kevin M Karstens
Vice President
PNC Bank

Allecia A Harley
Director
Huron Consulting Group

C Moore
Vice President
Baird

Kenneth Christensen
Director Business Development
SS&G Healthcare; Chicago

Doug Weinberg

Julie Melvin
Partner
talentRISE

Bryan Cali
Director
Navigant Consulting

Anna Buracker, CPA
Reimbursement Analyst
Centegra Health System

Pamela G Hill, MHA
Chief Financial Officer
Vista Medical Center

Carla J Salvo
System Manager, Financial Counseling
Cook County Health and Hospitals System

Richard G Greenhill
Lean Six Sigma Program Manager
James A. Lovell Federal Health Care Center

Chuck Badtke
Regional Sales Director
PatientKeeper

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Rajiv Ghosh
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Internal Auditor II
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Florina Dekalo
Manager, Internal Audit
Northwestern Memorial Hospital

Christine Misiak
Senior Internal Auditor
Northwestern Memorial Hospital

Jodi Bui
Channel Account Manager
TransUnion

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Consulting Services Associate
MultiCare Consulting Services

Sarah Willis-Kanter
Product Manager, Fiscal Solutions
McKesson

Ruby Mann
Director, Patient Financial Services
Adventist Midwest Management Services

Andres Arias
Director of Finance & Post Award - Pediatrics
University of Chicago

Catherine Cygan
Accountant
Crowe Horwath

Scott A Kehoe
Regional Director, Health System Solution
Walgreens

Maggie Stremel

Shivani Mishra
Analyst
Huron Consulting Group

Sara E Cline
Huron Consulting Group

Dan Murphy

Rachel Maze
Strategic Planning Manager

Betty Heeren
Staff Accountant
Wolf & Co, LLP

Laura Grunwald
Manager
Wolf & Co, LLP

Jesse W Ostrow
Director, Investment Management
MedProperties Group

Audrey J Anewishki Pennington
Director of Finance, Health Divisions
Aunt Martha's Youth Service Center

Paul J McBlaine
Director
KPMG LLP

Kandace C Lenti
Chief Credit Officer, SVP
Wintrust Commercial Banking

Bradley R Hunter
Senior Director
MedeAnalytics

Ashley Yost
Advocate Health

Philip Quick
Manager Patient Access Services
Advocate IL Masonic Medical Center

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AccretivePAS

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Sr. Accountant
Rehabilitation Institute of Chicago

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PNC

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University of Chicago Medical Center

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Gautam J Char
COO
Inventurus Knowledge Solutions

Barton S Richards
Managing Director
The Claro Group

Deborah D Schmidt
Senior Vice President
Accretive Health

New Member Profile

Richard G. Greenhill

Demographic Information:

Name: Richard G. Greenhill

Organization: James A Lovell Federal Health Care Center/U.S. Navy

Current Position: Lean Six Sigma Program Manager/Deployment Leader

Education: MHA, MBA

Certifications:

- Fellow of the American College of Healthcare Executives (FACHE) Candidate (Advancement date 03/2012) Certified Associate Project
- Management (CAPM)

Years in healthcare: 19 years 7 months

Questions:

Why did you decide to join First Illinois HFMA?

I sought out First Illinois HFMA to expand my knowledge base in financial operations as I prepare to transition from public sector healthcare (U.S. Navy) to the private sector.

What is your greatest achievement outside of work?

Completion of a full marathon

What is the best advice you ever received from a mentor?

"Be deliberate about every facet of your life and remember that only dead fish go with the flow; so always swim."

Finish this sentence:

I think healthcare reform… *is needed* but I am not sure that the current legislation contains the right mixture of elements to provide a real solution to our nation's issues.

First Illinois *Speaks*
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter

Publication Information

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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
April 2012	March 10, 2012
July 2012	June 10, 2012
October 2012	September 10, 2012
January 2013	December 10, 2012

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2012

For a current listing of all upcoming First Illinois HFMA Chapter events, please visit: http://firstillinoishfma.org/events/calendar-of-events/

Thursday, January 26, 2012
Compliance Education Program & CFO Breakfast

Wednesday, February 8, 2012
Webinar: Winthrop Resources - Financing Technology: Mitigating the Business & Financial Risks with Technology

Thursday, February 9, 2012
Revenue Cycle Education Program

Thursday, February 16, 2012
Physician Education Program

Thursday, February 23, 2012
Dinner & Play - Social Event

Friday, February 24, 2012
CFO Breakfast

Tuesday, March 6, 2012
aIPAM

Thursday, March 8, 2012
Managed Care Education Program

Tuesday, March 13, 2012
Webinar: American Express - Maximum Efficiency: Inside the Procure to Pay Process

Friday, March 23, 2012
CFO Breakfast
Strategic Planning Program

Tuesday, April 10, 2012
Webinar: Amerian Appraisals - Successful Healthcare Acquisitions: Getting the Valuation Issues

Thursday, April 19, 2012
IT Education Program

Friday, April 27, 2012
CFO Breakfast

Tuesday, May 8, 2012
Webinar: FirstSource - Healthcare Reform and its impact on Revenue Cycle

The First Illinois Chapter Sponsors

The First Illinois Chapter wishes to recognize and thank our sponsors for the 2011-2012 chapter year. Thank you for all your generous support of the chapter and its activities.

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