First Illinois Speaks
hfma healthcare financial management association
HFMA's First Illinois Chapter Newsletter
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Believe to Achieve

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Captured Events & Updates

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The Financial Impact of Safe Patient Handling

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

With so much hype surrounding cost reduction through improving quality, hospitals need to identify initiatives that demonstrate an immediate and positive impact. It's obvious that if left-behind sponges and wrong-side surgeries are avoided, that quality will improve and, as a result, other financial risks will be eliminated. But what is the financial impact of improving on how patients are handled?

There are many variables that factor into how patients are handled but common practice for years has been people moving people. This formula, even when carried out by an experienced lift team, presents a risk of patients or employees getting hurt. In both cases, such incidents produce unfavorable outcomes that can have material and negative financial impacts on an organization.

When an 85 year-old grandmother breaks a hip or sustains head trauma as a result of a fall in the hospital, new costs become part of the equation. Because these costs are associated with a hospital acquired condition, they will no longer be reimbursed by the Centers for Medicare and Medicaid Services (CMS). Additionally, the family may see this as a reason to take legal action against the hospital, a highly probable situation if the injury from the fall proves fatal. Examination of several past malpractice cases that had similar characteristics indicates that it isn't unrealistic for settlements to reach $1 million or more.

Without the proper patient handling equipment, it can be challenging to provide care, especially for frail and obese patient populations. The risk for a fall or for the development of hospital acquired pressure ulcers (HAPU) is high. In 2007, CMS estimated that the treatment costs of a stage 3 or 4 HAPU costs $43,000 per incident. Furthermore, an article from researchers at New York University that was published in the American Journal of Surgery in 2010 documents that stage 4 HAPU costs are higher than CMS estimates and can exceed $125,000 over a two plus year period of time

Handling patients is an occupational hazard for many caregivers. When an employee gets hurt handling a patient, it costs the hospital dearly in the form of workers compensation exposure, productivity, employee satisfaction, retention and cost of labor for replacement coverage.

Quantifying costs associated with patient handling can sometimes be a challenge. The Metropolitan Healthcare Council analyzed data from twenty-five

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Exhibit 1 Safe Patient Handling Avoidable Costs		Achievable Reduction Target (18 months)	Potential costs out of the System
Sample size = 25	25		
Reported wage index data	2009		
Total staffed beds	4,768		
Total admissions	190,720		
Total workers compensation costs as reported	28,780,354		
Conservative estimate of works compensation cost attibuted to patient handling (35%)	10,073,124	60%	6,043,874.34
Estimated cost of turnover and staff replacement	57,216,000	20%	11,443,200.00
Cost of falls (80% census, 2.5 falls/1000, 75% no injury)	6,593,376	20%	1,318,675.27
Cost of HAPU's using published FAPU rate of 3.5%	73,060,064	20%	14,612,012.80
Legal settlements	not calculated		
Cost of patient dissatisfaction	not calculated		
Total estimated avoidable costs	$146,942,564		33,417,762.41

Chicago area hospitals with some conservative assumptions aimed to measure the financial impact of patient handling incidents. The sample group represents a cross-section of the Chicago area market. The model summarized in Exhibit 1 indicates that the hospitals in the sample group have an opportunity to save nearly $147 million by implementing safe handling practices. The opportunity comes out to more than $5.8 million per hospital for these avoidable events. This cost doesn't take into consideration the avoidance of risk related expenses like the large potential settlements identified above and the impact of trickle-down patient dissatisfaction.

Many hospitals are equipping their organizations to transform how patients are handled. As an industry, we must strive to eliminate 100 percent of patient falls and HAPU's. The 18 month improvement targets have been achieved by hospitals that have focused on this issue, and the sidebar case study is one of many examples of hospitals that are having success in reducing unnecessary costs associated with patient handling.

Equipping a hospital is a start, but the real impact comes from changing the culture that embraces the use of new tools and techniques. Several conversations with hospitals that are eliminating these costs have indicated that patient lifting equipment is necessary, but it is only as good as an organization's expectation of how staff uses it. The real results come from changing a long-embedded culture of how patients are handled. One hospital leader interviewed explained that their organization implemented a safe patient handling policy which stated that non-use of the equipment could be cause for termination.

With reimbursements on the decline, the need to reduce cost is greater now than ever before. How patients are handled is low-hanging fruit that is actionable now and results in a reduction of the consumption of care that in the post-reform era will have no reimbursement attached to it. Better patient handling improves patient and employee safety and satisfaction while also reducing legal and workers compensation exposure.

CASE STUDY

Safe Patient Handling Program helps Methodist Medical Center.

Methodist Medical Center in Peoria, Illinois:

- 330 bed hospital with $330 million net revenues
- Mission statement: "Commitment to delivering outstanding healthcare. Period."
- Workers compensation costs, lost days and injuries were on the rise

In May 2007, Methodist became one of the first hospitals in Illinois to initiate a Diligent Safe Patient Handling Program. Utilizing a facility wide assessment with corresponding financial analysis paved the way for equipment purchase, planning, education and implementation. By integrating the program into their daily delivery of care it became part of their journey to achieve Magnet status as well as their Healthgrades© Patient Safety Excellence award.

Over the last four years, they have built a successful, sustainable program with a significant reduction in the number and severity of patient handling injuries as well as cost savings:

- 90 percent reduction in staff injuries
- Lost days reduced from 288 to ZERO
- Restricted days reduced from 2,363 to 29
- Litigated claims decreased or eliminated
- Significant workers compensation cost reduction: $292,180 – $9,324

Methodist continues to strengthen its program and is linking the program with clinical outcomes in the reduction of pressure ulcers and falls.

President's Message

Dear First Illinois Chapter Members:

As your new president of the First Illinois HFMA Chapter, I want to welcome you to our new Chapter Year of 2011/2012 as of June 1st. I am honored and privileged to serve as your President for this year.

The theme this year is "Why Not". The origin of this theme comes from the June 1968 speech given by then Presidential Candidate Robert Kennedy who said, "Some people look at things and ask why; I look at things and ask why not". This year, we are trying to make major changes and we have many ambitious goals for the Chapter.

Among them are:

1) As of mid-June, a totally revamped website. This will not only change the look and feel of our website, but will dramatically improve our capabilities to better improve communications with our members.

2) We are currently the #2 Chapter in the country in terms of total members (second to the Florida Chapter). It is our stated goal to become the #1 Chapter in the country by the end of our HFMA year (5/31/12).

3) We have increased the total number of full day educational programs by one (a total of nine) and have added twelve (12) monthly webinars which are provided free of charge.

4) Our Chapter Survey showed that members wanted more "social and networking opportunities." We will have eight (8) dedicated social programs and nine (9) networking programs (cocktail hour after each full day program) for a total of seventeen (17)!!

5) We have had tremendous success in recruiting and retaining Chapter Sponsors. Our goals for this year are to make sure our Chapter Sponsors are fully integrated with the Chapter and begin a new program for providers to become Chapter Sponsors.

I realize that this upcoming year will be another one of significant change for the Metro Chicago Healthcare Environment. We will see a tremendous number of mergers and acquisitions within our marketplace, further challenges to reimbursement, greater regulatory and compliance challenges, etc. Our organizational goal is to provide the highest quality education programs and industry resources to our membership so they can remain current on issues impacting healthcare.

The best way to utilize your HFMA membership is to get involved. Active participation in our Eductional Programs (whether as a participant or as a committee member) will not only provide CPE credits, but will help you establish other long term relationships. We will begin an active process in June 2011 to recruit members to actively participate in our committees. By participating more and connecting with your fellow members, you can become more effective and maybe have a little fun along the way.

I look forward to working with all of you to make this upcoming year a personal and professional success for you and the First Illinois HFMA Chapter.

Why Not!!!!

Patrick M. Moran
2011 – 2012
Chapter President,
First Illinois, HFMA

The Myths and Menace of Multi-Tasking

BY VICKIE AXFORD AUSTIN

Driving and talking on your cell phone. Sneaking a look at your Blackberry during dinner. Listening to a webinar on mute while preparing for your next meeting.

Welcome to the World of Multi-Tasking. Pressed for time and trying to do more with less, we're faced with multiple priorities in an environment with 24/7 access through e-mail, texting and the Internet. What's the cost to us—and to our organizations?

The Cost of Infomania

"In my role, I have to take time out of my day to think strategically about an issue," said Dan Yunker, vice president and CFO of Metropolitan Chicago Healthcare Council. "I may be deep in thought and then someone walks in the door, throwing me off target. Whatever that great idea was, if I didn't write it down, I have no way of recovering it," Dan said, adding the cost might be that "you don't know what you could have built."

Research supports that. Dr. Glenn Wilson, a University of London psychologist, did a study for Hewlett Packard on unchecked "infomania"— the addiction to incoming information such as texting, e-mail and phone calls. The irony is that rather than increasing our capabilities, multi-tasking makes us less efficient, according to an article by John Naish in an online issue of London's *Daily Mail*. Dr. Wilson's study demonstrated that being distracted by multiple priorities can result in a 10-point reduction in IQ—"worse than marijuana" and comparable to losing a night's sleep.

"The human brain doesn't multi-task like an expert juggler," Naish wrote. "It switches frantically between tasks like a bad amateur plate-spinner."

Multi-tasking can even risk our lives. Virginia Waterstraat, vice president of Strategic Reimbursement, Inc., in Elmhurst, swore off multi-tasking after a serious automobile accident in which she ran a red light while talking on her cell phone. She's now a single-tasker when it comes to driving and she insists anyone she's driving with do the same. However, Virginia understands the pull of multi-tasking. She says that if she's waiting for her computer to calculate something, she'll switch to another task to utilize her time wisely. "We're all cost-effective, conscious people," she said, "and I try to be very efficient with my time."

Toggling vs. Multi-Tasking

Perhaps it isn't multi-tasking that we're doing but rather "toggling" between tasks. Margie Saucedo, director of reimbursement for the University of Chicago, says that due to the nature of her job, she has "several pots going at once." About 70 percent of the time she's juggling tasks that need her attention, but "you need to know when you need [to put] your attention on just one thing."

Mike Hedderman, senior vice president of finance and CFO at Marianjoy Rehabilitation Hospital in Wheaton, agrees. "You're always getting that phone call from corporate or someone on the board who needs something right away… it's hard to take just one issue, one problem, and go from start to finish."

Gloria Mark, an "interruption scientist" and professor of informatics at the University of California at Irvine, found people who are diverted work faster but produce less. She coined the phrase "task switch cost," demonstrating that resuming concentration on the original task takes an average of 23 seconds. And people report higher levels of stress and frustration about their performance, according to a story in the university's *Quality Digest* by Taran March.

Clarity of Communication

Gregg Mylin, owner of Essayons Solutions, Inc., a healthcare consulting firm in the Greater Chicago area, sees a spectrum of people, from those who can't tear themselves away from their Blackberries to an attorney who allows his phone calls to go to voicemail when he's in a meeting. Gregg says the pace of our workloads is a factor and he favors writing a letter rather than firing off an e-mail when he's dealing with something critical.

"If it's important, slow down," he cautions. Gregg also tries to manage client expectations. As a sole proprietor, he says there are certain things he has to be "dialed in on," but he's cautious about responding too quickly when there's a need for clarity because "a quick response can be misunderstood."

Staying Present

We can't always tune out our phones and turn off our e-mail. But we can discern when a task needs our full attention. Linda Klute, national

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The Myths and Menace of Multi-Tasking

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healthcare practice leader for Tatum, has a habit that helps her stay focused.

"When I get a call, I turn my chair around away from the computer so I can focus on the phone call," Linda said. Like other healthcare finance executives, Linda has to "bounce" in order to stay responsive to her clients and her partners. But when it's important, "I try to stay present."

Dan Yunker believes that the higher one goes up the ladder of success, the less routine a job becomes and the more we need time for studied reflection. He sums it up like this: "I may have multi-tasked the day but not the issue."

Vickie Austin, founder of CHOICES Worldwide, is a business and career coach and a professional speaker based in Wheaton, IL. She turned off her phone and ignored her e-mails while writing this article. You can reach her at 630-510-1900 or vaustin@choicesworldwide.com.

Back to the Basics

BY JIM BOHNSACK, VP – TRANSUNION HEALTHCARE AND
ERIC CRITES, REGIONAL SALES EXECUTIVE – TRANSUNION HEALTHCARE

Hospital executives are focused on creating ACOs by consolidating IPAs with their IDN using an EHR connected to an HIE. MCOs are replacing FFS with P4P to support HEDIS. Everyone must replace ICD-9s with ICD-10s and convert ANSI x12 4010 with ANSI x12 5010 for HIPAA. PPACA and HITECH are providing incentives for MU and regulating MLR. Patients can use an HIE to select an HMO, PPO or CDHP with an HSA while viewing their PHI through a PHR.

When industry outsiders wonder why healthcare is so complicated, refer them to the paragraph above! A fragmented industry with competing priorities, antiquated technology and acrimonious payer and provider relationships have resulted in legislative action of historical proportions. So, entering 2011, how can we drive meaningful change?

Let's begin on the golf course. No, scrapping it all and playing golf is not the answer, although some of you might take that path. Golf provides some interesting parallels to healthcare in that it is complicated, frustrating and rewarding at the same time. The key to healthcare as well as golf is mastering the fundamentals.

Ben Hogan, the famed professional golfer, provided his insights in a book titled "Five Lessons: The Modern Fundamentals of Golf." In summary, Mr. Hogan breaks down the complicated golf swing into the fundamental aspects that will allow for a consistent, repeatable action. The stance, grip and posture are foundational aspects that when flawed create problems throughout the swing. When a swing does not produce the desired shot, it can usually be attributed to a faulty foundation.

The foundation of any good business is defined by people, processes and technology. Similar to the stance, grip and posture in golf, a flaw in any one of these key fundamentals can create poor outcomes. As the world of healthcare becomes more complicated, healthcare executives need to focus on the fundamentals of the business to improve results.

A prime example of a healthcare process that is becoming increasingly complicated is the revenue cycle. The core technology systems, patient management and patient accounting systems, are being overridden by "bolt-on" revenue cycle management applications. For each bolt-on application, the process must be redesigned and the people must be trained. Rather than jumping to yet another bolt-on application, healthcare executives need to consider the compounding complexity of that solution. Can you solve the problem in another way?

By focusing on fundamentals, the revenue cycle process can be simplified. Patient management systems (a.k.a. registration systems) can support many of the revenue cycle processes housed in bolt-on applications. For example, identity and address information can be integrated into the patient management system to notify the end user of discrepant information in real time. This allows the end user to focus on one application and correct errors in the core system that may have downstream processing ramifications. Ultimately, this type of process can limit the amount of training required and the technology support needed from IT.

Additional examples in the revenue cycle include insurance verification, ability to pay information, charity determination, claim status transactions and self-pay collection prioritization. All of this information can be integrated into a patient management or patient accounting system. By focusing on integrating the data rather than acquiring a bolt- on application, end users can optimize their usage of core systems, reduce the need for training and simplify their processes. In addition, this approach can limit the technology investment required for implementations, support and ongoing maintenance.

In today's complicated world of healthcare, focusing on the fundamentals of people, process and technology can yield real results. Rather than adding to the moving parts, review the underlying process and determine the optimal technology enhancements required to support the achievement of the end goal. Simplifying the process and streamlining the technology infrastructure makes training the people far more achievable and ultimately improves overall job satisfaction.

Whether you are fixing a slice or reducing denials, focusing on the fundamentals can yield significant improvements. Understand how the process is supported by the technology and how that enables people to facilitate that process. Reduce the moving parts, design a streamlined process and support that process with optimal technology design. The results will be right down the middle!

Grabbing the Reins of Your Self-Pay Population

BY DOUG KENNEDY, CSI FINANCIAL SERVICES

While Patients and Hospitals Struggle with Debt, There is a Win-Win Solution

The term "Perfect Storm" has been used many times during the current economic downturn. It is especially true when referring to the increasing challenges patients are facing while trying to afford healthcare.

Consider this: Employers are offering fewer benefits, which results in employees paying higher deductibles and more out-of-pocket medical expenses. Despite reduced insurance coverage, healthcare costs continue to increase, exacerbating the burden of medical expenses on the patient. The Milliman Medical Index reports that healthcare costs for a typical family of four increased 7.2 percent in 2009 to an all-time high of $18,074.

With unemployment at a 27-year high, fewer patients have any form of health insurance, forcing more patients to use their rapidly dwindling savings to pay for the majority, if not all, of their healthcare expenses. Patients are doing their best to pay their obligations and avoid being sent to collections, however, there are fewer lenders in the market and the ***Credit CARD Act of 2009*** has made it more difficult for most consumers to obtain credit.

Patients who are not able to meet the provider's minimum payment guidelines are being referred to collections, which in turn contributes to a deteriorating hospital-patient relationship.

The Perfect Storm shows no signs of letting up. As Health Care Reform becomes reality, insurance companies will be required to insure more people, resulting in even higher deductibles and additional strain on patients and the hospitals that will have difficulty collecting payment from the patients. A survey by **AMN Healthcare** revealed that approximately 70 percent of healthcare executives believe reform will hurt their facility's financial stability.

ClearBalance by CSI Financial Services, which provides patient-friendly loan programs, reports that the volume of loans being processed has risen dramatically over the past few years while the average loan amount has dropped from approximately $1,500 to $850 per patient. This statistic demonstrates that the rising cost of healthcare combined with challenging economic conditions makes it difficult for patients to pay a lump sum paymentof nearly any size.

While the Perfect Storm continues, the sun is beginning to shine on self-pay patients and hospitals. Healthcare providers are embracing with greater enthusiasm patient financing programs that give patients the ability to pay out-of-pocket expenses over time, which also can help reduce their bad debt and, importantly, also reduce their A/R days.

The relationship between a healthcare provider and patient is critical to the provider, the patient, and the community at large. Giving patients a financing option with greater flexibility to pay their self-pay balance will not only help preserve that relationship and improve the revenue cycle, but also increase census as patients continue to look for affordable healthcare.

For more information about ClearBalance, visit www.ClearBalance.org or contact Doug Kennedy via dkennedy@clearbalance.org, 858-200-9229

Hospital-Physician Alignment:

Managing Change in the Shifting Health Care Environment

BY FRANK MARSHALL, CHIEF OPERATING OFFICER, MEDSYNERGIES

These are times of great change in the American health care industry. The current level of health care spending in this country is unsustainable, so economic and legislative forces are demanding that health systems and physicians reduce costs while improving the quality of care they provide. Achieving those goals will require a fundamental shift in the hospital-physician relationship from somewhat adversarial to cooperative. Effective change management will be critical to getting health systems and physicians to work together across the continuum of care.

This article will explore what change management entails, particularly in the context of hospital-physician alignment. It will highlight some of the differences between health systems and physician practices that create tension, and it will outline best practices for managing the shift toward a more collaborative relationship between the two parties.

What is change management?

Change management is the function by which new processes, technologies, systems, structures and/or relationships are introduced into an existing environment. It focuses on the impact of what will change on those who will implement the changes. Effective change management will gain acceptance of the new paradigm from key stakeholders by minimizing the friction caused by the changes.

The elements of a successful change management strategy will be the same in any industry:

- Consensus on the outcome or goal
- Inclusion of stakeholders in decisions
- Redesigning roles, jobs and teams
- Open communication
- Detailed plan for execution
- Detailed plan for communication
- Detailed plan for development and delivery of training
- Agreed-upon metrics and key performance indicators to measure success.

Best practices for change management include the following:

- **Visible and active endorsement of the change from leadership:** Executives and other leaders must demonstrate that they have bought into the change, talk about it and generate excitement about it. A clear vision of the change should be produced and shared.
- **Repetition of messages from appropriate sources:** Employees like to hear messages from two sources: CEOs and their immediate supervisors. Furthermore, people need to hear a message 5-7 times before they internalize it. Communication themes and/or talking points should be developed before a change management project launches. The messages can be communicated by CEOs, supervisors, HR and other sources via any means available, including intranet, email, newsletters, bulletin boards, etc.
- **Two-way communication:** Messages must flow not only down the organization, but also up it. Employees will have questions about changes, and if answers are not provided, the information void will be filled with rumors and speculation. Something as simple as an email account for questions can facilitate the exchange of information and assure employees that their concerns are being heard.
- **Empowerment of people:** A broad base of people must be empowered to take action by removing as many barriers to change implementation as possible.
- **Definition of success:** Everyone wants to win, and part of the challenge of change management is defining victory so every stakeholder feels he or she can participate in winning.

How does change management apply to hospital-physician alignment?

To understand why a cooperative relationship between hospitals and physicians can be difficult to foster, one first must understand the traditional sources of tension between the two parties.

Health systems or hospitals generally are large, bureaucratic organizations concerned primarily with the efficient use of their capital and facilities. Physician practices typically are small businesses concerned with getting patients in and out the door and getting paid quickly for their services. As a result of these differences, hospitals and the physicians who use them will disagree over the number of nurses, amount of technology and other resources necessary to effectively care for patients.

Furthermore, physicians frequently believe hospitals lack the experience and understanding to oversee the practice environment. They may have been a part of, or at least have heard about, hospital-physician alignment efforts from the 1990s that were unsuccessful because hospitals failed to provide sufficient practice-specific management services to their employed physicians. Practices need to be able to act quickly to remain profitable, and physicians often feel the hospital environment prevents them from making business decisions with the appropriate haste.

Who will be resistant to change in hospital-physician alignment?

People in every industry dislike change because they fear losing control. Therefore, change will be resisted wherever it is not managed.

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Here are some of the stakeholders who might be opposed to the changes that greater hospital-physician alignment entails:

- **Health system administrators.** They will fear losing control over the deployment of capital and the service-line management in their hospitals.
- **Physicians.** Fiercely independent by nature and largely accustomed to working for independent practices, physicians can be frustrated by the loss of autonomy inherent in hospital employment.
- **Hospital employees.** Think, for example, of a hospital's technology department. They will have to provide a different level of service for employed physicians than they will for other hospital employees. This will force them to alter the way they operate.
- **Practice administrators.** They do not like ceding control of the front-desk and data-collection processes or the hiring and firing of practice employees, among other functions.
- **Practice employees.** They may be resistant to changes in benefits and to dealing with a health system's bureaucracy.

Who should manage change in a hospital-physician alignment initiative?

No individual can be solely responsible for managing change. The stakeholders involved in a hospital-physician alignment initiative must come together to gain consensus on expectations and goals in order to identify gaps and build a business plan to achieve their goals.

One way to help manage the competing agendas is to create a stakeholder matrix. In a stakeholder matrix, representatives from each constituency are interviewed, and their responses are compiled to baseline expectations and critical success factors. Next, a gap analysis is performed to identify and understand the road blocks between where stakeholders are today and where they want to be. After the gap analysis is completed, an action plan should be developed to help navigate the gaps and set priorities and goals in the form of a business plan. Once the business plan has stakeholder buy-in, quarterly updates in the form of a scorecard should be provided. Stakeholder buy-in at all project stages is critical.

Again, open communication is key throughout the entire change management process. The concerns and needs of stakeholders will change over the course of the project. Questions and feedback should be solicited at all project stages to ensure that concerns are being addressed and that stakeholders are progressing toward goals. In a hospital-physician alignment initiative, monthly meetings of hospital and physician leadership may be appropriate venues for seeking input and providing progress reports.

Health systems undertaking a hospital-physician alignment initiative should also enlist the services of a project management organization (PMO). A PMO is an independent group that will oversee the execution of the change management plan. The PMO needs to be independent from all the stakeholders in the change so they can see that the process is transparent and impartial.

What changes must be made to facilitate hospital-physician alignment?

To create a successful hospital-physician alignment model, a partnership between the two parties must be formed. Traditionally the physician does not trust that the health system is concerned about the physician experience, and the health system does not trust the physician to use hospital facilities efficiently. Trust between the two parties can only be established if both feel they are valued and equal.

Health systems can show physicians they are valued by creating a governance structure in which the physician group is on par with member hospitals. The president of the physician group should be at the same table with hospital CEOs, helping to plan and direct resources within the system.

Additionally, health systems can do more to recognize the essentiality of physicians – and not just hospital facilities – to patient care. Systems then must compensate physicians for the value they bring to hospitals. Systems can do this in a number of ways, including the establishment of co-management structures for service lines and gain-sharing for cost reductions.

Health systems also need to recognize that their bureaucracies do not mesh well with physician practices; therefore, they should help create a management services organization (MSO) that is aligned well with the specific business needs of smaller, nimbler physician practices. A well-executed MSO will not only keep physicians happy by allowing them to focus on medicine instead of business, but it will also help to optimize revenues for their practices, reducing hospital subsidies.

Physician practices, for their part, must give up some autonomy with regard to business processes and become more efficient. For example, the collection of data has to be consistent across all physician practices within a health system so it can be used to make quality and cost decisions. Patient responsibility policies also must be common across the system, and charity care practices must be standardized. In other words, physicians must work within the overall governance model of the hospital to create an environment where patient care is improved while reducing costs.

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Hospital-Physician Alignment: Managing Change in the Shifting Health Care Environment

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Lastly, both hospitals and physicians must recognize the need to become more patient-centric. Their focus should shift from episodes and CPT codes, for which hospitals and physicians have been paid under the fee-for-service model, toward patient outcomes, for which they will increasingly be paid in the future under bundled payment models.

A hospital-physician alignment initiative requires substantial change for both parties, and if that change is managed poorly, then the initiative is likely to fail amid an environment of distrust and animosity among the various stakeholders. However, if the change is managed well – with good communication and consensus on goals, execution plans and metrics – then there will be an environment of accountability, greatly increasing the odds of the alignment initiative's success.

As chief operating officer, Frank Marshall oversees integrations, accounts receivable follow-up, payment posting, as well as information management and technology for MedSynergies, Inc. Mr. Marshall focuses on data and information to determine the right business process and measurement for the corporation.

Prior to joining MedSynergies, Mr. Marshall was the vice president of planning and control at The Associates Financial Services Company, Inc., and was responsible for financial analysis, financial reporting and accounting.

He holds a Master of Business Administration from St. Mary's Graduate School of Business and a bachelor's degree in economics from the University of Texas at Austin.

The Undeniable Value of Effective Claims Management: Tips to proactively clean up claims for accelerated third-party payments

BY ASHLEY SONN

There's no denying the negative impact denied claims have on the revenue cycle of hospitals and health systems of all shapes and sizes. Denied claims not only inhibit final acquisition payment, they deplete valuable time, labor and resources put forth by staff members responsible for handling and tracking those claims. It's not implausible for providers to lose literally millions of dollars in denied or underpaid claims over the course of a year.

As burgeoning costs and tightened reins on spending come into play, the bottom line is at the forefront unlike ever before. Providers are keenly aware that clean claims processing is the priority of prompt third-party revenue generation and an immensely important cost cutting measure, but what are some other practical tactics that can be used to ensure larger, more complete payment? Here are some effective methods for claims management:

- **Conduct claims reviews**: When denials occur, it's essential to assess what went wrong in order to remedy issues in the future. By conducting examinations of erroneous claims, providers can pinpoint problematic patterns and respond with solutions. In tandem, such reviews allow for identification of correct parties for handling specific issues leading to even more honed opportunities to avoid future denials. Culling thorough information of denied claims should also entail the assignment of dollar values to those losses so that the entire organization may fully grasp the imperative nature of clean claims submission.
- **Train before the denial occurs:** Engraining a culture of awareness may help clean up claims submitted and minimize claim denial occurrences. There is a short list of highly common reasons claims are rejected, including questions about beneficiary coverage and coverage of services rendered to problems with duplicate billing and an array of procedure code inconsistencies. Of course, some issues may be specific to providers or systems. Pre-knowledge of these denial triggers can help staff take measures for prevention.
- **Create a cross-functional team to address claims issues:** Certainly, it's of great help to integrate best practices throughout a provider's entire operation. The creation of an assigned team to tackle claims denials is a large step beyond the aforementioned training. However, a responsible team can take issue identification and staff training to more targeted, purposeful levels. From ensuring frontline staff ask the right questions at Patient Access and financial

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The Undeniable Value of Effective Claims Management: Tips to proactively clean up claims…

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representatives follow stringent procedures for claims adjudication post-care, providers may find their claims more frequently accepted, effectively tracked and fully reimbursed. Built in mechanisms for reporting and tracking success will also aid in effectiveness of this approach.

- **Invest in automation:** The reality is, provider team members are often woefully busy. With the ever changing details regarding benefits and eligibility, it's nearly impossible to keep everyone on staff thoroughly and appropriately apprised in order to ensure clean claims submissions, let alone updates systems with standard codes and payer edits. The investment in automation is most certainly a transformative and valuable one.

Using these four tips to proactively manage claims correctly will not only lead to effective claims management, but you'll also have less to write off in the end. Those are two benefits with undeniable advantages every provider needs today.

Emdeon is a leading provider of revenue and payment cycle management and clinical information exchange solutions, connecting payers, providers and patients in the U.S. healthcare system. Are you ready for effective claims management and accelerated third-party payments? For more information, email Pat Blewitt, Regional Vice President at Emdeon and First IL HFMA member, at pblewitt@emdeon.com or visit Emdeon online to discover more about how to transform your claims management processes to positively impact your bottom line.

Can External Call Centers Benefit Hospital's Access Departments?

STEVE CHRAPLA, DIRECTOR 3RD PARTY SOLUTIONS, REVENUE CYCLE PARTNERS/A DIVISION OF AVADYNE HEALTH

For years it has been suggested that the revenue cycle process needs to focus more attention upfront/earlier in the process. Access Departments have been proclaimed as to holding the ultimate solutions to achieving successful revenue cycle operations. The chart above has been used for years to describe the revenue cycle. However, with all the challenges facing our industry it is time to take another look at the traditional ways Access Departments have supported this process.

Historically, providers have tried to address revenue cycle deficiencies or opportunities by focusing on the back end of the cycle. Improved claims processing technology, more resources assigned to collecting unpaid claims and unpaid patient bills, and many more approaches have been the focus for improving the revenue cycle. While all of these techniques can be cost effective and may also produce favorable cash flow results, has the time come to expand our scope of possible solutions?

Healthcare reform places additional challenges at the door of providers. The Patient Protection and Affordable Care Act, as it is currently written, establishes compliance requirements related to patient billing and financial assistance. Experts have professed such screenings to meet these requirements need to be done on the front end of the revenue cycle. This will place additional responsibilities and challenges on our Access areas.

Regardless of how this legislation looks in the future, one thing is certain and everyone agrees.

Providers will need to find ways to be more efficient and provide quality service for less cost. In addition, there is, for lack of a better phrase, the "consumerism impact" on healthcare delivery that is requiring providers to take a more patient centric approach. This means enhancing the patient's overall experience and increasing the level of satisfaction the patient has with their healthcare provider. These tasks will require the complete involvement and cohesive cooperation of all clinical and administrative departments within a healthcare organization.

For the Patient Access Departments, their primary objectives will need to include:

- A more patient centric approach to all interactions
- Increase the patient's satisfaction with the provider
- Reduce the level of net operating expenses
- Increase the level of financial and clinical screening
- Establish clear financial and clinical expectations for the patients
- Reduce the level of re-work in post-treatment revenue cycle functions
- Reduce payer denials
- Increase cash collections

With these objectives here are the metrics to measure success in the Access Departments:

- Pre-Access processing and time lines for completion
- Customer service and patient satisfaction levels
- Telephone call processing effectiveness
- Financial processing
- Operational improvements and cost savings

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Can External Call Centers Benefit Hospital's Access Departments?

(continued from page 12)

Is it time we re-think how Access departments have approached work flow and process?

Revenue Cycle executives have long discovered the benefits of critical outsourced functions used in the back end of the Revenue Cycle. Can some of these resources serve the Access areas? Consider external call center operations a resource in achieving the objectives facing the Access Departments.

Current pre-access processes require extensive telephone interactions that are often redundant, yet require a specific skill level of the staff. The process requires accessibility for patients that volumes often create cost efficiency challenges. Staff interpersonal skills are essential to successful patient interactions but often not available or developed with Access Department personnel. The latest technologies are often cost prohibitive or even beyond the resource capabilities usually found in Access Departments.

Modern call center operations are well established in other industries and even in healthcare; however with expanded reliance on the patient access and pre-registration function, the benefits of centralized call centers may be surprising.

Some of the functions within Patient Access that would benefit from a modern call center operation would include:

- Patient scheduling
- Medical necessity screening
- Pre-registration
- Pre-certification of services
- Eligibility and benefits verification
- Financial screening and counseling
- Pre-service collections

These pre-access functions can have a significant financial impact on a facility, and just controlling denied claims can increase net revenues by over 2%. The reduction in re-work within the business office can also be impacted by over 60%.

A properly structured call center operation can provide the following benefits:

- Increased patient and physician satisfaction
- Standardized processes for all service areas
- Timely efficient scheduling
- Expedited registration
- Improved financial metrics/lower costs and increased reimbursements
- Reduction in payer denials
- Expanded hours of operations
- Skilled staff specialized in patient communications
- Financial counseling specialists
- Staffing complement with cross training to meet variable demands
- Technology including IVR's, call recording and predictive dialing
- Presumptive charity screening technology with hospital specific criteria
- Management knowledgeable in high-volume call operations

As with the development of any operational process, the identification and monitoring of key metrics is critical. Here are some best practices and metrics an effective pre-access call center would achieve.

Scheduling

- 100% of non-emergent patients are scheduled
- All cases are scheduled 12 or more hours in advance of service
- All surgeries are verified against inpatient only list
- Collection of all information prior to surgery in accordance with clinical criteria
- Medical necessity is validated to prevent ABN's
- "OK to delay" criteria is established with physicians

Re-Registration

- 95% of all scheduled patients are pre-registered
- 100% of all pre-registered patients have insurance eligibility and benefits verified
- Identify specific service lines requiring verbal verification beyond electronic verification and obtain 100%
- 100% pre-certification on all required patients

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Can External Call Centers Benefit Hospital's Access Departments?

(continued from page 13)

- 98% Patient demographic data quality

Patient/Guarantor Communications

- All non-covered services are explained to 100% of patients impacted
- 95% of all out of pocket costs are requested from patient/or as guided by patients prior payment history
- 80% of POS collection potential achieved
- 100% of patients with outstanding AR will be counseled
- Charity care guidelines explained to 100% of applicable patients

Call Center Operations

- 80% of calls answered within 20 seconds
- 50 second average call hold time
- <5% abandoned call rate
- 98% complete resolution on 1 call

While the benefits may be overwhelming, the success of moving to an external call center model has many factors to consider, as well as understanding important stake holders. It is critical you understand the barriers to success. The physicians may feel they have less involvement with their patients or will not influence the communications with their patients. Management may feel a loss of control or that an outsourced service may have an adverse public relations impact. Hospital clinical departments may feel they are losing control and will be negatively impacted. Most importantly will the marketplace or patients view this negatively and that they are dealing with a remote external corporation that does not care about them. All important points to consider as you develop the project plan for such a venture.

Begin with by performing an analysis of your current operations and determine the current and future financial impact you are experiencing. A GAP analysis will allow you to identify the potential of your Access Departments as well as impact of future revenues as the result of enhanced patient experiences. Process design with key stakeholders will be important to achieve buy-in and ensure the most appropriate processes are being developed. Develop implementation plans and always over communicate to minimize misinformation. It is also important to indentify your external partner and bring them into the planning process as early as possible. This ensures a high commitment level and the development of a true "partnership environment."

Access Departments like all operational areas within hospitals will need to consider solutions to challenges that may differ from approaches in the past.

Revenue Cycle Partners, a division of Avadyne Health provides account resolution services for hospitals nationally that improve profitability while enhancing the Total Patient Experience through regionally located call centers. Call Steve Chrapla at 847-395-7655 to learn more about our Pre-Access solutions including FAsTag our presumptive charity program and how they can assist your organization.

Medical Loss Ratio:

Three Questions Illinois Payers, Providers Should be Asking

BY KATHLEEN O'NEILL

The scope of the Patient Protection and Affordable Care Act (PPACA) is broad and deep, impacting how health care and support services are delivered, financed and regulated. There are still many decisions to be made, creating opportunities to shape the implementation of the law so that it best meets the needs of the American people.

As with any legislation of this scope, the consequences of the bill are uncertain and the possibility of unintended impacts looms large.

Since March 2010, when President Obama signed the health care reform bill, states have been active in analyzing the reform requirements. Many have formed task forces or commissions to sort out those requirements. Illinois is among the states that have taken action – in this case the medical loss ratio (MLR) r equirement.

Illinois State Senator Heather Steans has proposed a bill, SB 1618, which would bring Illinois law into conformity with this core consumer protection established by the PPACA, according to Illinois Health Matters.

A medical loss ratio (MLR) is the proportion of premium dollars that an insurer spends on health care services and certain recognized plan administration costs relative to health insurance premium paid by subscribers.

Hospital financial leaders may think that the medical loss ratio regulation doesn't really impact hospitals and health systems. However, there's more to this policy than meets the eye for providers, reports HealthLeaders Media.

MLR, which took effect Jan. 1, 2011, has broad implications for federal and state healthcare expenditures. This policy addresses the amount of premium dollars spent on a member care by, payers and the ripple effect will affect providers.

Under the PPACA, there is now a mandated minimum threshold that insurers must comply with regarding spending on member care. For instance, the amount of the premium spent on member care would be 85 cents on the dollar for large groups and for smaller groups it would be 80 cents on the dollar.

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Medical Loss Ratio: Three Questions Illinois Payers, Providers Should be Asking (continued from page 15)

The PPACA requires health insurers offering health insurance coverage in either the group or individual (non-group) market to submit an annual report to the Secretary of Health and Human Services on their MLR and to provide rebates in circumstances in which losses exceed permissible levels (80% in the individual market and 85% in the group market).

Three important questions are emerging from this policy:

- Where will payers look to find ways to cut costs to compensate for the losses from MLR?
- What are the broader implications of this policy for providers?
- What can providers and payers do to comply with this regulation?

Brenda Snow, executive vice president of strategic planning, for Kentucky-based Firstsource, a global provider of revenue cycle management services, works with both payers and providers and she offers her thoughts on these critical questions.

1) **Where will payers look to find ways to cut costs to compensate for the losses from MLR?** They'll have to review areas where there are administrative functions that can be cut, as opposed to medical expenses. This could possibly be their call centers or their claims adjudications areas. Also, they'll need to look at how they spend in those areas and determine if these are areas of core competency or can they improve them through automation, such as creating patient portals so patients can better manage their own care. Lastly, the payers are really going to need to make a paradigm shift regarding how they manage patient's care—instead of managing chronic care, now they need to focus on wellness and preventive care.

2) **What are the broader implications of this policy for providers?** Payers are going to need people with different skill sets to work with patients on preventive care, such as life coaches and nutritionists. For insurers, this hasn't traditionally been something they offered as member care—but they'll need to now. Also, payers are going to have to work with patients and providers to improve the quality of care and try to prevent illnesses or disease.

The potential ripple effect of this for providers is if the payers are using more funds toward member care, then ideally over the long-term it should result in members being healthier. That in turn would result in

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Medical Loss Ratio: Three Questions Illinois Payers, Providers Should be Asking

(continued from page 16)

a loss of inpatient admissions … in theory hospitals should see a decline in those, and it would directly impact their volumes.

3) **What can providers and payers do to comply with this regulation?** Hospitals and payers will need to continue to look at new mechanisms for reimbursement and shift away from episodic and disease state care. They will have to work toward prevention and wellness. They also need to look at different reimbursement models and changes that can be made to current models to incentivize prevention and wellness.

Providers and payers are going to have to start a real dialog around this topic. A number of payers and providers are experimenting with this [different approaches to reimbursement for wellness care] already and they've become very creative, using approaches like group appointments. In the future, payers may reimburse more for group appointments than they've done in the past to achieve the long-term goal of prevention and wellness. The payer's new goal is to keep patients healthier and out of the hospitals, and that should cost them less in the long-term.

If the payers reduce their costs long-term then that's better for them, but also better because it means healthier patients. Moreover it's a good reminder that providers also need to think differently now in order to stay ahead of the curve too.

Hospitals and health systems need to invest more of their attention and dollars on outpatient and preventive care programs, lest they suffer financial losses when their inpatient volumes dwindle, reports HealthLeaders Media. It's truly the circle-of-life for the patients, payers and providers—everyone's ultimate health or demise depends on the other person moving in the same direction to stay healthy.

Contributed by Firstsource

Firstsource delivers complete business process outsourcing solutions for healthcare clients. For more than 20 years, Firstsource's proven operational strategy and comprehensive suite of innovative, technology-driven revenue cycle management solutions have been helping healthcare payers and providers improve cash flow, maximize reimbursement, reduce bad debt and create value nationwide. www.firstsource.com

HFMA Captured Events

CFO Session: May 5, 2011

BY AL STAIDL

A wonderful time was had by all at the CFO Golf Outing held on Thursday, May 5, 2011 at the Medinah Country Club in Medinah, Illinois.

Please be aware, as many of you know, we had to reschedule our 35th Annual Golf Invitational due to the terrible thunderstorms on the day of the event. Subsequently, **the new date is September 14, 2011,** and we will honor and recognize all paid sponsorship and registrations for the original date. We have reopened registration for the event; there is limited availability so register now! If you're not already a Sponsor, there are also a few sponsorship opportunities still open.

CFO 2011 Dan Yunker, Marsha James, & Donald Wegmiller

CFO 2011 John Cronin

Visit our New Website!

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

Recent Awards

The First Illinois Chapter brought home several National Awards from the HFMA ANI (Annual National Institute) in Orlando!! The chapter was recognized for the following:

1) **Gold Award for Excellence for Membership Growth and Retention**
   Our Chapter is not the #2 Chapter in the Country and grew at a rate 3 times greater than the top 5 Chapter!

   Congratulations to Roz Ryan & John Masini (Co-Chairs for Membership) and their Committee for their outstanding work!

2) **Silver Award for Excellence for Certification**
   Excellent job! Please look for an e-mail from John Masini about the chapter's upcoming Certification Study Group (paid for by the Chapter)

3) **Helen M. Yerger Award for Special Recognition for Innovation in Sponsorship**
   Our Chapter increased its Sponsorship by 84% in 2010-2011.

   Special thanks to Carey Lewis, Mike Dermont and Tim Heinrich and all of the Chapter Sponsors!

4) **Helen M. Yerger Award for Special Recognition for Innovation in the Development of our Compliance Program**
   Special recognition for the development of HFMA's first Compliance Program.

   Thank you to Grace Daigel and Patt Marlinghaus for making this Program happen!

Event Notifications

Night at Wrigley Field

Please join us for First Illinois Chapter HFMA Night at Wrigley Field on Monday, August 22nd, 2011 as the Chicago Cubs take on the Atlanta Braves. Game time is 7:05 p.m., with the pre-game festivities beginning at 5:30 p.m. in the Dugout Room of the Stadium Club located inside Wrigley Field.

The price for this event is $95.00 for HFMA members and non-members. Price includes:

- Ticket to the Cubs vs. Atlanta Braves game
- Admission to HFMA Pre-Game Party in the Stadium Club including buffet, soft drinks and beer (cash bar available)

The Stadium Club opens at 5:30 p.m., game time 7:05 p.m.

VERY IMPORTANT: Your tickets will be at Will Call. No exceptions. Limited Ticket Availability.

For more details, vist the First Illinois HFMA website.

HFMA 101

The First Illinois HFMA Chapter will host its annual "HFMA 101" at the Hyatt Lodge in Oakbrook, Illinois. Are you a new member who would like to better understand the chapter and all the educational and network offerings available? Curious to know how to become more involved and meet fellow chapter members? Interested in diving into some specific healthcare areas? Or are you a more tenured member who is interested in becoming more involved?

Whether you are a new, current, or returning member, HFMA 101 is the perfect opportunity to hear about what the chapter does and how you can take advantage of the many offerings. Hear from current and past chapter leaders about the benefits and value and meet other chapter members.

Since we know folks are crunched for time, we are offering the program in a half day format beginning at 7:30 am and will have you out by the noon, including a box lunch to go!

Look for more details on the First Illinois website and a formal invitation in your inbox soon! We hope that you will take advantage of this opportunity and look forward to meeting you in August.

Questions? Please call one of the Co-Chairs:

Tracey Coyne – 312-602-8279

Paula Dillon – 815-971-5871

John Masini – 847-445-0874

Membership Drive

As you may know, we are having a Membership Drive to increase Chapter Membership. This Membership Drive is in effect from 6/1/2011 through 12/31/2011.

Our Membership Drive has a Promotion as follows:

- If you get 2 new Members – you win a very nice HFMA Dryfit Golf Shirt
- If you get 4 new Members – you win a $100 American Express Gift Certificate (plus the golf shirt)
- If you get 6 new Members - we will pay your 2012-2013 HFMA duesvalued at $275 (plus golf shirt & $100 AM Exp)
- If you get 10 new Members – 4 Cubs tickets or 4 White Sox tickets (plus the previous 3 items)

Please make sure that when a new members joins they put your name down as their SPONSOR.

In the month of June, we had 22 new Members join! Special thanks to the following for being Sponsors in June:

Tim Manning	Jeff Kaplan	Peter Leenhoos
Mickey Bernard	Pat Moran	Don Rogers
Kevin Shaunnessy	Michael Vaci	Russ Anderson

Welcome New Members

Paul Roberts
Chief Financial Officer
Norwgian Lutheran Bethesda Home & Retirement Center

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

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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. All rights reserved. *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
October 2011	September 10, 2011
January 2012	December 10, 2011
April 2012	March 10, 2012
July 2012	June 10, 2012

First Illinois Speaks
HFMA's First Illinois Chapter Newsletter

event-filhfmaorg@comcast.net

Chapter Educational and Events Calendar 2011

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

Tuesday, August 9, 2011
Webinar: Dell - Maximizing your IT Investment in System Conversion

Thursday, August 18, 2011
HFMA 101

Monday, August 22, 2011
Cubs Baseball Game

Tuesday, September 13, 2011
Webinar: Kaufman Hall - Building a Sustainable Physician Strategy

Wednesday, September 14, 2011
First Illinois HFMA Golf Outing

Thursday, September 22, 2011
OI Supply Chain

Friday, September 23, 2011
CFO Breakfast

Thursday, September 29, 2011
aIPAM

Tuesday, October 11, 2011
Webinar: MedSynergies - Best Practices Physician Services Organization Development

Wednesday, October 19, 2011
Accounting/Reimbursement Program

Friday, October 21, 2011
CFO Breakfast

Compliance Education Program

Tuesday, November 8, 2011
Webinar: McGladrey & MCHC - 340B

Thursday, November 17, 2011
CFO Breakfast

Thursday, December 8, 2011
Holiday Dinner

Tuesday, December 13, 2011
Webinar: PNC Bank - Winning Under Reform: Strategies to Optimize the Revenue Cycle

Thursday, December 15, 2011
CFO Breakfast

Treasury Education Program

Tuesday, January 10, 2012
Webinar: Financial Planning in a Healthcare Reform Environment - Organizing all the Moving Pieces

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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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