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

LEADERSHIP MATTERS

Highlights and Recap First Illinois Chapter Events begin on page 17

Captured Events & Updates

In This Issue

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 2012-2013 chapter year. I am honored and privileged to serve as your president this year.

The theme this year is **"Getting Value from your First Illinois HFMA Membership."**

As we created our education and event calendar for this chapter year we focused on creating:

- **Value** by attending our educational seminars and webinars – *All Educational seminars will be NASBA CPE certified. In addition, we have expanded our webinar calendar to include four additional webinars (for a total of 16 throughout the year).*
- **Value** by becoming HFMA certified – *We will be offering two certification study groups this year. One in the fall and one in the spring.*
- **Value** by Networking – ***We are kicking off our social calendar with a White Sox versus the Yankees outing on August 21.***
- **Value** by developing your personal leadership skills – *There is a multitude of volunteer opportunities within the chapter. Please contact me if you are interested in further developing your leadership skills.*

This upcoming year will be another year of challenges for the metro Chicago healthcare environment. We will continue to see mergers and acquisitions, declining reimbursements and greater compliance requirements. Our goal is to provide the highest quality education programs and resources to you to help you navigate this environment.

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 Chapter.

Tracey Coyne
2012 – 2013 First Illinois, HFMA Chapter President

LEADERSHIP MATTERS

National HFMA Chair's Message

Explanation of Theme Tagline: Leadership Matters

BY 2012-2013 HFMA CHAIR: RALPH E. LAWSON, FHFMA, CPA

The need for leadership in health care has never been greater. As our industry continues to grapple with fundamental, long-term challenges such as improving quality and reducing costs, we should all seek opportunities to take a leadership role in finding and implementing solutions. Leadership is not limited to those with certain job descriptions. "Leadership matters" conveys the idea that we are all accountable for the fulfillment of our organizations' missions. In today's challenging healthcare environment, all stakeholders should take the initiative to help lead our industry toward a better future.

"Leadership matters" encompasses many aspects of leadership, including each person's potential to make a difference, the importance of leadership in changing outcomes, and the abundance of leadership opportunities that are available to us as healthcare finance professionals.

- **One person's acts of leadership—however small-—can make a difference.** Acts of leadership on a day-to-day basis may not be acknowledged as they occur, yet that does not diminish their importance. Even the smallest acts of leadership and courage can change another person's life.
- **Good leadership can spell the difference between success and failure or mediocrity.** All other things being equal, having a leader who motivates and inspires is often the factor that tips the scales toward success.
- **It's important to stay vigilant for opportunities to exercise a leadership role.** Some of the greatest leadership opportunities may be disguised as ordinary, everyday situations in your personal and professional lives.

"Leadership matters" follows and builds on recent HFMA chairs' themes such as "making it count," "step up," and "believe to achieve." These themes emphasized the importance of leading the way to better health care at the organizational, community, and national levels. As 2010 ANI keynote speaker Sen. Bill Frist told HFMA members, "Somebody has to do something, and it's going to be—and it has to be—you." Several years later, his words still resonate. Who better than you, as healthcare finance professionals, to lead the way to a better future in health care in America?

Examples of "leadership matters" are all around us.

- Recognizing the important role patients play in their care, finance professionals take the lead in simplifying and streamlining the financial aspects of care so patients can focus on improving their health.
- Reflecting the need for a collaborative approach to leadership, healthcare finance leaders and physicians work together—formally and informally—to guide their departments, divisions, and organizations to success for the benefit of the patients we serve.
- As early adopters of contracts based on innovative payment models, providers and payers develop and implement value-based contracts, blazing a trail for others in the industry to follow.

"Leadership matters" is a call to action for individuals to engage in leadership, regardless of their position. Believing you cannot have an influence on your environment is like saying, "It's not my job" to make a difference. It takes "courage in leadership" to ensure that today's problems are not left to future generations to fix. As healthcare finance professionals, we need to lead the way.

Ralph E. Lawson
2012-2013 HFMA Chair, FHFMA, CPA

Legislation Connection

BY ANDREW DIGATE, HEALTHCARE CONSULTANT, PBC INC.

Quinn Signs Numerous Healthcare Bills – More Healthcare Legislation in the Future?

In the ending hours of the legislative calendar, Governor Quinn yesterday signed numerous healthcare related bills that are aimed, according to the Governor, "to save the state's Medicaid system from the brink of collapse and make the program sustainable for the future."

In the Governor's budget address in February, he urged both sides of the aisle to come together to address the Medicaid budget gap and mounting unpaid bills. Presently, pensions and Medicaid account for 39% of the state budget. He assigned Director Julie Hamos of the Illinois Department of Healthcare and Family Services (HFS) to craft a Medicaid rescue package in cooperation with a bipartisan Legislative Medicaid Advisory Committee, led by Sen. Heather Steans (D-Chicago) and Sen. Dale Righter (R-Mattoon) and Rep. Sara Feigenholtz (D-Chicago) and Rep. Patricia Bellock (R-Hinsdale).

The major bill just signed by the Governor, **SB 2840,** dubbed the SMART ACT ("Save Medicaid Access and Resources Together Act"), includes $1.6 billion in spending reductions. Many of these reductions will be achieved through measures such as enhanced eligibility verification of income and residency, limits placed on adult and children's prescriptions to four per month (with additional prescriptions available based on patients' needs), and cuts to nursing homes.

Here is a brief recap of other bills that were just signed by the Governor, (Additional detail on these bills is provided at http://www.ilga.gov. Simply type the bill number into the search box on the left hand side of this page.)

SB 2194 calls for a $1 per pack increase in the price of cigarettes. The bill also establishes an income tax credit for for-profit, investor-owned hospitals and would create criteria for property and sales tax exemptions for non-profit hospitals.

SB 3397 phases out the long-time practice of paying for Medicaid bills from one fiscal year out of revenues from future fiscal years.

HB 5007 would allow Cook County to enroll more people in the Medicaid program using local and federal funds but not state funds. HB5007 creates a waiver that would allow Cook County to start enrolling people who will be eligible in 2014, when President Barack Obama's health care reform plan is scheduled to go into effect. The waiver would expire if the U.S. Supreme Court strikes down the health care law. State regulations now bar expansion of the Medicaid rolls.

SB 3261 defines charity care for purposes of property tax exemptions for non-profit hospitals. It establishes standard language to be included in hospital financial assistance application forms and establishes uses of presumptive eligibility for financial assistance determinations.

Unfinished business remains in Springfield. As elected officials go home to their district for the summer, some will be out on the campaign trail. Others though, who are retiring, are undoubtedly planning their future. Election season plus retiring politicians create fertile ground for "lame duck" sessions, which could take place in the fall and/or after the election. In the past, highly controversial measures get debated and voted upon in a lame duck session. Whether or not elected officials push through legislation that is harmful to healthcare is uncertain. However, everyone should be aware of the activities in Springfield and their implications toward their respective organizations and healthcare in general.

Andrew Digate
Healthcare Consultant, PBC Inc.

Letter From the Editor

"Leadership Matters!"

That's Ralph E. Lawson's theme for 2012-2013, and he impressed upon the attendees of this year's *Leadership Training Conference* in Ft. Lauderdale, Florida, that "Leadership Matters" conveys the idea that we are not only accountable for the fulfillment of our organizations' missions, but to ensure we lead our industry toward a better future as well. Given the current state of healthcare, and the Supreme Court's ruling on the constitutionality of the Affordable Care Act, there is no doubt that organizational leadership will play a pivotal role in navigating the future of our industry.

With that said, strong organizational leadership will hinge on those individuals that recognize their own potential to make a difference. As Ralph stated: *"Leadership matters" is a call to action for individuals to engage in leadership, regardless of their position. Believing you cannot have an influence on your environment is like saying, "It's not my job" to make a difference. It takes "courage in leadership" to ensure that today's problems are not left to future generations to fix."* And, Doc Hendley, keynote speaker and founder of *Wine to Water,* drove that point home quite succinctly. As the once "small-town bartender" with little direction in life, he has brought clean water to people in need worldwide, in places like Haiti, Uganda and Cambodia.

In an effort to lead the First Illinois membership through these evolutionary times, our goal as the 2012/2013 Newsletter Co-Chairs/Editors is to facilitate the development of a quarterly newsletter that provides timely, relevant and actionable information to its members; to meet this goal, however, we will need your help. As Ralph contends, the strength of an organization resides in its individual membership – leaders in the field of healthcare finance who represent the foundation of our chapter and can influence organizational leadership and the direction of the industry.

Over the course of the next year, we encourage you to contribute to the chapter's newsletter. Anyone who has opened our Membership Directory knows that the breadth and depth of our membership is remarkable; all facets of healthcare finance are represented, and our chapter is in an extraordinary position to lead our members through these challenging times.

We look forward to your contributions.

2012-2013 Newsletter Co-Chairs

Tim Manning

Jim Watson

Energy Use: A New Executive Suite Cost-Cutting Initiative

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

2012 marks the second year of healthcare reform. Hospital executives throughout the state and nation are focused on finding new and innovative ways to unlock trapped capital and lower operating costs while still delivering high quality and a favorable patient experience. Operating costs being explored by healthcare administrative teams continue to include productivity management, supply costs, potential savings from clinical integration and general operating expenses, including energy use as a relatively new executive suite initiative. In an effort to better understand the energy cost savings opportunities, I had the opportunity to spend time with Jim Christie from Performance Services. The discussion below explores the topic of energy and how potential actions beyond standard practice can produce dramatic and sustained improvement to the bottom line.

1) In the past, hospitals haven't had a particular focus on utility bills as a cost-cutting priority because they typically represent a small percentage of a hospital's operating expenses. Why should energy be considered a strategic issue for CFOs now?

There are several key differences today than in the past. First, cost containment is a top priority in this day and age of reform. Every stone must be overturned. Second, energy prices are on the rise. Globally, energy dependence creates uncertainty, and energy costs are expected to continue to increase by as much as 25% over the next decade. Third, hospital facilities are certainly energy intensive; however, that energy use is both measurable and controllable. And finally, energy savings can be significant and the resulting savings can free-up much needed capital. Therefore, energy is appropriate as a strategic executive level initiative that can provide a high yield, low risk way to provide income to the bottom line.

2) What do you mean high yield, low risk and positive impact to the bottom line?

Hospitals spend an estimated 2-5% of their operating budget on energy, or roughly 15% of their profit margin. Consider that for a hospital achieving a 4% net margin, it takes $25 worth of services (gross revenue) to generate $1 of profit/net operating income (25 to 1 ratio). Therefore, in order to accrue $400,000 of net operating income, $10 million worth of services would need to be delivered. If we can think of energy as a distinct service line of its own, energy efficiency initiatives can very well achieve $400,000 or more to the bottom line (1 to 1 ratio) in annual savings. Therefore, energy savings should be viewed as an ongoing, high yield, low risk revenue stream that does not require services in the traditional sense to provide income to the bottom line of the hospital.

3) That sounds great, but I often hear CFOs say that once the savings are achieved (year one), the result creates a new marker. What about year two and future, ongoing savings?

We certainly understand this viewpoint because of the nature and concern for hospital financial performance, especially in this day and age with the uncertainty surrounding healthcare reform. However, energy initiatives should be designed to produce sustained cost savings to the bottom line. It's important to have long term energy goals so that these savings are being compounded or increased each year. Energy savings goals should help the CFO have a new marker every year. Ongoing reductions in operating expenses can and should be "the new frontier" to reducing overhead and, as such, improving financial performance in a time when other margins generated from revenues are declining. Comprehensive energy initiatives can certainly support that objective.

4) How can hospital CFOs go about getting started?

Actually, the "how" is simple. The critical prerequisite is to have an administrative team that supports developing an energy strategy. Hospital executives don't need to get involved "in the weeds" of developing the strategy, but do need to sponsor the energy firm, provide direction, be vigilant with a daily energy focus, and prioritize energy and Indoor Environmental Quality (IEQ) initiatives. Obviously, facility teams should be involved as well. However, what we have heard many times is that these teams have been downsized, and for the most part, spend a good portion of their time addressing daily maintenance issues. Also, there generally is not a person whose is exclusively dedicated to reducing energy consumption and costs. Please understand that our experience has shown that hospital facility teams are an extremely talented group, but in most facilities there are not enough of them to go around. Healthcare executives can benefit from an energy expert whose central mission and focus is energy and IEQ standards, how these dynamics work together, and will contractually guarantee both. Therefore, it is essential to partner with a firm that can work collaboratively to design a short, as well as a long-term strategy for reducing energy and assuring your IEQ. Please note that your strategy cannot include one priority (energy) without the other (IEQ) since they are interconnected.

5) Some Illinois hospitals are new, what can be done for them?

Many new hospital designs do a great job of creating an esthetically beautiful facility, but often are less focused on designing with energy consumption and IEQ as top priorities. Often, the first area that gets cut when the dollars start exceeding the original budget is the mechanical, electrical, and plumbing (MEP) design, building controls, and facility equipment. The term "value engineered" is often thrown around. Also, when a healthcare facility is being constructed and commissioned, there are system issues because the controls/building automation company is not usually under the same roof as the engineering firm. This fact doesn't always allow for good communication or deliver on a vested interest in energy performance standards. Because of this, each "individual" system is installed to prescriptive specifications versus being designed and installed with an integrated, holistic approach. Therefore, we are seeing a need in new hospitals to review and implement an integrated building strategy that includes not only the equipment and controls in the facility, but also a strategy focused on behavioral changes.

(continued on page 6)

6) Some organizations are considering additions/renovations to a current facility. What should they be thinking about as it relates to designing with energy savings and their IEQ (temperature, humidity, CO_2, outside air, etc.) in mind?

I recently talked to a CEO who told me that in all of the facility projects he has been involved in, he has never been totally happy with any of them. He either had issues with how the construction and install went, or had major warranty issues after completion. I am often surprised, given this fact, that hospitals continue down the same design, bid, build road with no guarantees, no commitments around a "no change order" policy, and have no long term "skin-in-the-game" accountability (five years or longer) from the firms who made the design and install commitments on the front end. A hospital should select a firm that owns their design and energy performance guarantees with a long-term partnership commitment through a single-source of accountability.

7) What should a hospital CFO look for when selecting a company to develop and implement a strategic energy plan?

It is extremely important to work with a firm whose entire existence revolves around improving the patient and staff experience through focusing on energy efficiency and IEQ. This company should not only have a talented group of energy engineers, but equally important is that the same company should be able to perform "custom" building automation and control system operations. Ongoing performance assurance measurement and verification functions are also a must. Having all of these disciplines under one roof is absolutely critical to achieving sustained and on-going results. The company shouldn't be tied to one equipment manufacturer but needs to be vendor independent (mechanical and controls) it has the ability to support multiple platforms and can recommend the best solution to reduce energy and improve IEQ. Look for a company willing to come into your facility at no cost and deliver a multi-tiered, energy efficiency strategy that includes guaranteed, "budget-neutral" options. A company must be willing to guarantee the energy savings and IEQ, but be willing to back it up by working with administration for a minimum of five years through continuous monitoring and performance assurance reporting.

Jim Christie joined Performance Services in 2011 bringing with him more than 22 years of service with GE Healthcare. While at GE, Jim held various positions with increasing responsibility, including Diagnostic Imaging Sales Rep, Six Sigma Sales Black Belt, Region Sales Manager, Strategic Account Executive and Customer Champion. In his Customer Champion role, Jim was the focal point for all of the GE businesses that touched the hospital including patient monitoring, hospital information systems, clinical systems (anesthesia delivery and monitoring, vital signs monitoring, blood pressure cuffs, etc.), diagnostic imaging, and Eco-Hospitals, GE's "Going Green" initiative. This experience helped Jim develop a more global understanding of the challenges and solutions facing hospitals today.

Dan Yunker

VP & CFO, Metropolitan
Chicago Healthcare Council

CMS 3-Day Payment Window for Wholly Owned or Wholly Operated Physician Practices

BY MARY CRONIN, DIRECTOR

If you have a wholly owned or wholly operated physician practice, you need to be aware of the new Medicare three-day payment window, which was published in the Federal Register (Volume 76 No. 228) on November 28, 2011, as a part of the "Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition and Other Revisions to Part B for CY2012" final rule.

Per the Federal Register: "Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a Medicare beneficiary's inpatient stay, the technical portion of any outpatient diagnostic service and non-diagnostic services related to the admission provided during the payment window. The new law makes the policy pertaining to admission-related non-diagnostic services more consistent with common hospital billing practices."

The payment window is only 1-day for non-subsection (d) hospitals (which is a hospital **not** paid under the Inpatient Prospective Payment System–psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals and cancer hospitals).

Per 42 CFR 412.2(c)(5)(i): "An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity."

The 3-day payment window policy applies to services related to the admission, including all diagnostic services and clinically related non-diagnostic services, other than ambulance and maintenance renal dialysis services, which would be paid for under Medicare Part B and that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient. This is not limited to physician offices or clinics; it includes any Part B entities that provide diagnostic or related non-diagnostic services, which would include a variety of entities such as clinical laboratory facilities, ambulatory surgical centers, and diagnostic centers.

Wholly owned or wholly operated entities that provide diagnostic services have always been subject to the payment window. This final rule is to encourage hospitals to bring any other wholly owned or wholly operated Part B entities into compliance with the 3-day payment window policy. Rural Health Clinics and Federally Qualified Health Centers are not currently included under the 3-day payment window since they are reimbursed through an all-inclusive rate.

For services provided within the 3-day payment window, the wholly owned or wholly operated entities will be reimbursed the professional component for CPT/HCPCS codes with a Technical Component (TC)/ Professional Component (PC) split. For codes without the TC/PC split, the facility rate will be paid to avoid duplicate payment for the technical resources involved.

The 3-day payment window does not make any changes to the billing of surgical services under the global surgical rules. Although if the surgery were performed within the 3-day payment window then the surgery itself may be subject to the 3-day window.

The hospital is responsible for notifying the practice of related inpatient admissions for a patient who received services in a wholly owned or wholly operated entity within the 3-day window prior to an inpatient stay.

Beginning on January 1, 2012, CMS payment modifier "PD" (diagnostic or related non-diagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within the 3 days, or 1 day) is available and wholly owned or wholly operated entities should begin to append the modifier to claims as appropriate. The modifier is not required until July 1, 2012, but CMS encourages hospitals and their wholly owned or wholly operated entities to work toward establishing the necessary internal processes to ensure compliance by the deadline.

The charges related to the technical component of all outpatient diagnostic services and admission related non-diagnostic services provided within the 3-day payment window must be included on the inpatient claim.

A hospital must also include the cost related to the technical component of all diagnostic and admission related non-diagnostic services furnished by wholly owned or wholly operated entities in the 3-day payment window on their cost report.

The final rule contains a number of examples regarding under what type of arrangement the 3-day payment window applies based on various relationship structures.

Since providers are required to start applying the PD modifier to their claims by July 1, 2012, this is an issue that needs to be addressed immediately. For many providers this will not be an easy process, since the wholly owned or wholly operated entities are often on different information systems than the hospital.

As hospitals and physician groups continue to align, affiliate and otherwise comingle business relationships, each should be aware of the

(continued on page 8)

CMS 3-Day Payment Window... (continued from page 7)

billing requirements and how they could affect their practice. Documentation of the business relationship, including policies and procedures should include a position on billing practices. In addition, as providers are ramping up efforts to acquire physician practices, careful consideration of the effect of this reimbursement mechanism should be considered during the strategic planning and negotiating process.

If you would like more information on the 3-day payment window and how it might affect your facility or affiliation, please contact Mary Cronin at mcronin@besler.com or 732-839-1217.

Mary Cronin brings with her over 20 years of progressive experience in healthcare financial services for a myriad of major healthcare clients. She has assisted clients with various Medicare and Medicaid regulatory and reimbursement analyses, the preparation and review of CMS 2552 and various state cost reports, strategic pricing analysis, third party payer analyses and appeals, and managed care contract analyses.

Mary Cronin currently serves as the Director of Strategic Solutions at BESLER. She previously worked with Innovative Health Solutions, developing enhancements for their software products. Prior to coming to BESLER, she served as a reimbursement analyst at a well-known New Jersey hospital.

Customer Service Excellence:
It's more than just a motto

BY STEVE CHRAPLA, CHFP, DIRECTOR 3RD PARTY SOLUTIONS, AVADYNE HEALTH

Customer Service within the healthcare industry has become one of the most critical components supporting the delivery of care to patients. Whether in a clinical or administrative setting, with the advent of The Patient Protection and Affordable Care Act, HCAHPS scores, Healthcare Consumerism, and general market competition, customer service has become crucial in all aspects of patient interactions.

However, merely saying we provide excellent customer service does not suffice! Customer service needs to be more than a motto, a plaque on the wall, or words on a website. Customer service is a state of mind. It must reside in the heart and soul of an organization's culture.

All of us have experienced poor customer service at one time or another, so let's talk about how to achieve customer service excellence, as well as the actions required to be a World Class Customer Service provider. First and foremost, you must set an organizational standard that, in every encounter with a patient, you will go above and beyond what the patient expects. It is not simply answering a question or dealing with an issue. Instead, you must reach the next step: establish a level of comfort in the mind of the patient that all their needs (realized and unrealized alike) are being addressed.

Setting these substantial expectations–and maintaining the support necessary to carry them through–requires leadership. Communicate the message and expectation loud and clear:

- Post it prominently on your website that customer service is paramount.
- Post it throughout your organization and departments, where patients and staff alike will be constantly reminded of its importance.
- Reflect your commitment to world class customer service in every communication that goes to patients: letters, billing statements, clinical reports, and so forth. Emphasize your organization's care and concern for patients and their needs.

That's the easy part. What's next is the hard part… Walk the talk!

As leaders, you need to ensure that your staff has the resources to be successful. This includes outsourced processes with external vendors, which is sometimes overlooked because it is incorrectly perceived as someone else's responsibility. In reality, it is more important that external partners are just as committed (if not more committed) because of the challenges of being a separate organization. This means that customer service-related interactions need to be part of every job description. You can't simply say "I want you to provide excellent customer service" and then evaluate staff performance based on other criteria. Patient interactions need to be evaluated based on an established level of customer service that can be measured and monitored.

Ultimately, customer service-related criteria can be used to support compensation levels. Along with revised job descriptions, you need to establish productivity measures that encompass the time required to interact with patients–the very interactions necessary to provide that extra level of service you are aspiring to.

A critical aspect to achieving excellent customer service is to ensure that all staff interacting with patients demonstrate specific abilities. An empathetic-yet-calm personality lends itself to these interactions, as do solid communication skills, and what some experts have re-

(continued on page 10)

ferred to as "emotional intelligence." This means staff have developed the personality characteristics as well as the emotional control to deal with extremely sensitive patient issues. It is critical to train staff to interact very empathetically (and not over-emotionally) to assist in finding solutions to issues and patient challenges.

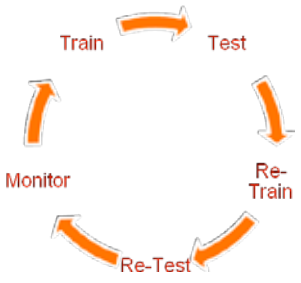
> Remember that two of the most sensitive emotional factors that people face are health and money. Our healthcare environment places the patient in the crossfire, simultaneously dealing with both these sensitive topics; such a situation has the potential to devolve swiftly into a major customer service challenge.

Even a 5-minute phone call allows for the building of a positive relationship with the patient. Such a relationship creates the opportunity to achieve excellent customer service. However, to achieve this you will need to recognize four basic personalities and/or communication styles that patients exhibit:

- **Spontaneous:** likes to talk – estimated 40% of the population
- **Agreeable:** avoids conflict – estimated 25% of the population
- **Directive:** to the point – estimated 25% of the population
- **Logical:** wants to see data – estimated 10% of the population

These personality types are important to identify, because correctly identifying the patient's will best guide successful interaction with that patient. Spontaneous people will respond emotionally to points discussed, and will question rules unless they understand–and agree–with those rules. Agreeable people are people oriented; with "nurturing" and encouraging interactive style, they will respond positively. Directive types need to see the big picture, act independently, and may come across as impersonal. Finally, and least commonly, patients of the Logical type are responsible, structured, like to see facts, and follow rules. Recognizing these personalities in early interactions is not always easy, and people typically have some blend of these characteristics, and may even display different types across multiple interactions. Nevertheless, accurately identifying the closest type in a given situation–and knowing how to react and respond to the differences–can go a long way in winning consensus over a difficult situation.

Even taken together, communication skills, emotional intelligence, and good listening abilities do not completely constitute the ideal staff member. There are additional levels of knowledge that must be mastered. These require development of technical skills and ongoing training to be knowledgeable enough to deal with the challenges that arise. Proper training is a constant and never ending circle.



Call centers operating in healthcare facilities need to ensure that their staff is educated and trained on all the organization's current policies and procedures, as well as the healthcare industry revenue cycle and payers processes. These technical skills, along with the aforementioned empathy, communication, listening, and other interpersonal skills, are essential components of all training programs. For staff to become–and remain–proficient, following the ongoing training circle is a must.

Avadyne Health, a national healthcare revenue cycle management firm, has implemented a training model to provide specific focus in the customer service area to all patient account representatives. This model, designed to enhance the patient experience and assist patients, centers around a very specific approach to each call and contact with the patient. The telephone call is guided by addressing the personal desires of the caller through this approach labeled SMART.

S.M.A.R.T. ™

S – Set the Tone/Actively Listen

M – Meet/ Acknowledge with Care & Empathy

A – Ask the Right Questions

R – Resolve/ Recommend/ Resolve

T – Thank the Caller/ Effectively End the Call

Each call is reviewed for evaluation and training purposes, and then ongoing QA is conducted and a weekly review/coaching session occurs with each rep to score the call's effectiveness toward patient resolution of the issue. Scores are tracked to monitor continued compliance and performance improvement.

To enhance your level of patient satisfaction and achieve a world class customer service operation you should ensure you have these areas addressed within your organization.

- Establish and communicate your commitment to customer service.
- Your organizations and department mission statement should describe your commitment to excellent customer service.
- Senior leadership must endorse and publicly support the initiatives.
- Foster an environment where staff recognize that commitment/customer service mission statements need to be visible in all work areas.
- Evaluate job descriptions and requirements to support excellent customer service.
- Staff performance measures need to recognize customer service initiatives.
- Ensure you have the right people with the right skills in all patient contact areas.
- Establish a training initiative focused on customer service techniques.
- Develop a QA process to review staff interactions with patients.
- Utilize telephone call recordings for both training opportunities as well as recognizing successful interactions with patients.
- Recognize and celebrate successful customer service calls and promote the positive experiences throughout the organization.

Steve Chrapla

For more information on how to enhance your patient experience and achieve a world class customer service operation please contact Avadyne Health. www.avadynehealth.com

Steve Chrapla is Director of 3rd Party Solutions for Avadyne Health and a member of the First Illinois HFMA Chapter. He can be reached at 847-395-7655.

Going Green While Improving Environment of Care

BY STEVE BLAU, PE, LEED AP, ILLINOIS TRANE

Hospital administrators are concerned about how the Patient Protection and Affordable Healthcare Act will affect their balance sheets. According to a recent American College of Healthcare Executives (ACHE) survey, more than two-thirds of hospital chief executives see financial challenges as their organization's most serious problem.

No wonder hospital administrators, staff and caregivers are teaming up to manage costs without taking their eyes off healthcare's other bottom line–providing an environment of care that contributes to positive patient outcomes.

Using green technologies to improve building performance is a win-win opportunity for healthcare facilities. High performance buildings equipped with modern heating, ventilating and air conditioning (HVAC) solutions, building automation systems and other green features can deliver substantial savings in energy and related costs. Meanwhile, dozens of studies cited by the Center for Health Design found direct ties between positive patient outcomes and the cleaner, safer, more comfortable indoor environment that these technologies enable.

Hospitals often overlook benefits of going green

There is plenty of room for improvement in the energy and environmental performance of healthcare facilities. Inpatient facilities consume nearly three times the energy per square foot as the typical commercial building, according to the Environmental Protection Agency (EPA), producing more than 30 pounds of CO2 emissions per square foot. Only restaurants use more energy per square foot.

The EPA estimates that U.S. healthcare organizations spend a mindboggling $8.8 billion on energy each year. If that number is hard to grasp, consider that the agency estimates that the average hospital spends an amount equal to or greater than 15 percent of profits on energy.

A number that large should create a considerable target. But most hospital CEOs feel helpless when it comes to cutting their energy bills; according to Energy Star, 75 percent say that energy costs are their least controllable expense.

Passavant Area Hospital improves care environment, building performance

In late 2008, management at Passavant Area Hospital began looking for ways to improve the quality of care at their facility, a 93-bed non-profit community hospital located in Jacksonville, Ill., which serves five West Central Illinois counties.

During a preliminary study, conducted with an energy services company (ESCO), Passavant gathered staff members' thoughts on how the hospital's physical environment affected clinical performance. After analyzing input, the management-ESCO team concluded that infrastructure improvements could help expedite the healing process, reduce the risk of infection, improve patient and staff satisfaction, and provide various other benefits.

Equally important to the management team was the opportunity to shrink the facility's carbon footprint by reducing energy consumption and leveraging the savings to offset improvement costs.

The study team recommended an investment-grade systems audit, which was conducted in early 2009. The audit identified infrastructure improvements that would help the hospital enhance the environment of care, better manage energy costs and reduce greenhouse gas emissions.

After evaluating audit findings, the hospital's board of directors approved a $2.3 million infrastructure improvement program that started in mid-2009 and was completed early this year.

Improvements deliver benefits for patients, staff and bottom line

The improvements address a wide range of concerns raised by the staff. For example, new automated temperature controls improve comfort throughout the facility, eliminate the need to disturb patients to make manual adjustments and let caregivers focus on patients' needs.

Upgrades to HVAC systems, ductwork and other infrastructure allow more precise air quality control, improving comfort and infection control. And more efficient HVAC components reduce noise levels, responding to noise complaints from staff and patients and creating a better healing environment.

Energy savings for the project are estimated at more than $313,000 per year. According to a model developed by the EPA, that number provides a financial benefit to the hospital equal to about $7 million in incremental annual revenue. The energy savings provide environmental benefits equivalent to taking 525 cars off the streets each year.

(continued on page 12)

Going Green While Improving...

(continued from page 11)

By using an innovative energy performance contract, Passavant was able to use future energy and operational savings to help fund the project, which is expected to pay for itself in about 6.5 years.

Healthcare facility managers play key role in improving organization performance

As administrators face the challenges of a dynamic and rapidly changing healthcare delivery system, they rely on the unique expertise of facility managers to make sure the organization is a good steward of the natural resources needed to keep the facility operating effectively.

By working with an experienced ESCO with a proven track record, facility managers can implement sustainable energy strategies that contribute to the hospital's financial wellbeing and, more importantly, to its ability to serve the community and provide an environment of care that leads to consistently positive patient outcomes. A variety of professional organizations, including the National Association of Energy Service Companies (www.naesco.org), provide guidance on finding and selecting a qualified ESCO.

For more information, contact: Stephen Blau, Illinois TRANE, by phone: 630-734-6083 or email: sblau@trane.com

Understanding Staff Motivation is Key to Filling Shifts

BY CHRIS FOX

The healthcare industry is characterized by constantly fluctuating inpatient volume due to seasonal epidemics like the flu and other various circumstances, resulting in frequent, last-minute staffing shortages. Without the tools to accurately predict patient volume, many healthcare organizations struggle to find a cost-effective solution and oftentimes turn to promoting financial incentives or utilizing staffing agencies. Such a reactive, silo-based approach to labor management can be an expensive, time-consuming process that causes frequent disconnects between staffing budgets and actual labor costs, unnecessary, expensive overtime, worker fatigue and poor morale, all of which eventually have a negative impact on patient care.

Debunking the myth that "money talks"

According to research conducted by Avantas, a provider of strategic labor management consulting services and technology, at the root of this problem is a fundamental misperception regarding what actually motivates staff to pick up open shifts in healthcare organizations. To understand staff motivation, the Omaha-based labor management experts administered a two-part study to two multi-hospital systems in the Midwest and eastern United States with the following survey interventions:

1) An initial survey asked staff members' shift choice processes.

2) A follow-up survey was employed each time a staff member chose and confirmed an online shift that was related to each individual's motivation for picking up a particular shift.

The study illustrated the following findings:

- Incentives calculated by degree of need in advance of the shift are more efficient than high-dollar last-minute incentives.
- Individuals' perceptions of what motivates them in selecting a shift and how those motives manifest in reality are often contradictory. In other words, individuals stating financial incentives were the primary motivator in shift selection demonstrated that their shift selections had as much if not more to do with how that shift fit into their schedule.

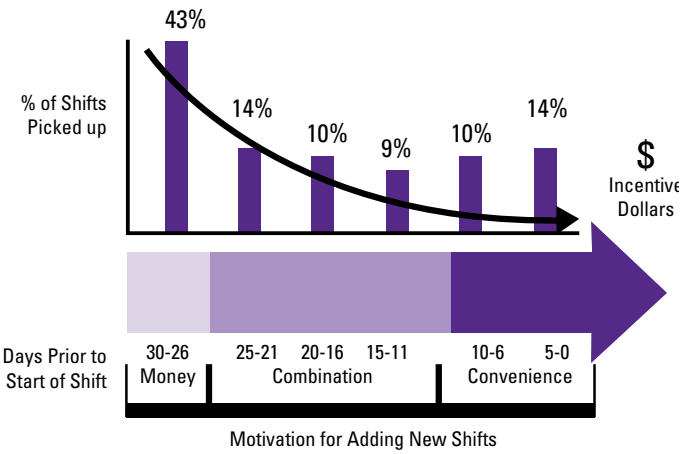
Contrary to the belief that financial incentives are the primary staff motivator, the documented staff behaviors demonstrated that shift flexibility is actually the most powerful staff scheduling incentive. The perceived versus actual motivations to pick up open shifts points to the reason why reactive, last-minute incentives are essentially wasted dollars and can result in program abuse (e.g., 11th hour bartering), inefficiency, perceptions of favoritism and spiraling costs. The reactive staffing model also creates a sense of entitlement among nursing staff as the expectation developed over time is that all additional shifts picked up should be tied to the highest incentives–a mindset that often leads to a stalemate that fails to fill the shift, decreases morale and creates lasting tension between managers and staff.

However, while this study demonstrated that schedule flexibility and financial incentives were the two most important factors considered when picking up a shift, there were two stark differences between contingency staffing groups and core staff regarding shift motivators:

- Contingency staff was less motivated by money closer to the day of the available shift as convenience and additional hours were the main reasons they would pick up a shift less than one week in advance.
- Core staff members working over their full-time equivalent (FTE) were more motivated by money than float pool staff.

The convenience-motivation of contingency staff coupled with the financial-motivation of core staff point to the need for a scheduling module of decreasing financial incentives as shift dates approach. As money becomes less of a motivator as the shift date nears, it makes little sense to bait an immediate open shift with a high incentive. Rather, a proactive scheduling model with attractive monetary incentives well ahead of the shift that decrease as dates draw closer satisfies both contingency and core staff.

As the following figure illustrates over the 30-day study, 75% of shifts were picked up more than two weeks before the day of the shift and 43% of shifts were picked up 30 days in advance when peak incentives were offered.



Proactive Scheduling Aligns with Staff Motivation

By tying the level of staff incentives to how far in advance nurses are willing to schedule a high-need shift, this model of declining incentives effectively fills needed shifts up to 30 days in advance, solidifying staffing plans sooner while offering a lifestyle incentive calculated to meet the needs of a flexible schedule.

(continued on page 14)

Understanding Staff Motivation is Key to Filling Shifts

(continued from page 13)

Best practices for a proactive labor management approach – the enterprise-wide model

However, in order to initiate a proactive scheduling model, healthcare organizations must be able to accurately predict patient demand, a capability that requires the right combination of analytics-powered labor management software and proven industry best practices. Included in these best practices is finding the correct ratio of core to contingency staff and developing the appropriate layering of contingency resource groups needed to adjust to the ebb and flow of patient demand.

Once an organization implements the tools to predict demand, open shifts can automatically be posted within the schedule reflecting the difference between the number of staff scheduled and the anticipated need. Incentives then, set within a customizable range by each organization, are attached to the open shifts and fluctuate automatically in real-time relative to need.

As this study suggests, many healthcare organizations have a tendency of managing labor from a reactive, sometimes silo-based, labor-intensive scheduling approach, causing frequent disconnects between staffing budgets and actual costs.

By implementing an enterprise model approach to managing labor and employing the tools to support it, healthcare organizations can evolve their workforce management strategy into a more advanced, transparent model that incorporates the proven best practices associated with automating the planning, scheduling, staffing, deployment, and reporting process that is unique to healthcare.

This evolution requires a pivot in the way most healthcare organization's think about meeting patient need. This cultural shift is just as important as implementing the strategies and technology to automate the process–turning the reactive filling of open shifts into a predictable and repeatable process.

As demonstrated year after year by several prestigious healthcare organizations around the country that have implemented this approach, an enterprise-wide model of managing labor increases staff satisfaction and retention, enables better patient care, and effectively controls healthcare's largest cost center.

Leadership Does Matter...Like Never Before

BY VICKIE AXFORD AUSTIN

Imagine you're in a bookstore, wandering through the business section looking for books on "Leadership." When you come upon the shelves of books related to the topic, you're overwhelmed. There are hundreds of books written by leaders, about leaders and for leaders, authored by folks famous and infamous, noted and diverse. Or maybe you've gone directly to Amazon's website to load a book onto your Kindle or iPad. You typed in "books," followed by "leadership," and up pop more than 80,000 titles.

This is clearly a topic about which much has been researched, written and reported. Yet leadership continues to intrigue us, inspire us and sometimes elude us. Are leaders born or made? Can we teach leadership? What are the qualities most required by leaders and appreciated by the people and organizations they lead?

The Dangers of Leading

Among those many books on leadership is one called ***Leadership on the Line: Staying Alive through the Dangers of Leading*** by Ronald A. Heifetz and Marty Linsky. Published in 2002 by Harvard Business School Press, the book is as relevant today as it was ten years ago. The authors, who serve on the faculty of the John F. Kennedy School of Government at Harvard, begin with this cautionary note: "Exercising leadership can get you into a lot of trouble.

"To lead is to live dangerously because when leadership counts, when you lead people through difficult change, you challenge what people hold dear—their daily habits, tools, loyalties and ways of thinking—with nothing more to offer perhaps than a possibility," the authors write. The book exposes the truth about the hazards of leadership, balanced by the rewards. "Many leadership books are all about inspiration, but downplay the perspiration," according to the authors.

HFMA Members Chime In

I asked members via HFMA's LinkedIn Group, "What do you think are the key requirements to being a leader?" Here are some responses:

- A leader must understand the issues and be able to communicate issues, values and purpose to other people in order to be able to build consensus…" from John Roemer, interim CFO and business consultant from HFMA's Connecticut chapter. "A true leader must also be a person who can mentor, train and motivate…"
- A good leader will take personal responsibility when things don't go according to plan or when a project fails as well as award credit when credit is due," wrote Christina Hsu, HFMA member from St. Luke's Episcopal Health Systems in Houston, Texas. She added, "Good leaders are creative… listen to all ideas and give everyone a fair chance to express ideas… remain level-headed and maintain a sense of humor. They inspire the group to stay focused."
- Leaders require "confidence, communication and good people with involvement in the hiring, discipline and evaluation process," according to Dawn Fellows, operations coordinator for Southern Minnesota Surgical.
- Tanya Lawson, pursuing her master's in healthcare administration in Austin, Texas, wrote that leaders must have behavior that is consistent so people don't wonder, "Am I getting Jekyll or Hyde today?"
- And from the United Kingdom, Duncan Brodie wrote that leaders require "the courage to make the tough calls; able to win hearts and minds and get the support to make change happen; [and have] great people skills."

The Agony and the Ecstasy

"What's the downside of being a leader and what are your greatest joys?" I asked. "The buck stops with you"; "Losing someone from your team, even when you know it is absolutely the right thing to do" and "Pressures to perform or lead a particular way" summarized the downside. Joys included "I get to take a talented employee under my wing and see him develop and grow"; "Seeing others grow, achieving personally and getting through challenges that seemed impossible"; and "I LOVE mentoring people and seeing them succeed."

News from the Top

As this article goes to press, leaders at ANI are tackling the same topic. "Leadership is about doing the right thing even when it's incon-

(continued on page 16)

venient," HFMA Chair Ralph Lawson told attendees at the conference kick-off. HFMA President and CEO Joe Fifer added in his first address to HFMA members that "Change is coming, and there's a lot we need to do to get ready. Don't sit back and wait for changes to happen to you. Create the future yourselves."

Creating the future seems to be the chief responsibility of a leader, a role not without its challenges. But according to authors Heifetz and Linksy, it's a challenge well worth the risk. "By making the lives of people around you better, leadership provides meaning in life. It creates purpose."

Leadership also provides a legacy, as any outgoing HFMA chapter president can tell you. As he or she hands the gavel over to the new incoming president, the torch is passed. Congratulations to the new group of leaders who are poised to take First Illinois HFMA into the future!

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

CFO Golf Outing May 14, 2012

Steve Scogna, David Crane, & Tom Wright

Tracy Packingham, St. Louis HFMA Chapter President, Deb Schimerowski, Regional VP of Finance, Provena, Ellyn Chin, Trinity/Loyola/Gottlieb Hospital, VP of Finance, Tracey Coyne

Dan Yunker, Jeff Robinson, Dave Yeager, Dave Reynolds

IT Education Program April 17,2012

Mah-J Soobader and Gilbert D'Andria

D. Yunker, E Barthel, J. Silva, T. Jacobsen, C. Whitaker and P. Ingram

Janet Guptill, Shea Huston and Linda Klute

Special Letter of Recognition

OFFICE OF THE MAYOR

CITY OF CHICAGO

RAHM EMANUEL
MAYOR

June 26, 2012

Mr. Richard Clarke
President and CEO
Healthcare Financial Management Association
3 Westbrook Corporate Center
Suite 600
Westchester, Illinois 60154

Dear Mr. Clarke:

As Mayor and on behalf of the City of Chicago, it is my pleasure to extend warmest congratulations on your 25 years of outstanding service to Healthcare Financial Management Association (HFMA).

As President & CEO of Healthcare Financial Management Association, you have not only demonstrated true leadership and dedication to a multitude of healthcare financial management executives and leaders but also to the Chicagoland community. Through your unwavering commitment to define, realize, and advance the financial management of healthcare you have helped healthcare professionals improve their business performance and have made HFMA and our city a better place. I commend you for your multitude of accomplishments, service, dedication and work ethic, and join the Healthcare Financial Management Association in honoring you on this special occasion.

On behalf of the people of Chicago, please accept my sincere congratulations and best wishes for much continued success.

Sincerely,

Rahm Emanuel

Mayor

HFMA Committee Updates

Chapter Certification Update

BY TIM STADELMANN

You've seen it in movies like *Lord of the Rings, Band of Brothers,* and more recently, *The Avengers*–people accomplish more when they work together to accomplish a goal.

One of Pat Moran's many legacies as chapter president will be his efforts to see more members become Certified Healthcare Financial Professionals ("CHFPs"). Specifically, he took an idea he saw in other chapters and brought it to First Illinois, with a twist. Building off our monthly webinars idea, he decided to bring together a study group dedicated to becoming certified by studying together online using the same online format instead of gathering members from all over Chicago to meet in one location.

In February, I was challenged to take the certification chair position in order to help make this group idea a reality. With the help of Adam Lynch, our webinar chair, and others, we began a series of seven online study group meetings in 11 weeks, with studying provided materials on our own in the interim periods.

The first group of 17 CHFP study group members were among the first to respond to Pat's original email. In the future, we will be starting a second group (likely this fall) of those on the waiting list, and plan to host one to two study groups per year.

As a result of our efforts, and given Tracey Coyne's ongoing commitment to certification, we would like to see First Illinois become a leading chapter in the nation in equipping healthcare finance professionals to achieve CHFP designations.

While certification is a bit different than defeating aliens or dark lords as we often see in major summer films, I can honestly say I wouldn't have come as far as I have without my peers and friends helping me along the way. If you are interested in getting on the waiting list to join a group and becoming certified, or learning about this process, please reach out to me at tim.stadelmann@advocathealth.com or call at 630-990-5088. I look forward to seeing you take your next step.

Tim Stadelmann works for Advocate Health Care in the Strategic Financial Planning department, analyzing hospital and physician acquisitions, as well as joint ventures, capital budget requests, service line analyses, and financial reporting. His work in healthcare finance began in 1998 working for a boutique consulting firm on the East Coast specializing in nursing home and senior housing analysis, primarily surrounding mergers and acquisitions.

Best Practices: Obtaining Authorizations and Preventing Denials

BY VICTOR MARCINIK, VICE PRESIDENT, PRODUCT MANAGEMENT, RECONDO TECHNOLOGY

"A hospital with $300 million in revenue typically writes off $7.7 million annually to denied claims."

— The Advisory Board Company

The US Healthcare Efficiency Index (USHEI, March 2010) measures efficiency in the US healthcare system. The study shows the adoption rate and cost comparison of electronic versus manual for various electronic transactions between providers and payers; eligibility/benefits, authorization/referral, claims/remit, claim status, and payment posting.

http://www.ushealthcareindex.com

Many organizations are attempting to leverage these standards of communication, many processes and workflow changes must also be accomplished. This starts with moving authorization and denial management to the front of the revenue cycle. This yields savings from reducing the number of denied claims and re-allocating staff from managing authorizations full-time to other areas of the facility.

Creating a plan to reduce authorization related denials starts with understanding what your baseline is. How do the denials breakout in terms of total dollars, payer, patient type and service area. Next the key stakeholders should be identified.

Stakeholders and Influencers for Authorization

- Physicians
- Patient Access
- Case Management/Ancillary Depts.
- Business Office
- Administration/Managed Care
- Payer Network

Relationship with the physician community is vital.

This is the front line of authorization activity for scheduled services. Hospital staff should be diligent in requesting and documenting insurance information, specific services and diagnosis information, and request authorization numbers that have been obtained.

From a payer compliance perspective, physicians are contractually obligated to provide clinical data to the patient's insurance(s) to ensure the payer has adequate information to determine if precertification criteria have been met.

Best-performing facilities have proactive relationships with the physician community to discuss payer requirements and share exception reports when requirements were not achieved.

Facility Scheduling

Whether your organization scheduling services are centralized or decentralized, best-performing facilities initiate authorization activities at time of scheduling. Along with clinical procedures and diagnosis, schedulers need to capture the insurance data and assist with coordination of benefits when multiple insurance(s) are present. The facility scheduling system at minimum should be able to house the insurance data, precertification number, patient type of the authorization, and comment fields.

Patient Access

Scheduled:

As part of preregistration, the Patient Access team should monitor authorization exception reports from the scheduling and/or HIS system. This will provide enough time to address any exceptions before the patient arrives for services. Exception handling will uncover any constraints with payer timeframes and the ability to discuss the need to reschedule services in order for patient benefits to apply. In some circumstances, the hospital should have available a notice of non-coverage to present to patients if they choose to proceed in having services without securing the authorization approval from the payer(s).

Unscheduled:

Daily, the Patient Access team should monitor patient type changes and direct admits. Patients admitted through the emergency room should be promptly reviewed and payer(s) notified when insurance is known. Any delays in obtaining patient demographic and insurance data should be concurrently documented to assist in timely notification appeals.

Patient Type changes/Maternity

Best-performing facilities also have strong controls to monitor daily other patient type changes and maternity and newborn length of stays. The ability to document the patient type with the authorization allows for quick identification of a mismatch. Patients that convert from outpatient surgery to observation or even inpatient are easily identified as an exception and prioritized for processing.

Maternity cases are a little more challenging, but the Patient Access teams that monitor length of stays, service transfers, and have regular communication with the labor deck team as to delivery type (C-Section versus vaginal) benefit the most with very few authorization exceptions with this service.

Case Management

Case Management is the second line of defense for scheduled and unscheduled authorization activity. This team should take the initiative to communicate patient type changes to other teams within the organization in a timely manner. CM must take ownership of observation and inpatient statuses and make the appropriate departments aware of changes to ensure Patient Access and HIS systems are updated with current status. CM dept should have a worklist to monitor accounts for concurrent review activity and proactively communicate with payers on continued stays and document additional days approved.

(continued on page 21)

ACOs, Round One... (continued from page 20)

During concurrent review, CM should communicate, document and take the initiate to resolve any denied days. Case Management must take action and provide clinical information on weekend discharges, short LOS visits, and other retroactive encounters. Best-performing facilities have policies and procedures to address variances in service levels, patient types, or delays in service denials.

Business Office

The Business Office must have the ability to track payment denials for every encounter. This team needs to communicate the payer activity on every registration to the organization. High-performing facilities have the ability to timely assign unique denial codes and/or unique $0 payment codes to pull reports to track and trend payer activity by patient type, service, and department.

The Business Office should be appropriately staffed to identify and appeal unauthorized services. Organizations that don't have available staff or skills sets have successfully contracted with vendors who perform this activity on contingencies. This department should have access to legal advice and avenues for payment demands.

Best-performing facilities have an active Denial Committee, which is often attended by patient access, business office, case management ,and managed care. The Business Office Patient Accounting System generated the data for the committee. Denial data should be tracked and trended by payer and separated between technical, clinical, and administrative denials. he committee chair should identify action items by respective departments to minimize future denials.

Managed Care/Administration

Managed Care communication and feedback is another attribute of a best-performing facility. Managed Care should solicit input from multiple departments within the facility to address any exposures before a contract is signed. Several departments manage a patient throughout the life cycle of the encounter, and each department must understand respective obligations to secure proper payment. Managed Care should work with other departments to promote and find efficient ways for entities to communicate and interact.

Payer

Authorization requirements should be published and made accessible. The requirements must be clearly defined as to patient type, CPT, and clinical description for inpatient services. Payer's provider relations or marketing department should be visiting the physician community to assist with training and to educate them on their responsibilities for authorization activity.

Encourage payers to adopt family CPT ranges for authorization versus specific CPT which you often experience in radiology. The radiologist has the discretion to change, augment or add to the order for providing the best care of the patient. Adding additional overhead expense for the change in CPT order is costly and burdensome to both the payer and providers.

Finally, payers should promote and embrace electronic communication of patient information and activity with the provider and HIS vendor community.

Conclusion and Next Steps

- Determine your baseline, this will make it easier to measure a program's success
- Engage your stakeholders
- Develop a plan, including milestones and responsibilities
- Assess and leverage technology…it's out there
- Leverage existing resources – trade associations, state hospital association, CORE, WEDI, etc.

Author: Victor Marcinik, Vice President, Product Management, Recondo Technology, and former Chief Operating Officer for HCA Revenue Cycle Operations in Denver, encompassing seven acute care facilities.

Welcome New Members

Pearl M King
Regional Business Manager
Accretive Health

Matt Hartzman
EVP, Managed Services
NET(net), Inc.

Zenobia M. Bell
Sr. Reimbursement Auditor
BC/BS Info Resource Center

Laura Hoey
Partner
Ropes & Gray LLP

Gregory W Lonergan
Director, Business Development
Winthrop Resources Corp.

Charyl Kavner
Vice President, Senior Healthcare Product Mgr
Fifth Third Bank

Travis L Temple
Assurance Supervisor
McGladrey & Pullen, LLP

Meredith Siegel
Operations Analyst
National Surgical Hospitals

Sanjoy Musunuri
State President
Wellcare/Harmony Health Plan

Kimberly OQuinn
Treasury Solutions Officer

Eric R Wells
Senior Finance Manager for Department of Medicine
Northwestern Medical Faculty Foundation

Sara Spector
Program Manager
Accretive Health

John Lund
Account Executive
Equifax Healthcare

Marco Pambianco
Senior Consultant
The Claro Group, LLC

Leticia Rivas-Martinez
Accounting Manager
Elmhurst Memorial Home Health

Shyreeta N Benbow-Horton
Supervisor, Revenue Cycle Recovery OP
Vaughan Holland Consulting Inc.

Donisha Dunagan
Coding Analyst
Vaughan Holland Consulting Inc.

Judy Denise Slowinski
Medicare Coding Supervisor
Vaughan Holland Consulting Inc

James J Garner
Regional Vice President
First Financial Healthcare Solutions

Sherry Finley
Supervisor, Medicare Recovery Specialist
Vaughan Holland Consulting, Inc.

Sabrina G Moore
Chief Finance Officer
Friend Family Health Center, Inc

Rohan P. Vaidya

Ciro Olivarez
Billing Supervisor
Vaughan Holland Consulting

Sharat K Mathur
President
Analytic Harmony Inc.

Alejandro Segoviano
Data Analyst
Vaughan Holland Consulting, Inc.

Nickolas Kalamotousakis
Collection Manager
The Pellettieri Group

Dimas H Ortega
Controller
Swedish Covenant Hospital

Daniel Land
Chief Executive Officer
Landmark Compliance Group

Julie Haug
Marketing Manager
Stratford Advisory Group, Inc.

Keith Richardson, FHFMA
Chief Financial Officer
Adventist La Grange Memorial Hospital

Julie A. Burke, CPA

Dan Skiles
Southern Illinois Healthcare

Amanda Shatzman
Manager of Financial Affairs
Northwestern Memorial Hospital

Lisa Macholl
Patient Financial Services Project Consultant
Northwest Community Hospital

Anita Singh
Director
MBOS

Cheryl L Barr
Account Manager
American Hospital Association

Janis L Mason
American Hospital Assocaition

Annie Stein
Associate
Melio and Company

Robb Kanter
Manager Regulatory Integrity
Advocate Health Care

Robert J. Stryczek
Account Manager
Next Recovery Source

Nicholas J. Del Priore
Consulting Services Analyst
MultiCare Consulting Services, LLC

James Brock
Director of Medical Billing & Collections
Walgreens

Kari L O'Connor
Manager
Ernst & Young

Carolynn F Heimlich
Account Manager
McKesson

Nick Morse
Chief Financial Officer
Apex Healthcare Solutions

Marcella Graf
Executive Controller
Apex Healthcare Solutions

Jennifer Grande
Regional Vice President, Midwest

Jamie W Paul
Senior Vice President
Citibank

Ronald J Michalak
Director of Business Resource Solutions
Metropolitan Chicago Healthcare Council

Cindy Ferianc
Director of Revenue Management, Physician Services

Bob Wilhelm
Chief Executive Officer
Adreima

(continued on page 23)

Welcome New Members

(continued from page 22)

Ryan D. Siemers

Mary D Treacy Shiff
Vice-President Finance
Advocate Good Samaritan Hospital

Joseph P Tuma
Regional Sales Director
dbtech

Anthony G. Evers, CPA
Chief Finance Officer
Norwegian-American Hospital

Loren F. Chandler, CPA
Consultant
Tatum

Don N. Kleinmuntz
President
Strata Decision Technology LLC

Maureen Bryant
President and CEO
Provena Mercy Center

Member Opportunity to Contribute

Are you new to First Illinois HFMA? A student member? Are you looking for an opportunity to contribute to the chapter and learn? We are looking for members to attend our seminars **– free of charge –** in exchange for providing "recaps" of the events for our newsletter. If you are interested, please contact Tim Manning via email at Newsletter@hfma.com.

New Member Profile

Ronald J. Michalak

Demographic Information:

Name: Ronald J. Michalak

Organization: Metropolitan Chicago Healthcare Council

Current Position: Director of Business Resource Solutions

Education: MBA

Years in healthcare: 25+

Questions:

Why did you decide to join First Illinois HFMA?

Great resource, information, education and networking.

What is your greatest achievement outside of work?

I know it sounds cliché, but raising two great daughters who have just completed their college education and are going on to great careers themselves.

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

"It's all good….everything presents an opportunity."

Finish this sentence:

I think healthcare reform will… *quickly evolve into a model that this country has never before experienced. It will present great challenges and will need the strategic direction of great leaders to weather the transition and take it into the future. Again, it presents a great opportunity for leadership and innovative ideas."*

Need for Speed in Your Revenue Cycle?
Let HIM be the Engine

BY TAYLOR STEINHOFF

Similar to many consumers, I constantly fall victim to a catchy tagline in an overplayed commercial. For years, the J.P Wentworth's reference to structured settlements reiterated, "It's your money; use it when you need it!" Recently, when working with healthcare professionals to improve their revenue cycle turnaround time, this message resonated strongly.

In healthcare, the billing cycle is often on hold until all services are rendered and the patient is discharged. Delayed billing can equate to millions of dollars of absent revenue for services already performed. Just like that commercial, your healthcare facility demands, "It's my money, and I need it now!"

Undoubtedly, many departments throughout the healthcare facility can make changes to positively affect the bottom line. A financially beneficial place to start is with the team that first handles the patient records post-discharge.

The staff in the health information management (HIM) department is one of the hospital's most valuable resources, and the critical initiatives on the HIM plate are unceasing. Scanning in the HIM department signals the start of the revenue cycle race. By scanning more efficiently, the revenue cycle will improve and the HIM department can free up full time equivalents' (FTEs) time to focus on ICD-10, meaningful use, and other critical priorities.

The type of scanning process a healthcare facility employs will affect the number of FTEs, cost, and turnaround time for billing. More traditional methods tend to require more staff because the prep process is time consuming. During prep, extensive time is spent checking for bar codes, removing foreign bar codes, sorting and grouping like documents, chronologically sorting documents in date order, and insuring the patient identification information is on each page for compliance. By utilizing technology, it is possible to automate many of these manual processes and improve efficiently and accurately in the electronic record for patient care.

In my experience, intelligent technology combined with best practice workflow often reduces the number of FTEs required and the turnaround time from scanning to coding can be reduced to 24 hours or less, which often results in substantial improvement in the revenue cycle. The chart below compares various scanning methodologies based on an average of three million images per year.

3 Million Images Scanned per Year to the Document Level

FTE Scanning Method	*Prep*	*Scan*	*Index*	*QC*	*Yearly Total*
Separator sheets	9.00	.75	1.25	2.50	13.50
Bar coded - 85%	5.50	.75	1.00	1.50	8.75
Intelligent scanning technology	2.25	.75	.75	.75	4.50

Traditionally, healthcare facilities use separator sheets or bar coded forms to automate the scanning process. Separator sheets are the most time consuming and require an average of 13.50 FTEs per three million images per year. This process is labor intensive and requires HIM staff to insert bar coded sheets throughout the patient chart in order to index to the document level. Document level indexing provides the physician with quicker access to specific areas of the scanned chart when the patient readmits for quality patient care and improved physician satisfaction. If a healthcare facility chooses to use bar coded forms, the manual processes of applying individual labels to documents within the chart will be a continual issue, which will inflate cost. Hospitals using bar coded forms may have approximately 40 – 85% of the documents preprinted with bar codes. For example, a healthcare facility that has 85% of documents bar coded will require approximately 8.75 FTEs per three million images, per year. If a bar code is missing, a sticker or separator sheet must be applied so the chart can be indexed to the document level. If the bar code is misread, it must be manually indexed by hospital staff. These processes require extra staff and often slow the turnaround time in the department.

In comparison, healthcare facilities using intelligent technology with best practice workflow average 1.5 FTEs per million images scanned per year. For example, a 500-bed hospital that was approximately 60% bar coded was scanning roughly eight million images per year using 23 FTEs. By implementing intelligent technology that did not require bar codes or separator sheets in their scanning process, they were able to:

- Increase the total number of scanned images per year to 10.5 million, which created a more complete electronic chart
- Eliminate their need for third shift staffing
- Decrease average turnaround time from 96 hours to 13 hours
- Improve downstream processes and reduced their DNFB

Often, the importance of the scanning process is minimized in the revenue cycle, but it's a critical area where process improvements can nearly always positively impact the healthcare facility's revenue. The easiest path forward may seem like continuing with current HIM processes, but in that case, expect stagnant results. If turnaround time from scanning to coding exceeds 24 hours, then challenge HIM staff to reevaluate their resources and make process changes to achieve new benchmarks. As a result, an increase in scanning productivity should correlate to a decrease in DNFB, and your healthcare facility will be singing a new tune. After all, you need your money, and you need it now, right?

First Illinois Speaks
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 2012	September 10, 2012
January 2013	December 10, 2012
April 2013	March 10, 2013
July 2013	June 10, 2013

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

Chapter Educational and Events Calendar 2012

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

Tuesday, August 14, 2012
Webinar: "Closing the Gap in Clinical Variation" - VERRAS

Thursday, August 16, 2012
HFMA 101

Thursday, August 21, 2012
Social Outing: White Sox Game

Tuesday, August 28, 2012
Webinar: "Managing Productivity to Ensure Appropriate Staffing/Getting Strategic About Cost Management" - Kaufman Hall

Tuesday, September 11, 2012
Webinar: "Increasing Customer Satisfaction While Improving Financial Results" - Connance, State Collection Service

Wednesday, September 12, 2012
Golf Outing: Gleneagle Country Club

Thursday, September 20, 2012
OI Supply Chain

Tuesday, September 25, 2012
Webinar: "Are You Prepared for the Major Medicaid Changes?" - Peterson Healthcare Organization

Friday, September 28, 2012
CFO Breakfast

Thursday, October 4, 2012
Revenue Cycle 101

Tuesday, October 9, 2012
Webinar: "Direct Bank Purchase of Section 501c3 Bonds" - JPMorgan Chase Bank, N. A. and Ungaretti & Harris

Thursday, October 18, 2012
Accounting/Reimbursement Program

Tuesday, October 23, 2012
Webinar: "Closing the Loop - Orders, schedulstration to clinical results" - Passport Health Communications

Friday, October 26, 2012
CFO Breakfast

Tuesday, November 13, 2012
Webinar: "Accessing Low Hanging Fruit Opportunities in Your Hospital to Achieve Dramatic Bottom Line Improvements" - Healthcare Insights

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