First Illinois *Speaks*

hfma healthcare financial management association

HFMA's First Illinois Chapter Newsletter

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Funds Flow in the Era of Healthcare Transformation

INTEGRATION: KAREN BIRD, MICHAEL RENEY, AND RYAN ROSS

As healthcare reform creates incentives for greater alignment among industry players, organizations across the healthcare continuum will see their bottom lines increasingly tied to partnership success. Yet that success will prove elusive if organizations have not developed an effective approach to manage the flow of funds between partner organizations. To this end, a critical step in forming any partnership involving different types of healthcare organizations is to develop a plan—or guiding framework—for funds flow within the partnership.

Funds flow is a term regularly used in academic medicine in reference to remuneration to reflect the agreed-upon value within a transaction. With the proliferation of many different types of partnerships in health care, this term's meaning can be expanded to include any such remuneration between partnering organizations. Examples of such arrangements include:

- A clinical partnership between an academic medical center (AMC) and community hospital
- An accountable care model in which cost and quality incentive payments are shared among

hospitals and physicians

- An arrangement between a health system and a stand-alone post-acute provider for clinical care coordination and allocation of bundled payments
- A health system partnership with a retailer, community-based not-for-profit organization, or governmental agency in support of population health management
- Two distinct medical centers that jointly develop a service line center of excellence, building upon the strengths of each (e.g., care model, facility capacity, physician sub-specialists, research, access to clinical trials)

As the various types of partnerships are developed, funds flow can become complex and opaque, underscoring the need to develop an agreed-upon approach to promote clarity in funds flow processes. By serving as a guiding framework for the integrated partnership, the funds flow plan also can help to define and organize individual agreements between the parties. It is important that these individual agreements—such as those for specific purchased

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(continued from page 1)

services between the partners or shared resources among departments (e.g., staff, research support)—support the larger partnership agreement and do not overshadow it.

As shown in the exhibit below, the plan should be fair, agile, transparent, and easily understandable to all stakeholders across each organization.

Funds Flow Plan Imperatives

FUNDS FLOW FRAMEWORK IMPERATIVES

Fair	Agile
Each party perceives that it derives accumulated benefits from the partnership in proportion to its respective contributions.	Specific elements of the plan can be altered in response to changing circumstances without requiring complete renegotiation of the overall plan or partnership contracts.
Transparent	**Easily Understood**
The processes and authorities for initiating, approving, and administering the plan are open.	The plan is clearly written so each party can discern the terms, performance measures, and funds flow methodology, and track performance through back-to-management reports.

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The Blueprint

Funds flow frameworks typically govern the flow of monies in the following types of arrangements that can define a partnership:

- **Purchased services agreement.** The parties agree on specific services each will sell to, and purchase from, the other.

- **Discrete joint operating agreement.** One party pays the other to manage a service, yet ownership of assets is unchanged.

- **Joint investment/cost sharing.** The parties share operating or capital costs for specific services from which they jointly operate or benefit.

- **Shared margins for new services.** The parties share margins for new, jointly developed services based on the initial investment percentages for those services.

- **Virtual joint venture.** Total enterprise margins are shared for all services based on a predetermined methodology.

The purpose of the funds flow framework is to govern funds flow wherever the partnership involves such agreements or arrangements. The framework serves as a navigator and reference point when circumstances necessitate revisiting partnership parameters, as described below. It should allow for growth and expansion while leveraging overall partnership goals and objectives to individual agreements. For instance, language may be included that allows for an expanded agreement with the advent of new clinical technologies, geographic expansion, health system aggregation, or changes in reimbursement models.

The exhibit below depicts a generalized example of a plan blueprint involving both an overall margin-sharing agreement and supporting individual service agreements. Based on those agreements, the parties calculate a total dollar amount each owes the other, which is usually settled quarterly through a net transfer of funds or intercompany payables/receivables.

Example of a Funds Flow Partnership Framework

EXAMPLE OF A FUNDS FLOW PARTNERSHIP BLUEPRINT

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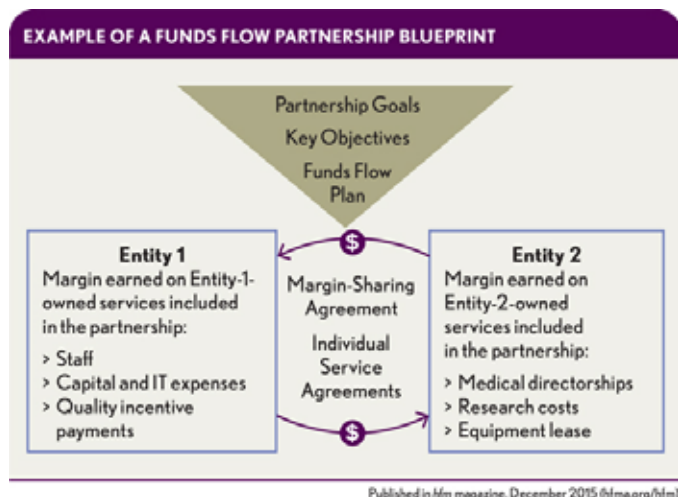
Laying the Foundation

Designing the plan may be straightforward, but developing the specific funds flow parameters requires a focused effort, with great attention to detail. Management of operations, measurement of performance, and calculation of payments must all be addressed. Partnering organizations should create mechanisms for revising the parameters as the environment or individual partnership circumstances change, including the "trigger points" described below. New payment models will be introduced. New technologies will alter clinical best practices. Competitors will continue to target profitable services. Growth opportunities will sprout. In short, the plan should be sustainable to honor the original intent of the partnership without becoming subject to minutiae such as minor yearly fluctuations in accrued margins to each partner, timing of accruals, and sharing of administrative processes.

A clearly written funds flow framework will contain the following foundational elements, although circumstances often require that others be added. These elements best support the plan when they are clear, specific, and in written form.

Governance. Specific delineation of authority to initiate, approve, and revise agreements is essential, although there might be good reasons to limit the number of individuals involved in this process. Ultimately, agreements should have an explicit governance structure with a clear link to each partner's organizational chart up to the executive leadership team.

Clinical support. Agreements between healthcare entities should support patient care and patient navigation through the care continuum. If a funds flow framework creates or incentivizes additional and unnecessary steps in the patient care protocol or layers of bureaucracy between the organization and the patient, it will put the organizations at a competitive disadvantage in the long run.

Market competitiveness. A partnership's impact suffers if the organizations, individually or collectively, fail to pay attention to market threats. Concern about "securing what is ours" within a partnership can cause organizations to focus inwardly at their own peril—

# Funds Flow in the Era of Healthcare Transformation

resulting, for example, in a failure to recognize organizational blind spots that hinder expansion into new geographies, or opportunities to bring additional partners into the mix or to address competitive threats.

Accounting basis. Prudent organizations periodically review the basis for their funds flow plans to ensure incentives continue to align with organizational goals and strategies. Accounting methodologies, major line items, and period-end adjustments should be transparent and easily understood by stakeholders whose individual performance is tied to overall partnership performance as measured by these figures.

Trigger points. As circumstances change, one party may feel that the agreement starts to favor the other. It is much easier to bring both parties back to the negotiation table if such a step is precipitated by a predetermined "trigger point." Some examples include payment thresholds, service volumes, margin-sharing percentages, and splitting of surplus/deficits.

Each of these elements should be specifically addressed at the outset, but with the understanding that the plan is not static. Although partnerships are inherently built upon trust, change in organizational leadership is a fact of life and could have significant impacts on the future atmosphere and operations of a partnership. An enduring framework will live beyond its creators and allow for the evolution of the partnered organizations.

Shared Margin for New/Expanded Services

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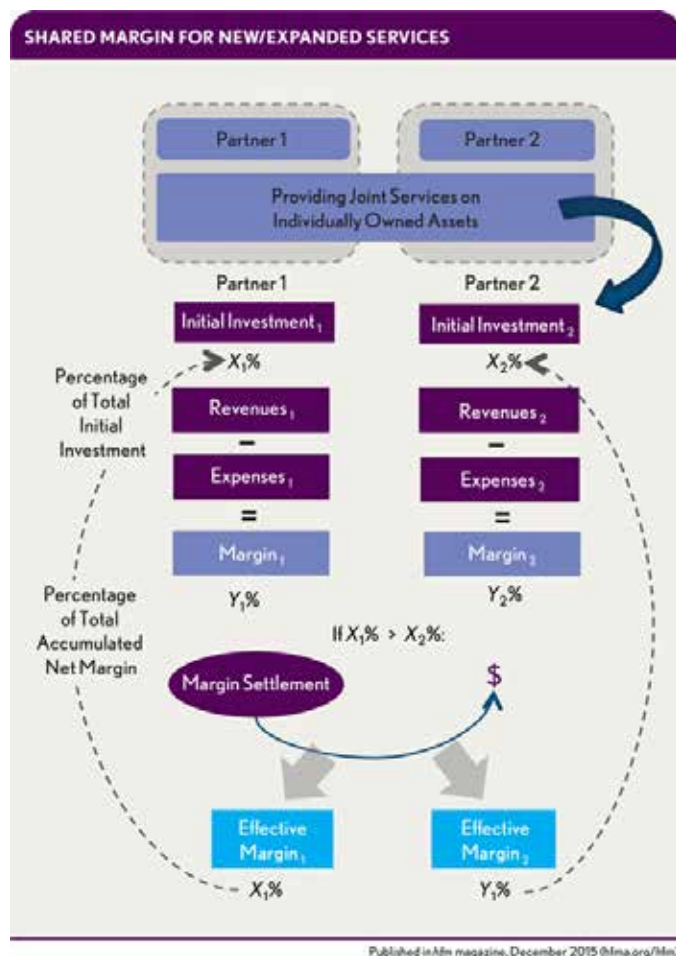
Framing the Margin-Sharing Calculation

Margin sharing is typically the crux of the funds flow framework. Margin can be shared between partners based on initial capital contributions, agreed-upon measurement of efforts, or a number of other methodologies. When each party maintains ownership of individual assets, margin sharing becomes more complicated; however, it is often a driver for mutually beneficial partnerships.

The illustration at left shows how two organizations may frame their overall margin sharing agreement. In this example, Partner 1 and Partner 2 each contribute a specific percentage of the initial investment (X1% and X2%, respectively). Through the course of operations, each accumulates revenue and expenses on its individually owned assets such that the resulting respective margins as a percentage of the total margin (e.g., Y1% and Y2%) differ from the initial investment percentages. Therefore, a margin settlement from Partner 1 to Partner 2 is made so that the effective margin of each partner is in line with the original investment percentages.

Of course, this relatively straightforward example can become more complicated over time, with parameters such as margin

calculation methodology, margin settlement floors, and agreed-upon subsidization of certain programs. For this reason, the margin-sharing framework should be periodically reviewed to ensure it has not shifted away from the plan's foundational elements. Furthermore, the margin-sharing framework and any supplemental agreements (as explored in the sidebar, "Supporting the Partnership," on page 45) should be routinely revisited to ensure that they work together to support the overall partnership goals and objectives.

Related Sidebar: Supporting the Partnership

As Individual as Their Organizations

There is no one-size-fits-all approach to managing funds flow; each approach will reflect the uniqueness of the individual organizations and partnerships that adopt it. Over the next few years, new affiliations across industry segments will create new challenges and complexities, but with a focus on achieving mutual objectives, healthcare organizations can find true partnership success.

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HFMA Weekly Update 12/2/15

This Year's "40 Under 40" Includes a Couple Close Friends

BY JIM WATSON, PARTNER, PBC ADVISORS, LLC

Every year *Crain's Chicago Business* publishes its "40 Under 40" list, which is a listing of successful and influential young executives under the age of 40 who are making their mark in Chicago business and industry.

This year there are two people on that list with close "family ties" to FI HFMA: First, our current FI HFMA president, **Adam Lynch** (whose day job is senior director, Shared Services at Metropolitan Chicago Healthcare Council/MCHC), and **Jason Montrie**, president at Land of Lincoln Health/LLH.

On behalf of all of us at FI HFMA, we'd like to congratulate Adam and Jason on this recognition. Aside from being very talented and successful at a young age, those that know Adam and Jason know that they are both great people to be around. For those of you that perhaps missed that edition of Crain's, we'll recap what the "40 Under 40" had to say about them.

Here's a recap of what they had to say about Adam Lynch:

- It's a good thing he is calm and has a deep knowledge of the hospital industry because his job involves "soothing a lot of headaches."

- Adam is "charged with making sure a merger between MCHC and the Illinois Hospital Association (IHA) is the right fit."

Adam Lynch

- Adam is working feverishly to get the hospital community engaged in MCHC's regional electronic medical records hub (or HIE).

- He leads MCHC's effort to streamline the doctor credentialing process, which as anyone familiar with the credentialing process will tell you is an expensive paper chase needing process re-engineering. It is noted in the article that it is estimated that better management of credentialing could cut the cost by two-thirds, from about $40 million to $13 million a year.

- Dan Yunker, president and CEO of MCHC, calls Lynch a "wicked smart" relationship-builder. "He's the guy I'm going to go to when things need a heavy lift."

- In his spare time: Lynch enjoys afternoon tea with his wife, golfing with his son and attending Kid Rock classes with his daughter.

And of Jason Montrie:

- Jason is fighting for marketshare and survival in one of the toughest industries. LLH was one of the original "co-ops" nationally, created under the ACA (or "Obamacare" as often referred to in the article). Co-ops (which stand for Consumer Oriented and Operated Plans) differ from traditional insurers in their nonprofit status, consumer focus and organizational structure, governed by boards controlled by policyholders.

Jason Montrie

- LLH's second-year performance was a classic comeback story. Under Montrie's leadership, in year 2 of Obamacare, LLH snagged 10 percent despite consumers having even more choices. How? LLH slashed premiums by creating new plans built around eight health systems or networks. Patients got deeper discounts for seeing doctors in the healthsystem network. The result: Land of Lincoln captured a combination of more than 50,000 enrollees on and off the exchange.

- Elliott Richardson, CEO of the CEO of the Chicago-based Small Business Advocacy Council, says of Jason: "He provides solid leadership that people are able to see. He's able to pivot when things change in the health care market, which happens all the time, and forge new strategies to succeed."

- Montrie helped pay for his Indiana University degree by selling souvenir fraternity paddles and playing guitar in a cover band.

- In his spare time: The father of two spends time with his family, reading and walking on the 606 trail, the elevated park that opened this year on the North Side.

So how much under 40 are these gentlemen? Jason Montrie is 36, and Adam Lynch is 39. That makes some of us feel old. So while we've only just begun to see the impact that Jason and Adam will have in the market, we know that their work is meaningful in an increasingly complicated and challenging industry. We also know the industry is in transformation, and bright young people like Adam and Jason are driving that transformation in the right direction and with the right attitude and approach.

Congratulations, Adam and Jason, from all your colleagues at FI HFMA!

CAREER Corner

BY VICKIE AUSTIN

This month's "Career Corner" interview is with **David Pareja,** Director of Marketing and Sales for Horizon Financial Management and a First Illinois HFMA member since January 2014. David is a 21-year veteran of boxing and as an amateur he earned a full-ride college scholarship through the United States Olympic Committee. In 2004 he fulfilled his dream to fight professionally as "Dangerous Dave," finishing as a finalist on the TV show, "The Next Great Champ." He continued fighting professionally on HBO and Showtime until 2006 when he took time off from fighting to support his family. On August 22, 2015, he fulfilled another dream by successfully returning to the ring and winning his ninth professional boxing match via a second round KO.

David Pareja

Q: What was your first job?

A: The first job I remember was cutting lawns for people when I was in elementary school. Then in junior high my brother and I were hired by the developer/builder of our neighborhood to shovel snow, making $100 each time it snowed…BIG MONEY to us! Later I taught TaeKwonDo during high school… I did it for love (and sometimes money), and it was great early experience in teaching both adults and kids. The first "real" job I had was stocking shelves at Gordon Food Service (GFS). I only stayed there a couple months and didn't feel fulfilled, so I left.

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

A: I've had a few: Norman Vincent Peale; George Foreman; Evander Holyfield; my boxing coach, whom I call "Coach"—Willie "Butch" Elliott; and my friend and mentor, Mark Siebert, who owns the world's leading franchise consulting company.

Q: What had you choose healthcare financial management?

A: I really didn't choose healthcare…healthcare chose me. Growing up, my father was a family physician. When I was about six he started in private practice. Even way back then I grew up hearing about the challenges of collecting from insurance companies. As a kid, I wanted to do something to help my parents with the practice (my mom was the practice manager). I had the opportunity to do that as an adult and helped him to transform his medical practice which he was able to sell and then retire. I started consulting with doctors on their medical practices. I understand on a very personal level what it's like and what they go through in operating their businesses.

Q: What was one of your most "teachable" moments?

A: When I became a father… and ever since. Having children forces you to be teachable if you desire to be a good role model for them. I also make it my business to always be learning, growing and adapting. The more experienced I become the more I realize I need to learn.

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

A: Get mentors—people with a lot more experience than you who are 10-20 years ahead of you. Take them out for a nice meal, interview them, listen and then implement [their recommendations]. Develop good relationships with people. Focus on the relationship, and business will follow. Keep connections to recruiters in and outside of your industry. Be real.

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

A: HFMA has played a key role in my career development. The quality of people that I have the ability to rub shoulders with is second to none. You have the best and brightest individuals from around the country who are educated in health, finance, politics, and FUN. I love the culture of HFMA. People like to have fun…and of course we work hard, too.

Q: What are you reading?

A: At any given time, I'm reading 10 or more different books, depending on what I need to or want to know. Here's a sample of what I'm reading: **In Business as In Life, You Don't Get What You Deserve, You Get What You Negotiate** by Chester L. Karrass; **Psycho-Cybernetics: A New Way to Get More Living Out of Life** by Maxwell Maltz; **Subliminal: How Your Unconscious Mind Rules Your Behavior** by Leonard Mlodinow; **Management Consultancy** by Joe O'Mahoney and Calvert Markham; **The Negotiating Game** by Chester L. Karrass; and **Lean Doctors: A Bold and Practical Guide to Using Lean Principles to Transform Healthcare Systems, One Doctor at a Time** by Aneesh Suneja with Carolyn Suneja.

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

A: For anyone starting out anywhere my advice would be to follow your dream and what you are passionate about. In this profession in particular, stay with it. Too many people come and go so fast. This business is about longevity and being consistent. If you want to make it in this particular profession then stick around and don't quit.

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

Vickie Austin

Big Changes in 2016 to Marketplace Plans

BY JIM WATSON, PARTNER, PBC ADVISORS, LLC

We all just went through what is one of our favorite seasons of the year; no, we aren't talking about the Holiday Season (although it is one our favorite times of the year), we are talking about Open Enrollment Season. And while we have grown accustomed to Open Enrollment questions from our patients for employer-sponsored plans, as we enter the 3rd Open Enrollment season for "Obamacare", there was a tidal wave of new questions as we once again we are see dramatic changes to and questions about the health plans listed on the Marketplace (FKA the Exchange) for individuals who do not get insurance through their employer, or Medicare or Medicaid.   Couple that with questions and complexities around the state of Illinois' rapid migration to managed Medicaid, and the increasing popularity of Medicare Advantage plans, and one can conclude that we are now seeing the real transformative impact of changes in the U.S. health insurance models.

The focus of this article is Marketplace/Exchange product updates. The first two years of experience on the Marketplace has not been great for many health insurance companies. Many experienced significant losses and are withdrawing from markets, increasing premiums, and eliminating many products for the 2016 Open Enrollment Period. The average rate increase on existing policies was 17% in Illinois, with many premium increases in the 30-40% range. Additionally, many major insurers, including Blue Cross (BCBS) and United Healthcare (UHC), have introduced a variety of "Narrow Network" plans for 2016.   This continues a market trend proven successful in 2015 by Land of Lincoln Health, a pioneer in 2014 with the introduction of the Narrow Network (or Private Label) model.

There are two (2) reasons Narrow Networks are emerging as a hot new health plan model:

1. Eliminating "high cost" providers from the network lowers the overall premiums for the products/networks they are removed from, and

2. Narrow Networks keep referrals to those providers in the network who have demonstrated higher quality and/or have agreed to various provisions to support Accountable Care and Population Health Management initiatives.

The concept of a Narrow Network has been around for awhile. In Illinois, an example of that would be the Blue Advantage HMO, which was introduced over a decade ago as a lower cost version of HMO Illinois. It was lower cost because it did not include certain hospitals and healthsystems whose costs drove premium prices up. Removal of those providers from the network resulted in lower premium amounts for employers and in turn employees/patients. So the driving thrust of the Narrow Network trend was pricing.

Today's version of Narrow Network is also premised on price and overall cost reductions, but is also premised on improvement in "Quality" and medical cost management. Several 2016 Narrow Network products are exclusive to a specific provider network (often a "clinically integrated network" or "CIN"), or have higher benefits and lower out of pocket costs if you receive services from the narrow network of providers. These Narrow Networks promise lower costs and higher quality because physicians, hospitals and other care providers in the Narrow Network have agreed to certain contract terms that support the Narrow Network's Population Health Management (PHM) initiatives. By keeping patients in the Narrow Network, providers can better collaborate on care coordination, and often enjoy additional reimbursement via Contract Incentives.

Movement in the Marketplace: Highlights of Chicago-area health plan changes

The Illinois Marketplace enrollment has grown to nearly 300,000 as we enter Open Enrollment 2016. That number is expected to increase, perhaps dramatically, as employers increasingly seek alternative plan options to save money on their employee benefit costs (including the emergence of "Private Exchanges" which are expected to penetrate the market in 2017-2018). Below are a few examples of what's happening in the Marketplace/Exchange plan options in Illinois for 2016:
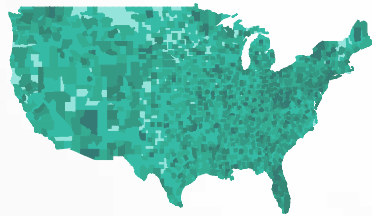
- Introduction of two (2) plans with the Advocate Health Care network as the core network: The "Blue Direct" plan from Blue Cross, and the "AETNA Whole Health Chicago" from AETNA Health.

- Continuation of Land of Lincoln Health Preferred Network products, Tiered Network plans, where members have less out of pocket for accessing providers in the "Tier 1" category.

Big Changes in 2016 to Marketplace Plans

- Elimination of "The Blue PPO" by Blue Cross. Blue PPO is the largest BCBSIL network, and it will no longer be sold to individuals and families who buy plans on and off the Exchange. People currently enrolled in Blue PPO will be automatically enrolled in the "Blue Choice Preferred PPO" with only 78 hospitals compared to the more than 200 hospitals in the Blue PPO network. Notably, several high profile Chicago area hospitals and healthsystems are not in Blue Choice, including Advocate Health Care, Northwestern Medicine, Rush University Medical Center, and NorthShore University HealthSystem and University of Chicago Medicine. This has significant implications to patients, and to physician practices that are in network for Blue Choice Preferred PPO, but now find that their affiliated hospital will be out of network.

The Impact to Physician Practices and Health Care Providers:

There are three (3) immediate potential impacts to physician practices and other healthcare providers that need to be considered in Narrow Network and Exchange products/contracts:

1. Increasing Bad Debt and Patient A/R
2. Impact to referral patterns
3. Administrative requirements, complexity and added costs to administer

Let's discuss each of these in more detail:

Increasing Bad Debt and Patient A/R: Marketplace products routinely have Deductibles $3,000-$6,000 per individual, and $6,000-$12,000 per Family and this is for In Network providers. Many patients with these low cost plans do not have the financial resources to pay these Deductibles, nor the hefty Co-Insurance amounts. As a result, Patient Bad Debt, Aged A/R, and Cost to Collect have skyrocketed in the first 2 years for these plans. Providers are increasingly implementing more aggressive "upfront" payment policies for patient liability (often referred to as "Point of Service" collections). For example, collect outstanding balances/portions of at time of service/registration, and collecting co-payments for today's visit today at time of service/registration). Additionally, many plans have Maximum Out of Pocket exposure exceeding $10,000-$20,000.

Impact to Referral Patterns: Typically, any given physician practice has any given number of established referral relationships in place, where they routinely refer to certain physicians in certain specialties, driven by your comfort in knowing that physician's clinical excellence and responsiveness to you and your patient. Historically, most physicians and most hospitals were in most health plan networks. Increasingly, across Narrow commercial networks, Medicare Advantage Risk Networks, and the emerging Medicaid Networks, one must be increasingly attentive to whom one is referring, as these networks are getting smaller and more contained, in fact limiting your choice and your patient's choice of whom you can refer. As if it wasn't complex enough, the introduction of Narrow Networks and Micro Networks exponentially increases the complexity of referring patients to the right "in network" providers. Couple this with "Tiered Products", "Private Label" and "EPO" product models, and it is clear that one of the more difficult jobs in the healthcare industry today for Hospitals and Medical Groups is managing payor contracts

(especially at the "front end" of Registration/Admission, and tying to the "Back End" to ensure appropriate payments and collection of patient liabilities).

There are also implications to not being in these new network models; specifically, (a) if a physician or other healthcare provider has to change referral patterns for certain products, they may increase re-direction of referrals for other products, and (b) if you accept a referral for a patient in a limited network, and/or you refer a patient to a non-network provider, you could face financial penalties and expose your patient to greater out of pocket expenses.

In a seemingly unprecedented move, one of the largest healtsystems in the U.S. (BJC HealthSystem, St. Louis, MO) made national news by initiating a public communications effort designed to tell patients NOT to come to BJC if BJC and their affiliated physician were Out of Network with the patient's insurance plan. They have made it a policy that Out of Network patients must pay in advance with a credit card for elective services.

There is no clear "one size fits all" strategic approach to a Managed Care Contracting Strategy for Exchange/Marketplace products, or Medicaid HMOs or Medicare Advantage plans. For some, you need to be "all in" to ensure alignment with your referral base and patient base. For others, you can be "selective", like BJC and others referenced in this article. Either way, the single most important thing you can do is understand what's going on so you can better position your organization for what's coming in 2016 and beyond.

Finding ROI in Deconstructed PACS
Enterprise solutions reduce barriers, optimize workflow and improve patient care

When called upon, a hospital's PACS (picture archiving and communication system) is a key component of patient care, essential to interpreting and communicating what is happening with a patient. Fast, easy access to images requires advanced systems and state-of-the-art technology working together in perfect harmony.

This harmony is within reach but presents a challenge for hospital CFOs. Constrained budgets, paired with the practice of postponing technology upgrades, have historically limited adoption of emerging technologies. But research shows compelling returns on investment for those who consider the full benefits of developing their own deconstructed PACS strategy.

Deconstructed PACS is defined as a standards-based strategy to deconstruct the core components of PACS (viewer, workflow and archive) and reassemble them with a vendor-neutral approach for enterprise viewing, enterprise workflow and enterprise archival/ storage of diagnostic and non-diagnostic images. Another related industry term for this concept is PACS 3.0.

Health systems and imaging services providers who have implemented their own deconstructed PACS strategy have quickly reached their desired operational goals through gains in productivity, turning technology into strategic advantage. This white paper explores how these solutions have advanced, perceived challenges to deconstructed PACS strategies, and where institutions can realize workflow and efficiency ROIs with new systems.

A brief history of deconstructed PACS

Deconstructed PACS is the third major revolution of the PACS architecture. The first revolution was in the 1990s, during the transition of images from film to digital using thick-client, hardware-intensive approaches. The gains in productivity, efficiency and satisfaction during that transition were extreme—in some cases, reducing turnaround time from 24 hours to just a few[1]. The second major revolution of PACS occurred in the early to mid-2000s, coinciding with the explosion of web-based solutions. Where the first revolution took PACS to academics, web-based PACS took the revolution to community-based and outpatient health care.

Today, the market has become saturated with these approaches to

PACS. In 2012, HIMSS estimated that nearly 91 percent of hospitals had a radiology PACS solution in place[2]. While these PACS solutions have clearly become the standard for interpreting and accessing radiology studies, the technology has essentially remained frozen in time. Despite demands for better functionality, usability and overall results, legacy PACS upgrades and replacements aren't offering the overhaul radiologists expect to keep up with today's imaging needs.

Radiologists are under significant pressure to maintain reading productivity, while also dedicating sufficient time to consult with referring physicians. With health care consolidation adding significant foundational complexity, combined with the lack of advancement in PACS, radiologists find themselves unable to efficiently read the number of studies required. Current and prior studies may not be readily available, imaging study size continues to grow in gigabytes, and cutting-edge modalities such as digital breast tomosynthesis (DBT), PET/MR and automated whole-breast ultrasound (AWBUS) are frequently unsupported or inadequately supported. Radiologists also may have limited access to a patient's record, so they don't have a comprehensive view of who this patient is and his or her medical history. Advances in mobile access are limited at best.

These frustrations are leading more institutions to explore best-of-breed solutions such as enterprise diagnostic viewers, enterprise workflow solutions and vendor neutral archives for their organizations. They are deconstructing the PACS to create a solution that they can exert control over, and that offers state-of-the-art capabilities and fits their budget.

At this point, most deconstructed PACS are in place at larger hospital and private practice networks that are also early tech adopters. However, as the solution becomes mainstream, institutions will increasingly be creating their own solutions on their own terms.
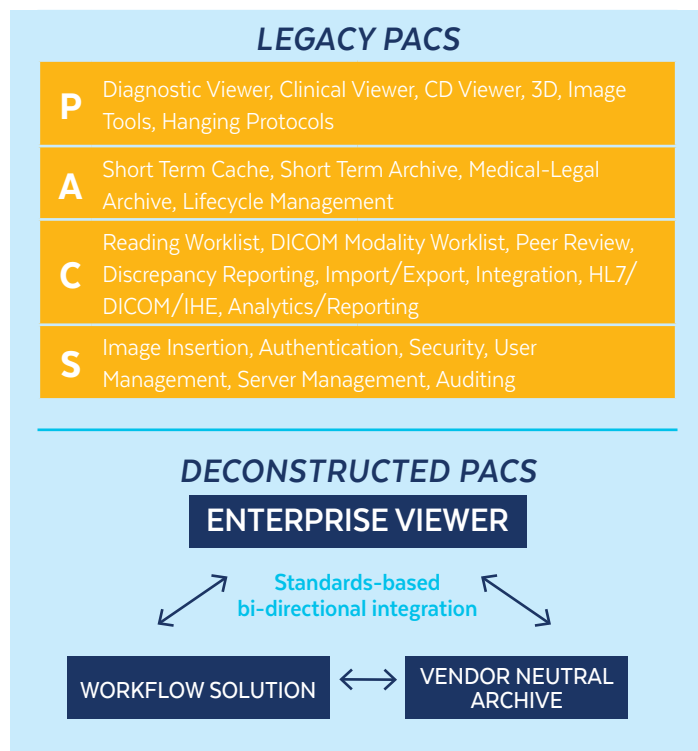
The market is showing this shift, with adoption rates for enterprise solutions forecast to rise in coming years while legacy system adoptions slow. Frost & Sullivan's US Enterprise Medical Image Viewers Market analysis showed the market anticipates growing revenue from $44.8 million in 2013 to $63.9 million in 2017, as hospitals and care systems of all sizes embrace the new technology to better serve referring physicians[3]. The vendor-neutral archive (VNA) market is

expected to grow from $110.5 million in 2011 to $210.0 million in 2018.

Defining the divide between legacy and deconstructed PACS

Legacy PACS and deconstructed PACS have the same components—

LEGACY PACS

P	Diagnostic Viewer, Clinical Viewer, CD Viewer, 3D, Image Tools, Hanging Protocols
A	Short Term Cache, Short Term Archive, Medical-Legal Archive, Lifecycle Management
C	Reading Worklist, DICOM Modality Worklist, Peer Review, Discrepancy Reporting, Import/Export, Integration, HL7/DICOM/IHE, Analytics/Reporting
S	Image Insertion, Authentication, Security, User Management, Server Management, Auditing

DECONSTRUCTED PACS

ENTERPRISE VIEWER

Standards-based
bi-directional integration

WORKFLOW SOLUTION ⟷ **VENDOR NEUTRAL ARCHIVE**

an archive, a viewer and a workflow/worklist solution. But the critical difference with deconstructed components is they have been developed to do one competency extremely well and also designed as enterprise-scale applications.rganizations can consolidate image viewers and processes across sub-specialty departments, improving workflow. Many radiologists operate on so-called "swivel chair workflow," where the radiologist has to move from viewer to viewer, from workstation to workstation, based on the type of study and which institution sent that study. Enterprise viewers can be used for all diagnostic modalities, accommodating the most common studies and leading to sizable reductions in the number of image viewers used in imaging. Server-side powered viewers are also orders of magnitude faster than legacy diagnostic workstations and clinical viewers, taking even today's largest gigabyte-sized imaging studies in stride.

Overcoming perceived challenges of deconstructed PACS

Despite the operational improvements seen with deconstructed PACS, some hospitals and health systems are hesitant to embark on the strategy. There are various perceived challenges to implementing a deconstructed PACS strategy; however, by examining the long-term system and patient care benefits realized through deconstructed PACS, a clear return on investment can be seen.

Michael J. Gray, principal of Gray Consulting, said in his experience, health care organizations arrive at the decision to make their own PACS when two ideas intersect: frustration and opportunity. Frustration stems from measuring the cost to upgrade one legacy system with

another. Opportunity grows when they realize they can create a custom solution, on their own, that does everything they need and want. This solution will likely have a longer life because it's the latest generation of technology.

Other hospitals arrive at a state of deconstructed PACS readiness when they experience a fundamental environment change, because systems that used to work well no longer do, noted Paul Pierre, president and enterprise imaging architect at DISYS Consulting. Mergers and acquisitions top this list of changes, when systems can't easily absorb and integrate new hospitals with old systems. He also shared some of the top perceived challenges he's seen amongst provider organizations.

Challenge #1: "Our solution isn't broken. It doesn't need to be fixed."

Legacy PACS are tied to vendor-specific solutions, which means that all components are designed to work with—and work best with—other one-size-fits-all components from that vendor. They are delivered as a packaged solution. Add-on integrations are available to add functionality, but these come at the price of third-party expenses.

In contrast, deconstructed PACS employ neutral components as a custom solution for institutional needs. These deconstructed architectures hinge on three best-of-breed components: a vendor neutral archive, an enterprise viewer and an enterprise workflow/worklist solution. These components remove two major legacy PACS

issues—interface challenges and workflow inefficiency— primarily because: They are vendor agnostic, support modern technology and are standards-based. They work flexibly with solutions from other vendors, and integrate with existing informatics systems, including the EHR. This removes the need for proprietary interfaces. This argument hinges on the idea that the legacy PACS is meeting the individual needs of radiology staff and referring physicians, as well as the overall needs of the hospital. While this may be true for some organizations, the argument falls apart as operations grow more complex.

As Pierre noted, a hospital network in acquisition mode often realizes communication difficulties when its new members' PACS are aging and from different vendors, and viewing studies are limited to the hospital where they originate.

Another area where legacy solutions have lagged behind enterprise components is mobile and remote access. It's critical that the PACS infrastructure securely support radiologists when they are outside the hospital's walls. As the newest generation technology, many enterprise components not only factor in mobile access, but build functionality for this purpose.

Challenge #2: "We're not sure we have the comfort or skill level to create our own solution."

This is a common concern among smaller hospitals and health systems. Building a customized best-of-breed solution requires more resources

than smaller hospitals typically have, Gray noted, and is a primary reason that large networks have been early adopters of deconstructed PACS. It's simpler and often effective to update the legacy PACS already in place.

However, options exist for hospitals that want to take advantage of the latest technology and implement an enterprise solution to improve mobile access or consolidate systems. In the future, systems integrators may come to market with a PACS based around the latest technology, Pierre noted, which will feature the advanced functionality of today's technology delivered in a packaged solution.

Challenge #3: "Our team doesn't want to learn new tools."

New technology is often met with resistance, and training is critical to overcoming these hurdles. There are long-term benefits to consolidating and aligning different departments and provider network locations on the same system.

Resistance to adopting new tools isn't always the case, particularly when longstanding barriers are leapfrogged through the use of innovative, deconstructed approaches. Patrick Ward, Central Illinois Radiological Associates' (CIRA) chief information officer, noted CIRA overcame access concerns by three methods—relying on standards-based reporting, offering a workflow to physicians about how to access data within the system, and including role-based permissions so only those involved in the patient's care could access the records. Physicians sending studies to radiologists at different locations no longer have to think about which system they're using to prepare and mark a study for review. Radiologists reading studies from different locations can eliminate inconsistencies to create more consistent, higher quality reports for physicians.

Challenge #4: "It's too expensive."

Access to capital is one of the biggest challenges to replacing a PACS. While it's usually less expensive to extend a support and maintenance contract for a legacy system, the cost of "status quo" operations will inevitably catch up, and hospital executives will find themselves being forced to make reactionary decisions. In terms of upgrades, stakeholders may feel or believe the perceived gain is not worth the direct and indirect costs, the cost of organizational change, or risk of the upgrade.

The full suite of deconstructed system components—enterprise viewer, enterprise workflow and VNA—may be more expensive than new legacy systems. However, for hospitals that examine hidden costs associated with inefficiency and third-party add-ons, the cost difference is neutralized. Gray noted that some of his clients who already had a VNA in place and have implemented a deconstructed PACS strategy saw economic returns. For example, if the cost of deconstructed PACS elements, not including the VNA, equals "X," his clients have found legacy solutions can cost up to 140 percent of that figure. The increase in cost comes from add-ons required to achieve desired functionality. On top of this, many legacy PACS vendors will not deduct the cost of an archive from the total price, even if a VNA is already live and in place, which can be seen as an excess expense.

Another strategy that hospitals CFOs are increasingly embracing to acquire the latest imaging technology and overcome capital hurdles is a utility-based payment model, said Brad Swenson, Winthrop Resources Corporation's senior vice president and chief product strategy and business development officer. This model works similarly to paying one's utilities, where a monthly "operating" fee covers all expenses associated with imaging capabilities. It allows health care organizations to quickly respond to demands for new imaging technology and functionality without funneling large sums of up-front capital to the expense.

Swenson added that he's seen cost benefits linked to upgrading hardware. For many industries, including health care, the cost to support legacy systems increases as technology ages. By taking advantage of the newest technology, hospitals can better control these support cost increases as they relate to enterprise imaging.

When measuring return on investment, look beyond the budget.

A deconstructed PACS strategy is an investment that's often met with skepticism because return on investment is not specifically or exclusively cost-related. Trying to measure a specific cost-related ROI isn't simple, especially when you take into account elusive hidden costs. How much does it really cost for IT to develop and support custom interfaces for legacy system add-ons? What is the opportunity cost of radiologist wages paid for inefficiency? What is the long-term cost of referring physicians not knowing which image viewer to use, and when they do, not having timely access to the images and the tools they require? When your CEO says you have 90 days to figure out an enterprise imaging strategy for the new hospital your system just acquired, and you don't have a plan, what is the cost? How do you put a value on patient care?

ROI for deconstructed PACS is linked to hard and soft benefits that ultimately affect the bottom line. These returns include enhanced efficiency and provider productivity, better access and integration, lessened IT stress and, most importantly, improved patient care. Adding together these ROIs, health care institutions can find a measurable strategic advantage in their market.

ROI #1: Radiologists and physicians can work more efficiently and productively when they have the right tools, at the right time. Salary better matches workload.

In 2013, average radiologist pay was $340,000. As one of the highest paid specialists on staff, it's critical that productivity levels stay as close to 100 percent as possible to get the best return on salary investment.

But if the legacy PACS only allows radiologists to be 75 percent productive by reading studies and creating reports, 25 percent of their time is lost to workflow issues like logging in and out of different systems, waiting for priors and returning inadequate secondary captures for repeats. That equals almost $85,000 paid for unproductiveness per year per FTE.

Ward said CIRA's primary goal by transitioning to a deconstructed PACS solution was to make sure their radiologists were as close to 100 percent productive by volume as possible. By solving inefficiencies with a best-of-breed system, CIRA boosted its radiologists' productivity, improved patient care and eliminated paying for inefficiency. (See the full CIRA story at the bottom of the next page.)

ROI #2: New hospitals and partners can more easily integrate into existing networks and access systems.

Legacy PACS frustration often culminates as new hospitals are added to a distributed health system. Data can be problematic to access, and for periods of time all data, studies and reports may be restricted to the four walls of that acquired hospital.

However, with a deconstructed system, the health provider has the advantage of a foundational, enterprise system at the core. When new hospitals are acquired, the core deconstructed PACS components are simply extended to the newly acquired locations. New imaging studies from those locations are redirected to the VNA to aggregate all of the enterprise's images centrally. Workflow, established at the enterprise level, is extended to the new locations for local optimization, but also to enable radiologist interpretation from any location across the health system. Finally, because the enterprise viewer is thin-client, literally overnight radiologists and referring physicians at the new locations can be using the same viewer that is used across the health system, and linked from the enterprise EHR. The legacy PACS will only be live for the duration

CIRA succeeds with deconstructed PACS

In 2009, Central Illinois Radiological Associates (CIRA) decided to face off against its PACS. As a group of 78 radiologists that provides subspecialty coverage to a variety of geographically distributed hospitals in its region, its team of radiologists was hampered by its workflow.

"We needed to bring the workflow together because our physicians were reading on different systems throughout the day," said Patrick Ward, CIRA's chief information officer. "On average, it took them 15 minutes to log in and out of a system. When you're working on as many as 13 systems throughout a day, that's untenable."

Ward said PACS was the group's problem. As a private practice group, they work on volume. And some of their physicians' reading productivity, specifically those at remote facilities, were less than a third of their expected reading volume because of issues with the systems' bandwidth.

The radiology group's primary goal by transitioning to a deconstructed PACS strategy was to ensure their radiologists were as close to 100 percent productive by volume as possible. This was especially true for radiologists on site at small, critical access hospitals, whose ability to efficiently access studies was often limited by network bandwidth.

Ward turned to a deconstructed strategy, which was initially met with skepticism. However, thanks to a skilled IT staff to design and manage the system, as well as relying on standards-based reporting, CIRA has seen an ROI for their system that couldn't have been realized with a legacy PACS.

The first ROI was what they hoped – radiologist efficiency. All physicians are 100 percent FTE by volume with the new system. A second ROI was realized as hospitals within their network asked to buy into their system. CIRA had created a state-of-the-art system that previously was out of reach for small hospitals. However, by constructing a contract option according to Stark Law, CIRA was able to share its system by passing through some of the deconstructed PACS' cost to interested partners. And the third ROI, Ward said, is what health systems are striving for with their PACS: better care through technology.

"If we consistently produce better quality results, with the volume needed to meet the needs of hospitals, we've improved patient safety, the delivery of care to these patients and the technology for the hospital," Ward said. "That's Imaging 3.0."

of archival study migration to the VNA, and once that is complete, it will be turned off. This process is repeatable, sustaining growth at the enterprise level, while also enabling the health system to fully realize the benefits of the newly acquired hospital(s).

ROI #3: Fewer systems alleviate IT department stress.

PACS management is a challenge for more than physicians and radiologists. The systems also challenge the enterprise IT department, especially when multiple PACS, workstations and viewing solutions are being used.

For example, an institution may have separate workstations for advanced visualization (3D/4D), PET/CT, echocardiography, PET/ MR, brain perfusion, etc. They may have a dedicated PACS for radiology, cardiology, breast imaging and other specialties that all have their own viewing workstations and isolated image archives. Each of these PACS also provides image access to referring physicians with their own clinical viewers. For health systems that have grown by acquisition, this could be an enterprise IT burden of dozens of image viewers, workstations and multiple variant PACS. To maintain these systems, enterprise IT has to monitor and manage all the different system/viewer permutations. Add into that end user training, help desk support and interface management for multi-vendor systems, and the pressure keeps mounting.

One of the significant benefits of a best-of-breed enterprise viewer is advanced clinical capabilities, Pierre added, such as the ability to

interpret specialty studies like breast imaging and PET/CT all on the same viewer as standard studies, including breast MRI. By having a single viewing platform and enterprise workflow, it becomes simpler for IT to maintain. Streamlined, consolidated environments free up hidden costs, especially those related to updates and system management. Now, for example, instead of needing 15 workflow update variations for different systems, one update can be implemented. In addition to benefits of consolidating systems, this creates additional benefits by saving FTE time and effort and being more nimble as an institution.

ROI #4: A better system means better patient care.

When it comes down to it, improving patient care is the end-goal of a deconstructed PACS strategy. Enterprise systems work faster and smarter, without requiring the radiologist to get out of their chair. Radiologists can access new imaging studies and all relevant priors quicker, and communicate reports back to the referring physician sooner, netting faster results for the patient. Some enterprise viewers can also stream images directly to radiologists, whereas legacy systems have to first archive the images, then send to the local client workstation for the radiologist to be able to display the studies. With direct streaming, the radiologist can see the studies extremely fast, and request different views before the patient has been departed, reducing the patient's radiation exposure, time on the table, and potential for repeat unnecessary imaging, Ward said.

Another benefit that's just being realized is the ability to integrate

Finding ROI in Deconstructed PACS

studies directly into the patient's record in the EHR. This benefits everyone – the radiologist, the referring physician, clinicians and the patient – because it brings radiologists into the care team. By understanding the patient's health history, the radiologist may be alerted to areas of focus in the study beyond what has been conveyed in the order from the referring physician. Similarly, when a patient comes back for additional treatments, the physician has quick access to prior reports, pathology, labs and more to better understand health history. This all nets outcome benefits for the patient and his or her future health, which is increasingly important to meet Affordable Care Act and Meaningful Use requirements.
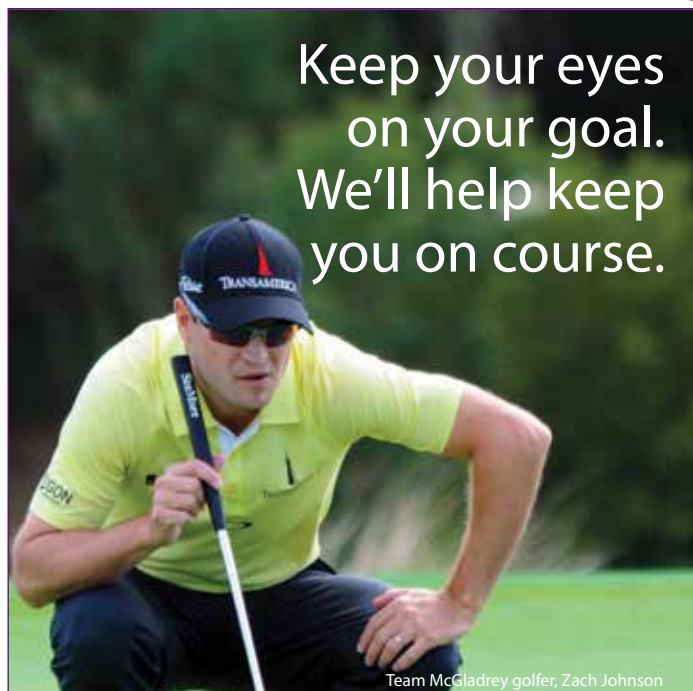
The ultimate ROI and the future of the market

Innovations are coming to make deconstructed PACS solutions more accessible to smaller community hospitals. Currently, some enterprise solutions can be developed as stand-alone PACS, but some forecasts include developing a new market altogether, where new vendors begin to assemble their own best-of-breed, component-based PACS solutions to offer as a package.

Supporting this shift is the strategic advantage realized by institutions that have already demanded a better way forward. Strategic advantage is the ultimate ROI, the outcome of efficiency improvements plus advanced functionality and better patient care. It is the ability to be more flexible, nimble and responsive through technology. Smart financing strategies, like a utility-based payment model, further enhance this advantage because it removes the budget barrier, to transform a conversation from one about capital to one about patient care and market position. By tapping into new technology and established financing options, health care institutions can find their own advantage in the market.

Is a deconstructed PACS strategy right for you?

1. Has your health system grown in recent years through acquisition, and as a result, are you managing multiple PACS from a variety of vendors?

2. Is your health system growing, targeting additional acquisitions as health care continues to consolidate? If asked today to incorporate a new hospital into your current PACS, are you prepared?

3. Are the imaging services of your health system competitive, or are you looking for competitive advantage?

4. Is your health care institution perceived as a technology leader, or a follower?

5. Has your health system implemented an enterprise EHR, connecting all providers and caregivers, enabling a single point of access for imaging?

6. Are your clinical viewers a point of contention with your referring physicians? Have they impacted patient care and reduced your referrals?

7. Have the capabilities of your legacy PACS become an organizational barrier to adopting new modalities, new workflows and patient care improvements?

8. Have you been required to implement inefficient workarounds and make sub-optimal business decisions because of the limitations of your legacy PACS system(s)?

For more information about financing options for enterprise PACS components, email info@winthropresources.com or call 952-936-0226

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Building a Denial Infrastructure

BY STEVEN STOCKI

Developing a denial strategy that incorporates effective reporting and corrective and preventive processes leads to more efficient revenue cycle operations.

One threat to the bottom lines of successful hospitals and health systems is loss of revenue from denied claims. Pre-denials (edits), initial denials, and appeal denials, require additional staff time and resources to resolve. In response, revenue cycle leaders can build a denial infrastructure that ensures the right processes are in place to identify, prevent or reduce, and resolve reoccurring denials.

Most revenue cycle leaders track accounts receivable (A/R) aging, A/R aging by payer, and the number of denials. However, revenue cycle leaders should consider less commonly used reports that add value to revenue cycle operations and denials management. Most of these reports with the correct Excel™ scripts can be easily automated and require minimal resources to maintain.

Using Reporting to Detect Denial Problems

Revenue cycle leaders can't fix a problem without knowing what to address. The following reports are designed to get to the level of detail needed to identify "revenue leaks."

1. Clean claim rate. This report will show the quality of the claims produced and how much extra work revenue cycle staff are doing because of incorrectly completed claims. These reports are best run at the end of the day. At minimum, the following data fields are needed to run a clean claim report:

- Total charges billed
- Total charges held up because of an edit
- Total charges successfully submitted

In addition, request the data by date of service (DOS) to check how quickly claims are being submitted along with claim ID, Service Department, Rendering / Supervising Providers/ Diagnoses, Procedures, Primary / Secondary Insurance, billed amount, user who created the claim, etc.

2. Edit/denial work queue. A hospital's practice management software should have a report function to show all claims in edit status or those that have been denied. Use the VLookup function in Microsoft Excel® to categorize each denial code into a specific section. (This helps simplify the different denial reasons by payer and your department's custom billing rules.)

First, create your VLookup table, input VLookup into A/R data in Excel™, and run your report.

3. Reassignment reports. Reassignment reports detect the "ping-pong effect," where claims are bounced between different departments for resolution. This causes frustration and increases A/R aging along with other negative effects.

Run reassignment reports to show the claims that most often are kicked back to other departments or staff. Pull a sample of 30 claims and determine why they are being kicked to other departments. If the reasons are valid, adjust the denial routing process. If not, provide user

Building a Denial Infrastructure (continued from page 18)

training and discipline if necessary.

Finally, run reassignment reports at the end of the month. Revenue cycle managers have the highest probability of catching those "inappropriate kicks" as staff move claims off of their desk to create a clean work queue for month-end productivity reporting.

4. Logic-based edit/denial reports. These reports should reflect the last three months of denial data to be used as benchmarks. Timeliness of information is critical. You don't want to hear about a massive spike in denials months later because a new hire wasn't trained properly on procuring referrals, especially with payers that do not backdate referrals or authorizations.

One solution is to set dollar thresholds for edits/denials, so when you see numbers go above that threshold, you can take action. For example, historically, a revenue cycle department has experienced no more than $5,000 in denied Medicaid claims due to no referrals on a weekly basis. But one week, a revenue cycle leader notices that $9,000 has been denied from Medicaid due to no referrals. Corrective action can be taken before additional revenue is lost.

Applying Corrective Processes

Implement the following steps to build on revenue cycle reporting efforts.

1. Bring denial analyst/trainers on staff. FTEs with coding, clinical, and billing experience should be dedicated to examining these reports and providing training. The Medical Group Management Association's Cost and Revenue Survey Report offers guidance on staffing ratios. For example, if documentation fails to support medical necessity, FTEs should use their experience with clinical documentation to train physicians.

These FTEs provide the link between those who run the reports and the physician offices. Do not rely on email communications to fix problems. Denial trainers should provide training and monitoring using face-to-face communications. Although it may be more costly to have in-house analysts and trainers, their presence is likely to deliver a positive return on investment.

2. Methodology. Next, connect the data and dedicated staff.

- Sort A/R edit/denial inventory reports by practice locations, determine the root causes of problems, and collect the past six months of denial analytics for these practices to determine whether increases in denials represent unusual spikes or consistent problems.

(Do not include claims with DOS as far back as two to three years because it is likely that significant changes have occurred since then.)

- Build data on these offices, including clean claim rate, edit/denial data (aged), write offs (recent), notes, and training schedules.
- Instruct denial analysts/trainers to visit the office locations and provide training with support to answer questions after the trainers leave.
- Monitor efforts by evaluating whether the training worked, whether the clean claim rate increased, and whether denials are declining.
- Group as many activities as possible to increase efficiency (e.g., Determine if a problem experienced in one office is also present in others).

3. Implementing Preventive Processes. In a perfect world, every

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claim created would be paid on time without any problems. However, people are not perfect, and they make mistakes. Revenue cycle leaders are in a position to incorporate the following processes to help prevent mistakes from occurring and improve denial infrastructures.

4. Payer updates. Frequently, payers will change their billing rules for claim adjudication. In response, revenue cycle departments should have a process in place where these updated billing rules are incorporated into the billing software's claim scrubber.

An updated claim scrubber is vital as it influences the clean claim rate. For example, if a claim scrubber is faulty (lacking adequate rules), the clean claim rate will be sky high. However, by reviewing denials, it will be evident that the clean claim rate is inflated because payer rules were not adequately reflected during claim creation.

Staff who update the billing software rules should examine why denials are occurring. For example, if a certain CPT is causing denials, they should build a rule into the billing software to prompt staff using that CPT to call the insurer for a procurement authorization. This authorization is important especially for add-on CPTs (unscheduled services) that have a 48-hour time limit to procure the retroactive authorization for that rendered service. If you wait for the denial, it may be too late.

Overall, billing software staff should have a clear communication channel with the denial analyst/trainer.

5. Internal claim audits. At the end of each week, team leads or managers should pull 10 claims handled by their subordinates. Grade these claims on how well they were worked (e.g., adequate notes, missing information). If the grade is high, extend these audits to a biweekly or monthly basis. If the score is low, increase the oversight and provide education.

Position these audits as learning opportunities that advance staff knowledge and make them more effective in their jobs.

6. Staff incentives. Front-desk staff have a variety of duties answering calls, talking to patients and physicians, scheduling appointments, handling referrals on top of working front-end related edits and denials. How can revenue cycle leaders motivate them to assist with denial management by running insurance eligibility checks on patients, capturing the right information and checking referrals and authorizations?

Successfully motivating staff is what separates managers from leaders. Managers drill down and identify what needs to be done. Leaders inspire and find a way to motivate. Some managers give bonuses, gifts, and higher salaries. Money does produce results, but people are motivated by something more enticing than money: self-satisfaction.

Instill pride in staff accomplishments by sharing their results and how they rank among their peers. Then, thank them for their efforts, not through email messages they get hundreds of those per day but through face-to-face communications.

Steven Stocki MSA, CIA, is an information systems and revenue cycle analyst, Steward Medical Group, Boston (Steven.Stocki@Steward.org). This article was originally published in HFMA's Revenue Cycle Strategist newsletter. Learn more about HFMA newsletters at hfma.org/newsletters

HFMA Committee Updates

CHFP Certification

BY LAUREN C. MARZURSKI

Have you ever wanted to pursue that coveted Fellow designation? Did you know that certification is a key step in becoming a Fellow? The Board of Directors and Chapter Officers support and encourage all members to become certified by HFMA. Please reach out to a member of the First Illinois Certification Committee to hear about how our chapter provides exceptional opportunities to members in the process of earning their CHFP including educational materials, study courses and waived examination fees.

Starting this year, HFMA has restructured the CHFP exam. Check out the information below to learn more about the new CHFP process.

Changes to HFMA's CHFP Certification Program

HFMA's strategic vision characterizes the current healthcare business environment as the transformation of care to achieve value. Providers, physicians and payers are all confronted with new business challenges. The nature of the business environment and its impact on industry stakeholders supply both the demand for and elements of a new approach to the CHFP.

New CHFP program features

A *learning* program designed to build comprehensive industry understanding and sharpen business skills; Two-module structure:

- **HFMA's Business of Health Care -** Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance and managing financial resources.

- **HFMA's Operational Excellence exam -** Healthcare Industry Stakeholder's Business Challenges; exercises and case studies on the application of business acumen in health care.

Why is the certification program changing?

The healthcare reform environment has caused the industry's key stakeholders—providers, payers and physicians—to fundamentally rethink existing business models. Care transformation is business transformation. The necessary success factor for finance professionals today is change-oriented business acumen. The existing certification program focuses narrowly on applied finance and financial reporting and does not address the business environment.

Earning the CHFP

It is important to note that the CHFP credential is awarded upon successful completion of module I end of course assessment and module II case study exercises and exam. HFMA membership is required for module II.

CHFP and FHFMA Certification holders

Individuals who have earned the CHFP (and Fellowship) prior to 2015 are not affected. Also, the new CHFP and how the program integrates with the Fellowship (existing FHFMA) are not affected. Both programs are on the same "knowledge – competencies" continuum. As such, they are integrated and not in opposition in three anchors: knowledge base, competencies-skills and currency-relevance.

Interested in learning more? Please reach out to Bart Richards, BRichards@TheClaroGroup.com or 312-546-3405, or Tim Stadelmann, Tim.Stadelmann@advocatehealth.com or 224-783-2954, of the First Illinois Certification Committee for more information.

Just Launched - First Illinois LinkedIn Group

"The First Illinois Provider Value Committee is pleased to announce the launch of our First Illinois LinkedIn Group. The First Illinois LinkedIn Group is intended to allow Chapter members a venue for discussion around important healthcare finance topics. So, please feel free to provide ad hoc content on current issues you are facing, allowing organic/unsolicited content that our community will want to hear and share.

Submit an Article for Publication in FI HFMA Newsletter

The FI HFMA newsletter is sent to over 1,000 healthcare industry leaders every quarter. We are always looking for "content" for our newsletter. And it's a great way to keep the local flavor to what we produce, allowing us all to communicate information, learnings and stories. If you have an article you'd like to see printed in the FI HFMA newsletter, or a link to an interesting article, please let us know. Your contribution for "content" does not have to be a thesis. Many of the best articles are short case studies of how someone learned something and implemented it in their job/life to have a positive effect. We also do like longer articles with tables and graphs. But we'll take either, so long as it is an opportunity to facilitate knowledge transfer among and across our membership. Feel free to email FI HFMA Newsletter Editor Shane Ramsey with any content ideas at shane@witsmd.com.

Panel Discusses Post-Acute & Transition of Care at 2015 Fall Summit

BY VICKIE AUSTIN

On November 13-14, 2015, First Illinois HFMA members and associates gathered at the Fall Summit in Naperville to learn, connect and hear from experts in the healthcare financial management profession. Adam Lynch, 2015-2016 president of the First Illinois HFMA chapter, welcomed members on both days and on Friday he introduced Chad Beste, partner at PBC Advisors, LLC, as moderator of a panel discussion on "Transitions of Care" with the focus on post-acute care in a changing marketplace. Panel members included:

Chad Beste

Julie Feasel

- **Julie Feasel,** vice president, Kindred Hospital Division. Ms. Feasel is responsible for the oversight of five long-term acute care (LTAC) hospitals in the Chicago District as well as Kindred's Integrated Market in Cleveland, Ohio.

- **Denise Keefe,** president of the Advocate Post Acute Network, part of Downers Grove-based Advocate Health Care, one of the largest integrated healthcare systems in the nation. Ms. Keefe is responsible for overall strategic direction, fiscal management, business development, clinical, quality and human resource management of 800 employees.

Denise Keefe

Bob Molitor

- **Bob Molitor,** chief operating officer of The Alden Network, which employs over 5,000 staff members and manages 44 locations providing health care services across the continuum. Alden offers post-acute care, skilled nursing, assisted living, independent senior housing as well as care for the intellectually and physically disabled.

- **Jim Prister,** president and chief executive officer, RML Specialty Hospital. Mr. Prister has been the president and CEO of RML Specialty Hospital, a partnership between Loyola University Medical Center and Advocate Healthcare, since June 1996. RML has two locations—one in Hinsdale and one in Chicago.

Jim Prister

(L to R) Tina Nazier and John Bartell from Wipfli LLP, pictured here with FIHFMA member J.V. Maganti, share about revenue cycle management at the Fall Summit

Here are some takeaways from the panel discussion:

- Post-acute care organizations need to get ahead of the hospitalization process and break down silos within the care continuum. "We want to get more people to the right care at the right time," according to Ms. Keefe, getting patients "back home where they want to be."

- Although a small percentage of patients come to post-acute care hospitals, this is also the highest cost setting. Mr. Prister said healthcare professionals need to "change the discussion" around post-acute care: "These are not your typical patients." Ms. Feasel agreed. "Long-term acute care is only two percent of discharges but these are very sick patients," she said. "If they skip getting the care they need, it may cost more in terms of resource allocation."

- Mr. Molitor reiterated that not every patient is the same, and healthcare reform has changed the way Medicare responds to patient care. "There's ten times more communication in the acute care setting," he said. With hospitals being penalized for readmissions, it's even more important to manage to the right level of care, he said.

- Mr. Beste, the moderator, asked if skilled nursing facilities (SNFs) can make up for volume with a smaller network of providers, to which Mr. Prister responded, "LTACS are not positioned to absorb risk." He said the patient population is still too fragmented and the risk equation is more prominent. Ms. Feasel added there will have to be more risk-sharing. Mr. Molitor said that vertically integrated organizations have more control over expenses like durable medical equipment, hospice and pharmacy. "There has to be more than being part of a network," he said, citing the need for increased communication with managed care organizations. "We're willing to take risks but we also need to stay in business."

James Fason of CarePayment Technologies and Mark Brennan provide an update on the Telephone Consumer Protection Act

The panel discussed the need to educate consumers, particularly seniors, on their coverage. "Most people don't understand co-pays and deductibles," said Mr. Molitor, adding that it often falls to the admissions director to explain the complex nature of Medicare and supplemental insurance.

When asked how Medicaid changes have impacted services, Ms. Keefe said Advocate is managing through the transition with a focus on affordability and working within narrow networks. "You can't manage quality and cost if patients can go anywhere they want," she said. Mr. Prister said they are focused on authorizations and approvals because the national criterion for length-of-stay doesn't always make sense for their patients. The panel agreed that geography and physician preference play a big role.

The topic of the electronic medical record generated consensus that we're far from the ideal since there are still too many systems that don't talk to each other (even within health systems), and physicians still resist using computers. "Someday all the systems will talk," said Mr. Molidor optimistically.

What do the panelists see in the next five years? "Higher acuity of care," said Mr. Molidor, with hospitals being forced to get patients out of the hospital more quickly. "The right level of care at the right time," said Ms. Feasel, with an emphasis on building transitions and collaborations. "Longer-term quality outcomes that are metric-focused, aligned with partners," said Mr. Prister, followed by "Integration of post-acute care services," according to Ms. Keefe. Whatever the future, it was clear from our panelists that the right leaders are in place to tackle the thorny issues of balancing reimbursement issues with patients' needs in the post-acute setting.

Peter DeAngelis, Jr., discusses strategic repositioning from the perspectives of the C-suite

FIRST ILLINOIS HFMA'S

Managed Care Meeting

FEBRUARY 4, 2016

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First Illinois HFMA 2015-2016 Scholarship Applications Now Being Accepted

Applications Due March 11, 2016

The First Illinois Chapter of HFMA ("the chapter") is proud to announce its ninth annual scholarship program for its members and their children seeking higher education. Scholarship recipients are chosen by the Scholarship Selection Committee made up of representatives from the chapter.

The chapter is pleased to award five scholarships—one for $5,000, one for $4,000 and three for $2,000. The First Illinois HFMA application cycle is as follows:

- First Illinois HFMA applications can be downloaded from the First Illinois Chapter website: http://www.firstillinoishfma.org/

- All applications must be postmarked by March 11, 2016

- 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 31, 2016

The eligibility requirements for applicants for the 2016-2017 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.

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 in July 2016.*

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

Welcome New Members

Laszlo C. Tarjan
Associate Consultant
Grant Thornton, LLP

Manimeet Taneja
Director of Finance
University of Chicago
Medicine

Scott K. Hori

Kurt Salmon

Roger Russell
VP Finance
Palos Community Hospital

William Faber, MD, MHCM
Vice President
The Camden Group

Theresa R. Croghan
Advisory Consultant
Deloitte

Nitika Agarwal
Director of Pharmacy
Marianjoy Rehabilitation
Hospital

Christopher A. Lewis
Financial Analyst
Presence Health

Rizwan Ali
Manager - Revenue
Optimization
ZirMed

Michael E. Mahoney
Senior Financial Analyst
Advocate Good Samaritan
Hospital

Arthur Mami, Jr.
Director, Strategic Accounts
HBCS

Brian Brock
Ludi, Inc.

Scott Refness
Treasury Analyst
Edward Hospital

Michael Hogarty
Director
Merus Management Group,
Ltd.

James Petersen
Consultant
PwC

Lisa Marie Wallace
Director
Alexian Brothers
Medical Center

Janet E. Zeigler
Shareholder
Polsinelli PC

Taylor N. Staten
Applications Analyst
Rehabilitation Institute of
Chicago

Corie O'Lena
Manager Patient
Financial Services
Rehabilitation Institute
of Chicago

Dana Lach
Shareholder
Polsinelli PC

Keena Johnson
Program Manager
Northwestern Memorial
Hospital

Michael A. Smith
Transplant Business Manager
University of IL Hospital &
Health Sciences System

Melissa Zuro
Marketing Manager
Adreima

Bianca Mroz
Revenue Integrity
Data Analyst
Northwest Community
Hospital

Sara Sanchez
Staff Accountant - External
Reporting
Rush University Medical
Center

Debra F. Levin
System Director,
Case Management
Rush University Medical
Center

Brittany R. Sanchez
Analyst
The Claro Group

Stuart Rozzi
Regional Executive
TransUnion

Danielle Bowsman
Matthew C. McKinnie
Sr. HealthCare Consultant
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Dean N. Korolis
University of Chicago
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Van Dawson
Director, Enterprise
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Northwest Community Hos-
pital

Anita Miriyala

Mark Vages
Director Payer Relations
Philips: Home Healthcare
Solutions

Kristina Uelsmann
Analyst

Kyle C. Garner

Charles Wendler
Relationship Manager
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Vishal Shah
Student

Tarek Behery

Kristia Saraon
Student
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Tim Olivos

Zach J. Nobis-Olson
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Bank of America Merrill Lynch

Anum Mirza
Student

Kate Nicholls
Manager, Acquisitions

Laura Czopek, OTR/L,EdM
Occupational Therapist
Clearbrook

Lagail Jennett

Jennie Folk

Brad Caudell
COO
ClaimsWorks, Inc.

Trever Sweeney
Asset Manager
Ventas, Inc.

Bryan Ramey
Director, Value Point
Mitchell Planning Associates

Martha A. Heredia
Senior Financial Analyst
Advocate Health Care

Natasha Purshotam Saw-lani-Vuppuluri
Manager, Financial Affairs
Northwestern Memorial Health Care

C. Angelique Steccato

Shana Viken
Manager, Revenue Integrity
Northwest Community Hospital

New Member Profile

Natasha Sawlani, MSA, MBA
Manager of Financial Affairs,
Department of Medicine,
Northwestern Medicine

Questions:

What was your first job?

Evanston's, St. Francis Hospital. I was hired as the first ever intern for their Marketing & Public Relations Department! It was my first professional foray into healthcare, and it sparked my love of hospital which has dictated the rest of my career.

Why Healthcare Finance?

I think my process was more about what I didn't want to do. My father is a cardiologist on staff at a number of Chicago hospitals as well as the Chairman of Cardiology at Presence Resurrection Medical Center, and my mother is also a very respected physician. Growing up around my parents contributed to my passion to make a difference. I had a few jobs where, although they seemed exciting on paper, they weren't fulfilling to me (a little bit of a millennial, I know). I had worked in healthcare in a few different capacities—public relations, business development and taxation—but something was missing. I took a leap of faith and went back to graduate school at Loyola's Quinlan School of Business for my MBA and MS in Accounting. I met other students in my program that were HMBA candidates. After networking with them, I decided to dive right into healthcare finance in the hospital arena, and I've loved every minute of it!

Career Perspective:

Healthcare finance is an industry that is constantly changing. It requires not only patience but also diligence and passion in order to succeed. Healthcare finance is multifaceted, requiring you to "operationalize" finance and come up with creative solutions to succeed in the face of the challenging changes in the industry. The best lessons I've learned along the way are, "don't chase money, chase happiness," "lead by example," and "stay hungry, stay foolish."

Why HFMA?

I am looking forward to networking and meeting other like-minded and passionate individuals who want to make a positive impact in healthcare. I find myself the most excited and stimulated around those who are enthusiastic about their work. They get me inspired and dreaming! I'm looking forward to studying and earning certifications, attending events, sharing my experiences and, ultimately, getting more people involved in HFMA.

What are you looking forward to in 2016?

I am looking forward to the 2016 updates to ICD-10! Just kidding—I am really looking forward to being involved with HFMA, traveling, spending time with my husband and two dogs, and enjoying another Chicago summer—nothing beats summer in Chicago!

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

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First Illinois *Speaks*

HFMA's First Illinois Chapter Newsletter

HFMA Editorial Guidelines

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Style

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

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

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