First Illinois Speaks

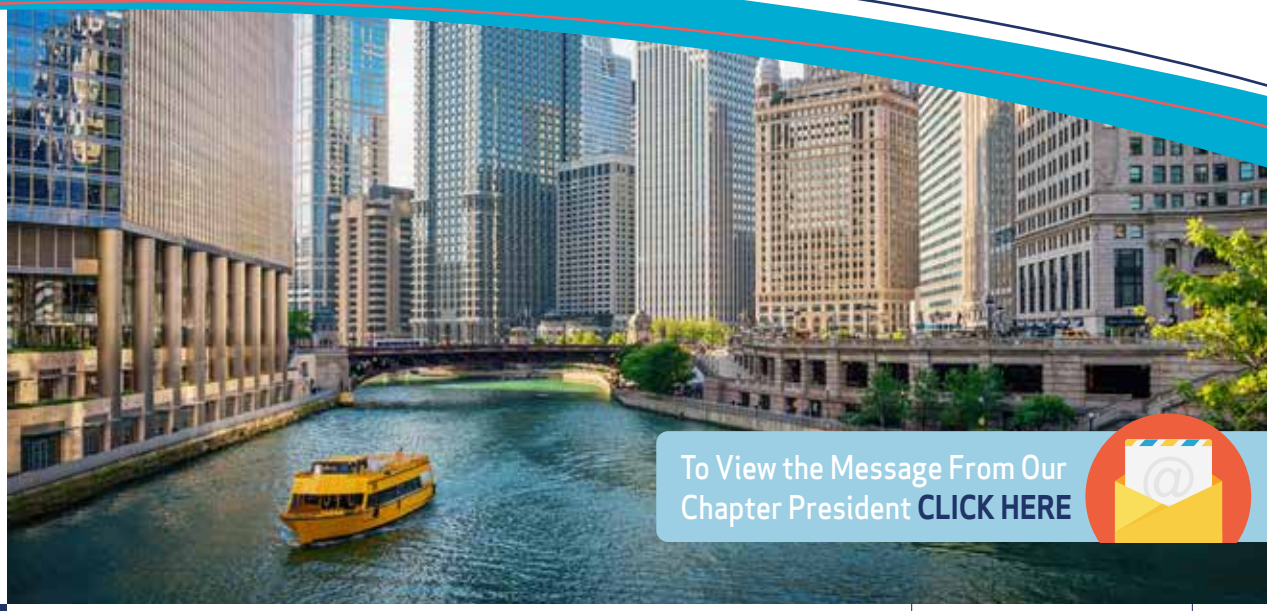
hfma

HFMA's First Illinois Chapter Newsletter

June 2020

hfma Your Challenge. Our Mission. 20-21

News, Events & Updates of the First Illinois Chapter begin on page 24



In This Issue

Reprinted from **HFM**

How Orlando Health stemmed healthcare costs by eliminating unnecessary clinical process variation

BY THOMAS KELLEY, MD; DONNA JANSEN, RN; BART RICHARDS, CHFP; NICK RADICE, CHFP

A six-step initiative by Orlando Health in central Florida to eliminate avoidable variation in healthcare delivery reduced the health system's average length of stay (LOS) by roughly 0.75 days, while yielding a corresponding financial benefit of about $1.2 million.

Variation in healthcare delivery is necessary to some extent because of the need to tailor interventions to each patient's unique circumstances. But it also can reflect inefficiencies in care processes that contribute unnecessarily to the nation's high costs of care.

Recognizing this reality, in 2017, Orlando Health, a $3.8 billion not-for-profit healthcare system serving central Florida and beyond, embarked on an initiative to eradicate unnecessary variation in care to its patients with the goal of improving quality and outcomes while addressing rising hospital lengths of stay (LOS) and resource utilization.

Unnecessary variation was defined as "differences in care provided by different caregivers for patients with the same diagnosis that increase costs without contributing to better outcomes." The health system branded the initiative internally as "Right Care."

Focus for Right Care

The initiative's goal was to design and implement standard processes, or care pathways, to deliver the most appropriate care to every patient, every time, across Orlando Health facilities. The care pathways aimed to define processes founded in evidence-based medicine wherever possible, and to supplement gaps in evidence-based care with physician consensus on how to deliver high-quality, consistent patient care.

The care pathways were designed to be interdisciplinary tools easily accessible for all Orlando Health providers. Although reducing practice variation was the primary goal, pathways were designed to allow for interventions to be tailored to unique patient needs.

(continued on page 2)

 (continued from page 1)

The initiative was led by Orlando Health's vice president of quality and clinical transformations with a project management team (Right Care team) that included representatives from clinical informatics, clinical transformation and the enterprise data warehouse. Deployment of the care pathways was preceded by two years of groundwork in project planning, communicating with physicians, and organizing and validating necessary databases. The overall initiative encompassed the following six steps.

1 IDENTIFY TARGETED DISEASE STATES

The initiative's first phase involved determining which diagnoses would be best to target first for developing care pathways. The Right Care team planned to use these initial diagnoses as a pilot to refine processes for developing and implementing pathways in the future. Based on the time commitment for each diagnosis and the level of impact desired based on the time and resources invested, the team decided to limit the initial focus to six diagnosis groupings.

The team determined that the most suitable diagnoses to focus on at this stage would be those that presented the greatest improvement opportunities. To identify where the greatest opportunities lay, the team analyzed key quality indicators based on patients' discharge diagnoses, looking at discharges from the system's five acute care hospitals for the prior 12 months of calendar year 2016.

Diagnoses were selected based on the following factors:

- Cases with high actual LOS compared with expected LOS based on the diagnosis' MS-DRG
- High-volume cases systemwide
- Disease states most capable of being standardized

Based on this review, the team selected the following diagnoses:

- Large and small bowel procedures
- Congestive heart failure
- Sepsis
- Chronic obstructive pulmonary disease
- Pneumonia
- Urinary tract infection

2 IDENTIFY CHAMPIONS AND BUILD CLINICAL CONSENSUS TEAMS

To lead in creating the care pathways, the Right Care team identified physician champions who possessed deep clinical expertise and a high degree of influence within the system. The physicians then provided input regarding who should be selected to be members of the focused multidisciplinary teams, called clinical consensus teams (CCTs), that would be charged with creating the pathways.

Although each CCT's composition was tailored to the particular diagnosis, CCTs typically included the physician champion, key specialist physicians and surgeons, hospitalists, quality officers, nursing staff, case managers, pharmacists and an executive leader. Depending on the nature of the diagnosis, the teams could also include representatives from therapy teams, nutrition, palliative care and other departments.

To incorporate input from across the system and increase physician buy-in, participants were purposefully selected from each hospital. Wherever possible, the teams also tried to leverage existing system initiatives focused on a diagnosis to reduce duplicative work.

3 DEVELOP CARE PATHWAYS

Once the CCTs were assembled, the Right Care team scheduled three working sessions with each team to collaboratively establish the process for creating care pathways. The in-person meetings were held in a conference room of the most centrally located and largest hospital in the system.

The rationale and goals for Right Care were introduced during the first of the three working sessions. The Right Care team reviewed with the CCT the benefits of reducing unnecessary variations in care and the reason for selecting the particular diagnosis as an initial area of focus for the project. To highlight the improvement opportunity, analytics were shared summarizing hospital and overall system performance in chief quality indicators for the targeted diagnoses.

Prior to each CCT's initial meeting, the physician champion identified key articles and resources with the most up-to-date, evidence-based practices for the diagnosis.

During the meeting, all attendees received flash drives with these resources and were asked to review them prior to the next working session.

The initial meeting concluded with an overview of the structure and benefits of care pathways.

Three to four weeks preceded each of the next two working sessions. These sessions were scheduled for four hours to provide

Top 10 clinical variation keys to success

- Physician ownership
- Hospitalist and specialist physician involvement
- Accurate and vetted data with analytical support
- Leadership engagement
- Strong project managers
- Organized communications plans
- Multidisciplinary clinical consensus teams
- Clinical informatics support
- Performance tracking scorecards
- Defined reevaluation structure

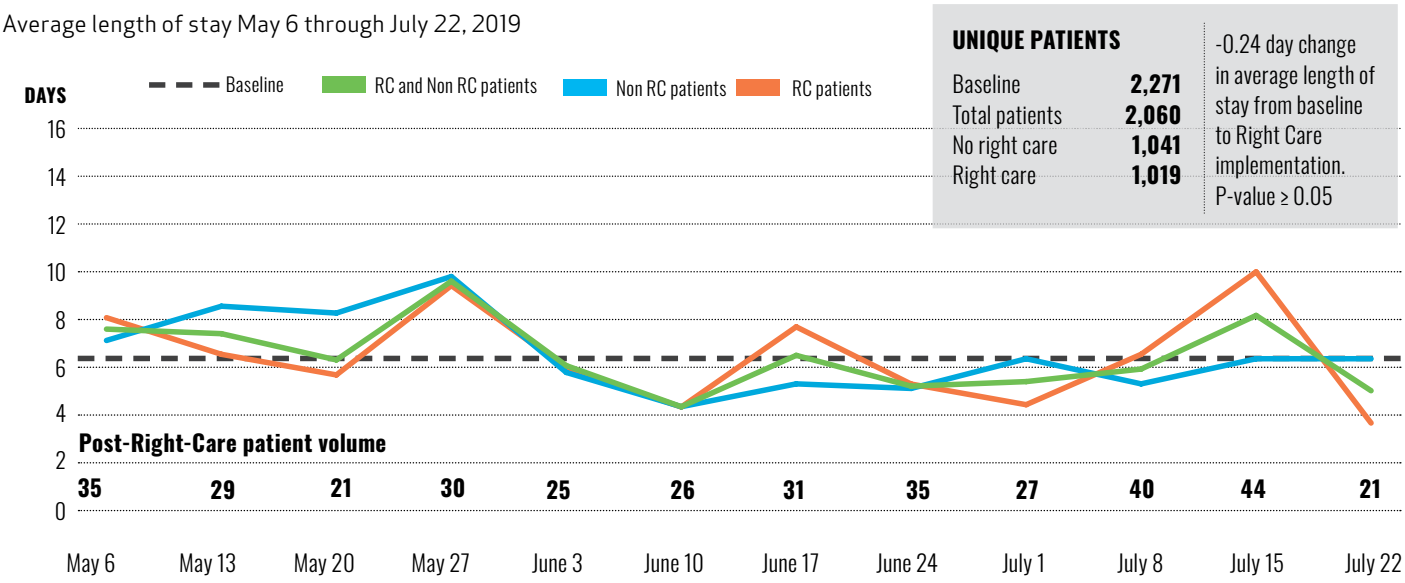
(continued on page 3)

 (continued from page 2)

Sample Right Care scorecard

This scorecard shows results and trends for patients in the Right Care pathway (RC) and those not in the pathway (non RC).

Average length of stay May 6 through July 22, 2019



UNIQUE PATIENTS

Baseline	**2,271**
Total patients	**2,060**
No right care	**1,041**
Right care	**1,019**

-0.24 day change in average length of stay from baseline to Right Care implementation. P-value ≥ 0.05

Source: Orlando Health, 2019

dedicated time for the CCTs to develop, review and finalize their care pathways.

Care pathways were goal-oriented and time-specific based on a patient's progression in care. Areas of focus varied depending on the diagnosis, but pathways typically accounted for the following:

- Patient education
- Consultations
- Assessment and testing
- Medication
- Dietary recommendations
- Recommendation for patient activity levels
- Discharge criteria
- Post-acute follow-up

Based on key questions and follow-up items discussed during the second session, subgroups of four to six members were deployed to explore ideas and best practices and then return to the third working session to report recommendations to the greater team. Subgroups focused on topics such as pharmacy, lab, patient education, nutrition and anesthesiology.

The third working session served as the platform to finalize and review the care pathway. During this meeting, the subgroups presented their recommendations on key action items, and any incomplete areas from the previous session were addressed. At the end of the meeting, the CCT was given an opportunity to review the final draft of the care pathway and relay feedback to the Right Care team and physician champion.

4 COMMUNICATE PATHWAYS THROUGHOUT HEALTH SYSTEM

To help all employees understand the mission and vision of the Right Care initiative, the Right Care team partnered with Orlando Health's marketing and communications team on developing a comprehensive internal communication strategy and plan.

The goals of the plan were to:

- Inform and educate
- Connect the dots to strategic imperatives and Truven 100 goal[a]
- Obtain buy-in that Right Care is everyone's responsibility
- Ensure compliance

The communication plan was executed using electronic communications via all existing portals to all audiences, posters on nursing units, presentations to operations and team member councils, and online assigned education through an internal platform. The plan helped to gain buy-in prior to the rollout of the pathways and continued to motivate the team throughout the implementation phase.

[a]Truven Health Analytics is part of IBM Watson Health, which annually recognizes the 100 top hospitals in terms of overall performance around quality of patient care, operational efficiency and financial stability. Truven uses publicly reported data, mostly Medicare, to compare hospitals' performance.

(continued on page 4)

 (continued from page 3)

5 COMMUNICATE PATHWAYS THROUGHOUT HEALTH SYSTEM

Once a care pathway draft was finalized, the physician champion brought the draft to the Orlando Health medical executive meeting for review and approval. Approved pathways then were rolled out at each of the system's hospitals simultaneously (with the exception of Orlando Health's children's hospital) without any intervening pilot program. Leading up to the go-live date, targeted communication plans were deployed to inform physicians of the release, changes to workflows and expectations moving forward.

The Right Care team recognized early that the success of the pathways hinged on willingness of the system's hospitalists to adopt them, and this was the reason each CCT included a hospitalist. During implementation, the teams conducted regular follow-up meetings with key hospitalists to socialize the pathways and reassure the physicians that their daily workflows would not be significantly impacted.

The Right Care team offered continuous support throughout the rollout to answer questions, collect feedback and quickly address barriers or concerns. Although the benefits of the pathways were clearly communicated, physicians were not formally required to use the pathways for their patients. To encourage adoption, the team developed and distributed tracking tools to demonstrate the benefits in care associated with the pathways.

6 MONITOR RESULTS

The Right Care team worked closely with members of the system's enterprise data warehouse to analyze and compare patient outcomes when care pathways were used and when they were not used. The outcomes were aggregated in monthly scorecards at the hospital and system level to monitor successes and identify improvement opportunities.

The scorecards tracked key quality metrics for patients who were eligible for a care pathway based on diagnoses and compared results with a baseline timeframe prior to Right Care deployment. Results were reported for patients on a pathway compared with patients not on a pathway to illustrate the benefits associated with using the pathway. The key quality indicators included in scorecards were LOS, mortality, complications in care, and readmissions.

The Right Care team also worked with the finance department to calculate the financial impact of the improvements in quality. These results were intermittently communicated to the physicians to further validate their efforts but not regularly tracked on the monthly scorecards.

Results and Keys to Success

Within a year after deploying the care pathways, Orlando Health realized the significant improvements in outcomes for patients with a pathway diagnosis. The health system attributed this success to strong project planning and execution, continuous communication, internal ownership and effective efforts to build a physician culture of continuous improvement.

Physician leadership, engagement and advocacy were paramount. From the very start, the continual and consistent physician messaging on the importance of clinical standardization and the expected benefits was instrumental in motivating physicians to get on board with the process of developing and utilizing the refined care pathways.

To ensure the pathways would live up to the promise of not substantially changing physicians' daily workflows, which was deemed critical to success, the Right Care team worked closely with the clinical informatics department to integrate the pathways into preselected order sets in the electronic health record. To encourage hospitalists to use the order set, the team used the scorecards and other means to show them that the tools would promote higher-quality care, based on the most recent evidence-based medicine, without requiring additional consults or otherwise adding time to their day.

Beyond the quality and financial benefits, the team knew it had achieved success when physicians began to come forward without any prompting, asking to be part of CCT for the next care pathway.

About the Authors

Thomas Kelley, MD, *is vice president of quality and clinical transformations, Orlando Health System, Orlando, Fla. Contact him at thomas.kelley@orlandohealth.com.*

Donna Jansen, RN, *is senior manager, Claro Healthcare, Chicago, and a member of HFMA's First Illinois Chapter. Contact her at djansen@clarohealthcare.com.*

Bart Richards, CHFP, *is managing director, Claro Healthcare, Chicago, and a member of HFMA's First Illinois Chapter. Contact him at brichards@clarohealthcare.com.*

Nick Radice, CHFP, *is a manager, Claro Healthcare, Chicago. Contact him at nradice@clarohealthcare.com.*

Message From Our Chapter President

BY LANA DUBINSKY, OUTGOING PRESIDENT, 2019-20 &
BART RICHARDS, CHFP, PRESIDENT, 2020-21

Farewell from outgoing FIHFMA president, Lana Dubinsky

Dear Friends and Colleagues,

I know that as a community we're being stretched beyond our previously conceived of limits. The work we do now will impact generations to come. The civil unrest over the past few weeks has created an opportunity for us as a community to look at the role healthcare can play in eradicating the systemic inequities across many diverse populations. I'm so proud to see our local organizations step up and denounce these inequalities while renewing their commitment to reimagine everything from provider networks to the level of access these underserved communities have to receive the care they need.

The work of our frontline healthcare workers in this challenging environment and all of you who support them through your organizations and clients has been amazing. Because of the valuable input from members and our First Illinois leadership team, I am proud to assure you that First Illinois will continue to provide value to your role, in whatever way we can. Whether that is through digital resources or educational events held online, in networking on our new online community, and in person when we get back together with new social distancing guidelines in place. Your interconnections in HFMA are more valuable than ever in this fast-changing new environment where the threat of certain healthcare resources being overwhelmed has vied with the reality that certain healthcare services have become under-utilized in the pandemic – both with major finance implications.

As I look forward to a promising year of FIHFMA value and activity under a new leadership team led by your new president, Bart Richards, I leave you with an update on a couple recent events:

Last Strategic Planning Session

May 21 was our virtual meeting to finalize the strategic plan for our coming year. Thank you to the leadership team for its hard work on this and the many members who gave them input. When we began the process, we didn't know that virtual engagement would become such a critical part of FIHFMA's coming year. During the meeting, we thanked our outgoing Directors and inducted our new Officers and Directors. With our traditional July Transition Dinner being held virtually, this action set the pace for a smooth transition as they took office on June 1. (see **page 24** for roster of 2020-21 Officers and Board)

Online Community

Our new HFMA virtual online community launched in May to give our entire membership opportunity to engage with the leadership team and ensure a way to network with each other. Don't miss out as our Membership committee is encouraging feedback now and will be giving away a limited number of $5 Starbucks e-cards for every idea posted and a grand prize of $50 for the idea with the most votes. ***Click here*** to access the site. ***Click here*** to instructions to register.

Finally, I want to extend my last official thanks as your outgoing FIHFMA president to my fellow members on the leadership team and to the many committee members and volunteers who continue to make First Illinois one of your best resources in healthcare finance. Thank you also to the many healthcare and science workers tackling this pandemic on the front line and all who've been supporting them. Kudos to our chapter members who have been working from home or in restricted office environments to resource and serve your organizations and clients despite a host of new challenges. Last but far from least, thank you to our chapter business partners without you continued support and confidence in First Illinois we would not be able to offer the level of resources and support we provide our community, thank you! It's been my honor and privilege to serve as your president, and I look forward to many more years ahead serving alongside you.

Lana Dubinsky
2019-2020 FIHFMA Outgoing President

Greetings from new FIHFMA president, Bart Richards

Thank you, Lana. The chapter is in a better place now after a year of your leadership. It has been great to work with you, and we look forward to our continued relationship in your role as Past President.

To start, thank you to everyone who has worked so hard during this pandemic, especially those who have sacrificed so much. I also wanted to acknowledge this historic time we are in. This is a seminal moment for our country, and it is an important time for

(continued on page 7)

First Illinois HFMA President's Message Continued

each of us to personally reflect on the current state of racism in the United States and what we can do as individuals to create meaningful and lasting change. HFMA's diversity statement says "HFMA values and respects diversity. Individual differences are viewed as assets that promote the growth and success of HFMA and its members. In principle and in practice, HFMA encourages and supports diverse individual viewpoints and contributions. HFMA believes that a diverse membership is a quality membership." I believe in this statement and will do whatever I can to live by this and lead the chapter this coming year accordingly.

Over the next 12 months, we will endeavor to continue some of the excellent work and initiatives that have been a focus over the last few years:

- Providing members excellent educational and social networking opportunities
- Holding our key programming events including our Fall Conference, Managed Care, Accounting and Reimbursement, and Revenue Cycle conferences
- Encouraging greater provider attendance at our events
- Continuing the First Illinois Executive Forum meetings
- Holding our executive golf outing
- Supporting individual professional growth through certification
- Driving membership and membership engagement, especially individual membership
- Supporting our Women in Leadership efforts

In addition, especially given the current state of affairs with COVID 19, we will be pursuing other initiatives as well.

- Holding more educational and social events virtually
- Creating new and exciting opportunities for our partner sponsors to be showcased
- Leveraging our existing social media platforms (LinkedIn and Facebook) to a greater degree
- Finding new ways to communicate to membership such as the President's Update via video
- Reinvigorating our focus on mentorship perhaps through focusing with our Women in Leadership committee
- As mentioned earlier, seeking greater engagement with membership through our new online community and Crowdicity tool

By way of background, I am a Managing Director at Claro Healthcare, and we live in Riverside, IL. I am married with two children, like to exercise and in the more recent years have enjoyed biking and triathlons. In terms of the First Illinois chapter, I began to volunteer with the chapter on the certification committee, was a board member and then part of the Executive Committee.

The chapter is in good hands for years to come. Rich Schefke, President-elect, and Ann Peterson, Secretary/Treasurer, are excellent leaders. Our board of directors are a dedicated group of involved members that are driving many of the initiatives listed above.

Bart Richards, CHFP
2020-2021 FIHFMA President

"You can't separate the clinical and the financial – not anymore."

People who know Healthcare, know BDO.

The BDO Center for Healthcare Excellence & Innovation

As the healthcare industry enters an era of unprecedented transformation, anticipating and understanding the future state model of healthcare is more important than ever. From advising on complex joint ventures, to M&A services, to healthcare redesign, BDO's multidisciplinary teams help organizations plan for and implement the financial and clinical changes needed to transform their institutions — and thrive in the years to come.

Chad Beste, Healthcare Advisory Partner, 847-410-5702 / cbeste@bdo.com
Janet Bliss, Healthcare Advisory Partner, MBA, 847-410-5710 / jbliss@bdo.com
Jim Watson, Healthcare Advisory Partner, MBA, 847-410-5711 / jwatson@bdo.com

@BDOHealth www.bdo.com/blogs/healthcare

Accountants | Advisors | Doctors
www.bdo.com/healthcare

BDO

Naperville Man Makes His Triumphant Return to the Ice

BY CHRISTIAN CANIZAL, NCTV17

It's seemingly business as usual for Jim Porter as he's lacing up his skates a second time, which is his usual pre-game tradition. But underneath the referee's stripes, a scar on his neck is a reminder to the Naperville resident that the night isn't just a regular game.

"I'm ready to go," said Porter. "I've been looking forward to this day for a long time."

Scary Times

In October, Porter had surgery to remove four deteriorating disks from his neck as the 51-year-old was suffering from spinal stenosis. His wife and kid recall what life was like during Jim's surgery.

"We just knew it was going to happen on November 4, but then in October he just suddenly could not lift his arms, and his spine was king of compressing. So, they had to have emergency surgery, which lasted nine hours," said Louise Porter, Jim's wife.

"It was kind of scary because I never thought my dad would be able to walk again," said Jim's son Zachary. "It was going through my mind that my dad was going to be paralyzed for the rest of his life."

Triumphant Return to the Ice

But thankfully, Jim made a full recovery and was back at the Rocket Ice Skating Rink in Bolingbrook to ref his first game since the surgery. Before he could hit the ice, he received some words of encouragement from his family.

"Don't fall down," Louise jokingly said. "Don't break any bones," added Zachary. "Protect your neck!" Louise said.

Smiling from ear to ear, Jim was back in his element, smooth skating across the rink and doing what he loves.

What He Missed the Most

"I missed the game of hockey and just being able to be a part of the game with the kids is what I missed," said Jim. "Tonight, getting on the ice I heard some people in the crowd yelling my name and it felt like where I belonged."

Alongside Jim was his longtime friend and fellow referee Mike Anderson, whom he called to ask for help.

"He was like, 'Hey, I'm coming back. I got my first game. I got it scheduled. Would you do me the honor and skate with me for that first game?' It was definitely an honor for me," said Anderson. "I actually had some other games scheduled, but I dropped those games and did this one with him."

Jim's Triumphant Return

The final score of the game in hindsight wasn't the most important thing that night, considering Jim didn't know a couple of months ago if he'd ever walk again.

"I remember sitting in that hospital wondering if I'd ever do this again, and here I am," Jim said while crying. "It's been a long time coming and I loved every minute of it."

As the final buzzer rang out at the end of the game, each of them shook hands and went their separate ways. And so did Jim, skating off with his arms raised high.

"I did it. Right? I saw a lot of my friends and I did it. I'm back," said Jim.

You certainly are Jim, welcome back.

Jim Porter is a former member of the First Illinois Chapter Board of Directors (2018-2020).

About the Author

Christian Canizal writes Sports Story Sunday for Naperville Community Television (NCTV17). Reprinted from https://www.nctv17.com/news/naperville-man-makes-his-triumphant-return-to-the-ice/.

Reprinted with permission from Naperville Community Television (NCTV17) https://www.nctv17.com/news/sports-news/naperville-man-makes-his-triumphant-return-to-the-ice/.

Sunshine Act Compliance Is Crucial for Reporting Physician Payments

It can also drive efficiency for health care and life sciences groups.

BY KEVIN MCMONAGLE, DIRECTOR, TECHNOLOGY AND MANAGEMENT CONSULTING, RSM US LLP

Understanding how to comply with the federal Physician Payments Sunshine Act—which went into effect in 2013—is crucial for biotechnology, pharmaceutical and medical device companies and health care providers. The law, commonly known as the Sunshine Act, was established in 2010 as part of the Affordable Care Act. Gaps in knowledge around compliance remain because the law is still relatively new, and companies have often used outsourced providers to handle related compliance work. Leadership at biotechnology companies that have commercialized in the past few years or are in the process of commercializing now may still be unfamiliar with how best to adhere to the Sunshine Act's regulations.

Companies subject to the law's strict requirements must track payments and other transfers of value made to U.S. physicians and teaching hospitals. The act requires all payments and transfers of value made to U.S. physicians with active licenses in the United States to be reported, regardless of where the medical activity took place (e.g., overseas).

Many interactions between physicians and the pharmaceutical, biotech and medical device industries occur to advance clinical research that is essential to discovering treatments and improving patient care. The Sunshine Act is not designed to impede these important interactions; rather, the law intends to provide the benefit of transparency and avoid the burden of inaccurate reporting.

In the current environment of the coronavirus pandemic, doctors may not have much or any time to meet with pharmaceutical representatives or attend conferences. But even as the health care system is overwhelmed by responding to the pandemic, it is important to understand the specifics of complying with this law. Here are three basic steps in tracking financial transactions, as required by the Sunshine Act:

1. **Identify the covered recipient (CR):** This could be the health care provider (HCP), the health care organization (HCO), or the health care agent (HCA).

2. **Capture spend data:** This entails accurately identifying, aggregating and tagging spend transaction data to the CR. The company must have ERP systems in place to track, aggregate, analyze and report spend transaction data to state and federal governments.

3. **Proactively share data:** Sharing data involves notification of spend transaction data to the CR prior to public filing of the reports. There must then be a 45-day window for the CR to review the accuracy of the reporting. HCP relationships must be managed through the notification, inquiry and dispute resolution process. This involves secure, private communication with the CRs to resolve issues prior to reporting and during public disclosure.

It is important to note the significance of identifying which HCPs in the United States qualify as providers. Payments and other transfers of value need to be reported only for those U.S. physicians who are currently licensed to practice in the United States, including medical doctors and doctors of optometry, osteopathy, dental surgery, dental medicine, podiatry and chiropractic medicine.

Under the Sunshine Act, meals provided to nurses and office staff will not be reportable and will not be attributed to physicians. However, some state marketing disclosure laws require disclosure of payments to a broader group of recipients, including nonphysician prescribers, nurses and office staff. Often, this spend is attributed to the physician or other prescriber in the office. For states with these types of disclosure requirements, these payments will not be preempted by the federal law, and thus are still reportable to the state. In addition, the AdvaMed Code of Ethics on Interactions with Health Care Professionals and some state laws prevent or limit meals to health care professionals under certain circumstances.

A clear understanding of the Sunshine Act reporting requirements allows companies to design useful reports within their ERP systems. Here is a look at the inputs required to ensure these reports are accurate:

Required reporting transactions:

- Meals provided to U.S. physicians

(continued on page 12)

 (continued from page 10)

- Contract services to U.S. physicians or teaching hospitals
  - Speaker programs
  - Advisory boards
  - Consulting
  - Clinical trials
- Travel-related expenses
  - Lodging
  - Hotel
  - Travel arrangement fees
- Educational items (no direct benefit to patients)
- Stocks and grants

Exceptions to required reporting transactions:

- Office staff meals

  When the value of physician meals is calculated, the total cost of the meal is divided by the total number of people who ate (including physicians and nonphysicians) and only the proportional cost that is attributable to each physician is reported. For example, if a company spends $200 on a meal for five physicians and five nonphysician staff members, the physician meals will be reported at $20 each and the staff meals will be excluded from Sunshine Act reporting.

- Meals at conferences and large-scale events

  The Sunshine Act does not require reporting of buffet meals, snacks, soft drinks or coffee made generally available to all participants at major conferences or other large-scale events.

- Patient educational materials

  Educational materials and items that directly benefit patients or are intended to be used by or with patients are not reportable. However, textbooks and journal reprints do not fall within the exclusion.

- Speaker compensation at accredited continuing medical education events

  Payments to physicians who serve as speakers at industry-supported independent continuing medical education (CME) events generally are not required to be reported, if the event is certified or accredited by the Accreditation Council for Continuing Medical Education or certain other organizations, the reporting company does not pay the physician directly, and does not select or suggest the individuals to be used as speakers.

In addition, all research-related payments and other transfers of value to U.S. physicians and teaching hospitals must be reported. Under the Sunshine Act, a payment or other transfer of value made in connection with an activity that meets the definition of research and that is subject to a written agreement, a research protocol or both should be included in the total amount of the research payment. Reporting must include both cash payments and the value of in-kind support.

According to the Sunshine Act, ownership or investment interests must also be reported. This includes ownership and investment interests held by physicians or their immediate family members and payments or other transfers of value to such physician owners or investors. The report must include the dollar amount invested and the value and terms of the ownership or investment interest, and any payment provided to the physician owner or investor. Stock options received as compensation are not an ownership or investment interest until they are exercised.

Pharmaceutical, biotechnology and medical device companies must submit reports to the Centers for Medicare and Medicaid Services by the 90th day of the calendar year. Those reports will then be published by June 30 of the same year. Before information is publicly posted, physicians and teaching hospitals will have 45 days to review submitted data and initiate disputes. If the dispute is not resolved during this 45-day period, an additional 15 days are provided to come to a resolution. If the dispute continues, the data still will be posted publicly but will be flagged as "disputed." Physicians and teaching hospitals are able to seek correction or contest reports for two years after access has been provided to a report with disputed information. Pharmaceutical and medical device manufacturers do not have the ability to opt out of the Sunshine Act report requirements.

A proactive approach to mitigating risk and designing a system for accurately tracking health care provider spending for Sunshine Act reporting requirements will help organizations optimize their operations. Designing an effective process and system for reporting health care provider spending will ultimately help pharmaceutical and medical device companies enhance their operational compliance and overall efficiency, which in turn will allow them to continue to thrive.

About the Author

Kevin McMonagle, director, Technology and Management Consulting, RSM US LLP, has over 10 years of accounting leadership experience from various industries including technology/ecommerce, software and life science companies. Most recently, he was the controller at an international life science software company where he was brought in to drive accounting/finance process change to enable the company for growth. Kevin eventually led the financial organization through the sale of the company from the bid process through integration, working directly with the investment bankers and acquirer. Contact him at kevin.mcmonagle@rsmus.com, or 267-419-2222.

Easing Revenue Cycle Workflow in an Era of Unprecedented Remote Work

BY CALEB BURRILL, FLYWIRE

Many revenue cycle leaders today are faced with a nearly impossible balancing act. Increase collections, erase bad debt, navigate the complex world of claims and do it with less workers than ever before. Oh, and if that wasn't enough, the workers that you do have won't be coming into the office any time soon.

Over 1.4 million healthcare workers in the United States have lost their jobs due to Covid-19; 266 hospitals have furloughed workers since the start of the pandemic. While the coronavirus has plummeted communities across the country into a health crisis, the loss of lucrative elective procedures and the unexpected costs associated with protective equipment have proven to be too much for health systems to bear.

The American Hospital Association recently predicted that U.S. hospitals and health systems would reach losses of $200 billion by the end of June. Elective procedures account for $160 billion of that estimated loss.

In Illinois, the financial stability of its health systems is similarly in question. According to the Illinois Health and Hospital Association, Illinois hospitals have seen outpatient procedures reduced by 50 percent over the last three months. In some cases, reductions have been as high as 70 percent. Likewise, inpatient procedures are down 30 percent. In a recent article by ABC News, the University of Chicago hospitals, Loyola University Medical Center and Lurie Children's Hospital have all recently announced employee furloughs. In the case of the University of Chicago, nearly 800 workers were said to have had their jobs impacted.

These right sizing measures are expected to continue deep into the year as many revenue cycle experts assume recovery will be slow even after virus cases decelerate.

In truth, many hospitals were already facing an affordability problem in their patient populations prior to the onset of the coronavirus. Higher deductible plans have forced the patient into an unfamiliar role as payer that they simply weren't prepared for. As many patients across the country lose their jobs, the loss of employee sponsored insurance and the depletion of well-kept

(continued on page 14)

 (continued from page 12)

savings will only elevate the need for health systems to implement more affordable solutions. Prior to the onset of Covid-19, 47% of Americans couldn't afford a medical bill over $400. After Covid-19, that figure seems even more daunting. To date, over 13 million Americans have lost their employee-sponsored health insurance.

Revenue cycle leaders need to learn how to do more with less, but how do you ease the burden off of remote staff and solve for patient affordability all while driving key metrics like days in AR, aging percentages and cash posted revenue that are still important for the overall healthy functioning of the business?

How Automation Can Help Support Your Remote Force

As always, leveraging available technology is the answer. Digital automation tools can be used to drive key initiatives like customer segmentation, patient engagement and pricing transparency. These tools are designed to complement remaining staff while leading to a host of other efficiencies and additional benefits, like rises in patient self-service, patient satisfaction and reductions in call volume related to payment.

Technology that specializes in workflow automation incorporates rule-based logic to streamline manual work. Automation tools are self-operating, thereby incorporating a "zeo-touch" framework to previously time consuming or complex revenue cycle processes like data entry, customer service, patient collections and claims management. The best workflow automation tools leverage machine learning and artificial intelligence, which synthesize large sets of data in order to build predictive models capable of continuous learning, iteration and improvement.

Automation tools have been proven to help revenue cycle leaders maintain or boost productivity, reduce human error and reap tremendous cost savings. Before the coronavirus, roughly five hours per week were dedicated to data collection from customers. That number accounted for nearly 13% of staff time during a given work week and has only increased. The elimination of cumbersome tasks like manual data entry offers a way for revenue cycle leaders to lift that burden from remaining remote staff allowing them to direct their focus to more high valued projects.

By automating large portions of their patient collections, our client Mosaic Life Care witnessed their staff-assisted payments drop by 38% year-over-year. Mosaic was then free to reallocate staff higher up the revenue cycle to assist patients with preservice financial planning. Mosaic also significantly improved their cash position for self-pay, including pure self-pay and balance after insurance. The system's days to payment was reduced by 86%, dropping from between 45 and 50 to just seven days with Flywire.

Automation tools can also allow revenue cycle leaders to experience significantly more flexibility and scalability than ever before, making swift changes to their collections workflow with minimal hassle. In a recent Becker's webinar hosted by Flywire, Michigan based Hurley Medical Center shared that their patient population was plunged into a deep financial crisis due to the coronavirus exacerbating already severe economic conditions.

Senior Director of Revenue Cycle Mike Marulli knew that they needed to adapt quickly: "We turned to our patient statement cycle and our payment plan program. We worked with Flywire to come up with some creative things that we felt were really beneficial. We quickly realized that based on calls that we were starting to receive from our customers that we needed to focus on our self-pay patients."

Hurley augmented the default date of their payment plans, pushing back the date from 30 days to 90, provided discounts to its patient's monthly balances driving them down in some cases by 90% while maintaining a minimum threshold of $25, and pushed timely communications out to their patient population including policy changes, available affordable options and financial education without having to involve staff.

By leveraging available digital technology, revenue cycle leaders can help solve meaningful challenges to remote staff while simultaneously creating real, affordable options for patients.

About the Author

Caleb Burrill is the Author and he supports producing content across a variety of areas at Flywire.

Resources

https://www.npr.org/2020/05/08/852435761/as-hospitals-lose-revenue-thousands-of-health-care-workers-face-furloughs-layoff

https://www.latimes.com/california/story/2020-05-02/coronavirus-california-healthcare-workers-layoffs-furloughs

https://www.beckershospitalreview.com/finance/49-hospitals-furloughing-workers-in-response-to-covid-19.html

https://www.beckershospitalreview.com/finance/how-2-michigan-health-systems-revolutionized-their-revenue-cycle-process-after-covid-19.html

https://abc7chicago.com/hospital-furloughs-health-care-workers-furloughed-healthcare-pay-cuts/6213405/

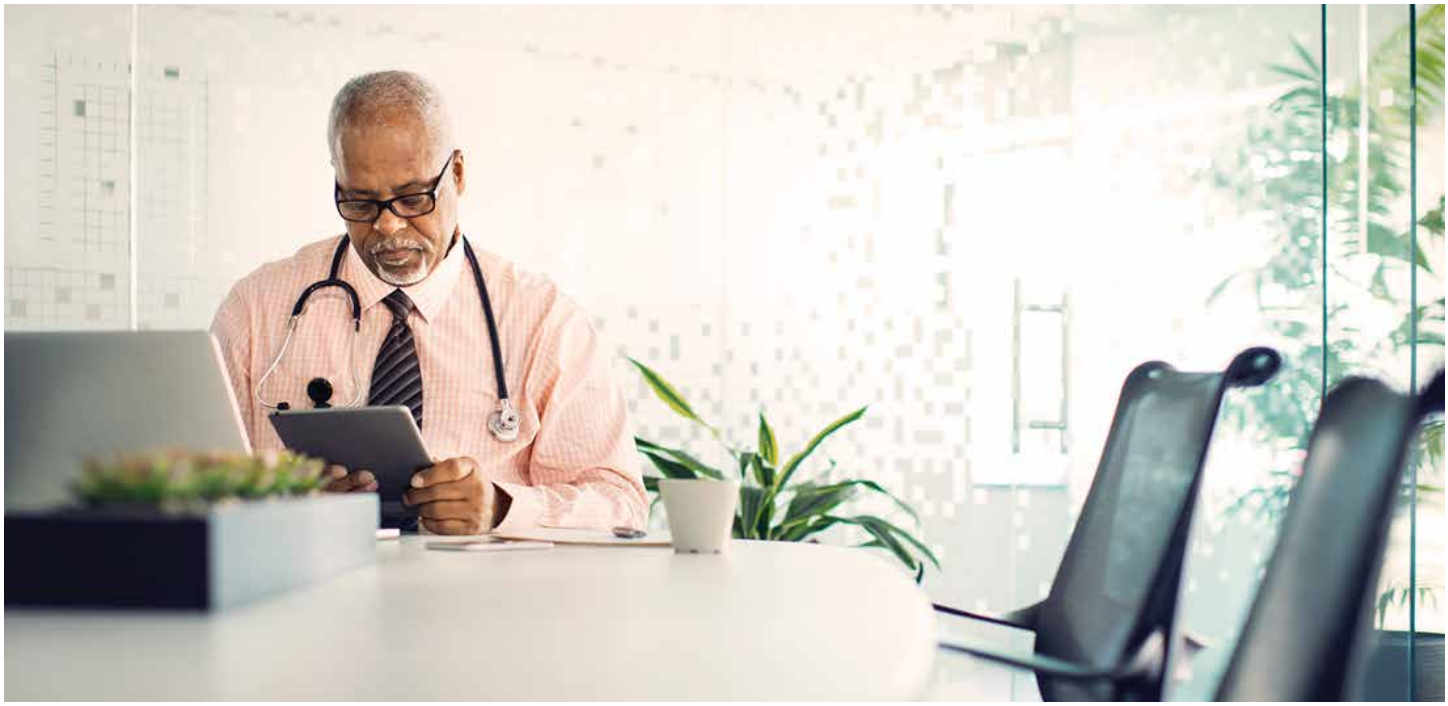
https://www2.deloitte.com/content/dam/Deloitte/tr/Documents/process-and-operations/TG_Google%20Machine%20Learning%20report_Digital%20Final.pdf

https://blog.capterra.com/machine-learning-and-artificial-intelligence-statistics/

https://www.beckershospitalreview.com/finance/how-mosaic-life-care-simultaneously-improved-patient-experience-and-collections.html

Emerging from crisis: A guide for healthcare providers

BY CHRISTOPHER JONES AND MATT WEEKLEY



COVID-19 Financial Impact Model for healthcare

Healthcare providers dealing with surges of COVID-19 patients struggle to look beyond the current crisis. But the actions leaders take now will set the stage for how they emerge from the crisis.

The COVID-19 pandemic is unlike anything we've seen. It's affecting communities in every state and nearly every country around the world. Some hospitals, health systems, physician practices, and senior care and living organizations are dealing with surges of COVID-19 patients, while other specialties have seen a drastic reduction in visits. These situations may make it hard to look beyond the current crisis, and yet, leaders of those organizations must begin to consider how they'll emerge from the current battle and what must be done now to ensure long-term sustainability.

Crisis management in the age of COVID-19 consists of three phases:

Phase 1 — Respond: Patient and workforce experiences are amplified during a crisis. The actions you take today and how they affect your people, patients, and their family members will be remembered forever, positive or negative.

Phase 2 — Restart: After an initial response plan is in place, organizations must prepare a plan to get back to business. But the transition will not be cut-and-dried. Expect to keep a portion of the leadership team focused on responding to the crisis, even as others start working on the important task of moving the organization forward.

Phase 3 — Be ready: The saying goes that you should never let a crisis go to waste. Understanding what worked and didn't work during the COVID-19 pandemic should inform healthcare organizations' long-term strategies and models of care so that they're prepared for the next crisis.

Successfully navigating the transition will require bold and sensitive leadership. Those who fail to provide that leadership may risk exasperating staff, providers, and patients, and falling behind competitors.

While it seems to be in the distant future, we will emerge from this crisis — and healthcare organizations will need to rethink everything about how they operate in the new normal of social distancing and medical distancing. Successfully navigating the transition will require bold and sensitive leadership. Those who fail to provide that leadership may risk exasperating staff, providers, and patients and falling behind competitors. Here we've highlighted some critical actions to put your organization on a path to full recovery.

Leadership and Governance

As you start to move beyond response management, remember that restart scenarios won't be perfect. In a recent article on how perfectionism will slow you down in a crisis, Dr. Michael Ryan, head of the World Health Organization Health Emergency Program, says, "If you need to be right before you move, you will lose. Speed trumps perfection." As leadership teams make the difficult decisions necessary to move beyond the current crisis, it's important that C-suite members embrace what's good about these imperfect

(continued on page 16)

 (continued from page 14)

ideas, rather than dwell on what's wrong, and work together to find an effective path forward.

The current crisis is challenging C-suite members to leave their silos and stretch new leadership muscles. That means being willing to listen to different voices and speak up when they have insights about domains outside of their areas of expertise.

Critical Actions:

- Maintain constant communication and collaboration so your executive team is complementing, rather than tripping over, one another.
- Consider partnering with other healthcare organizations — for example, share staff or pool funds to acquire necessary personal protective equipment (PPE).
- Review updated annual budget and three- to six-month rolling cash flow forecasts to assess the impact of lower elective volumes, increased COVID-19 spending and impact of CARES Act relief programs.
- Contemplate different scenarios for continued COVID-19 impact on patient volume, staffing and supplies.
- Determine at what point to bring back furloughed departments, restart elective procedures, and make capital investments.
- Review and update applicable policies and procedures, such as those for remote working arrangements and telehealth. Consider new policies to maintain appropriate social distancing, such as protocols for in-office visits by patients as well as vendors and others who visit the facility.

Workforce

In the midst of chaos and uncertainty, people crave decisive leadership. Leaders who are seen as indecisive will lose the battle for talent as the industry recovers.

During the restart phase, one of the most critical decisions is when to bring back furloughed departments and restart elective procedures. Leaders must balance several factors to make those restart decisions, including demand from patients and provider burnout. Most importantly, be completely transparent about how and why you bring some service lines back before others.

Critical actions:

- Prioritize employee safety, always.
- Instill confidence in leadership through honest, open and frequent communication.
- Cross-train clinicians to achieve twin goals of providing coverage in case of a future emergency and decreasing the number of interactions with a patient in each given process.
- To address and manage continued low volumes and reduced revenues, consider additional furloughs, mandatory paid time off (PTO), negative PTO balances, layoffs, or across the board salary reductions for managers and above.
- Assess how your culture has helped or hindered your response to the current pandemic. Reinforce what has worked, and work to change what has been a liability.

Financial Performance

With the short-term aid available to healthcare organizations, it's critical not to have a false sense of security. Based on an understanding of repayment periods and terms, financial leaders must put in place strategies to maximize financial aid and manage overall cash flow. Otherwise, their organizations will be debilitated by future cash shortages made worse by unanticipated carrying costs.

Most CFOs are in their comfort zones when it comes to financial projections, expense reduction, and liquidity management. But the restart phase is a new frontier that will challenge CFOs to look ahead and help the organization chart a path forward in an uncertain future. CFOs must push themselves to remain hopeful and optimistic, and to embrace imperfection.

Critical actions:

- Update annual budget and establish a three- to six-month rolling cash flow projection to reflect the impact of continued lower volumes of elective procedures, increased COVID-19 spending, and CARES Act relief funds and repayments over appropriate timelines. Assess and communicate how different timelines for recovery may impact the ability to repay advances and loans.
- Consider turnaround and restructuring activities to help put the organization back on solid footing.
- Draw on outside perspectives regarding likelihood of a resurgence of infections, as well as different scenarios for when area businesses will go back to work.
- Continue to focus on core financial management, including implementing a cash preservation strategy, revisiting and revising the capital expenditures plan, optimizing revenue cycle performance, and proactively reaching out to vendors and creditors to discuss issues with debt covenants or timely payments.
- Diligently capture all COVID-19 related costs for the purpose of supporting CARES Act relief funds received, which will either be forgiven or repaid based on the terms and conditions of the funding source.

Operational Efficiency

Operating in the pandemic likely shed light on ways to improve efficiency and better prioritize resources. As you begin to work through the backlog of elective surgeries and procedures, even small

(continued on page 17)

 (continued from page 15)

improvements in efficiency can make a big difference in the number of patients you can effectively serve in a day.

Consider ways to better deploy talent for greater operational efficiency. While most healthcare leaders would say that they're operating as lean as they possibly can, given that labor makes up 50 to 60 percent of healthcare organizations' expenses, it's worth taking another look to make sure you have the right people in the right place at the right time.

For hospitals and physician practices, scheduling and prioritization of patients will soon take center stage, and these decisions could make or break the organization. Do you have a plan for which patients will get priority? This prioritization plan might include factors such as the patients' health risks and comorbidities, the source of referral, payer type and provider availability. However you prioritize these visits and procedures, make sure you're ready to handle the increase in volume. Stubbing your toe on these delayed procedures could be disastrous for patients and for your organizational reputation.

Critical actions:

- Reassess staffing levels based on volume by unit, department or office.
- Assess vulnerabilities in the supply chain, especially for critical PPE, and reconsider the conventional wisdom of a just-in-time approach to supply chain management.
- Evaluate strength of referral network for critical services that are needed alongside your organization's procedures.
- Step up cross-training efforts, considering all qualified care givers and other staff.
- Continuously review margins in all operating entities, including clinics and other ancillary providers, and eliminate discretionary expenses as much as possible to reduce cash flow burden.
- Proactively develop a "back-to-work" plan that can be deployed upon elimination of restrictions.
- Participate in peer collaboratives to learn and share strategies.

Technology

The COVID-19 pandemic has given us a glimpse of how technology can be used to improve healthcare. Patients are far more willing to allow technology into the healthcare equation, and the remote monitoring and telehealth visits that are happening now will only increase. What does that mean to your workforce, your policies, your procedures, your patient relationships — even your physical office space? Healthcare providers must stay focused on the investments that will be necessary to maintain a competitive edge in the recovery. However, keep an eye on the long-term horizon for new and innovative technology applications. As patients and providers have successful experiences, their expectations about technology-enabled healthcare will continue to open up.

But beware: Unless proactively addressed, privacy and security concerns can create a major barrier that stops many patients from adopting new technologies.

Critical actions:

- Optimize telemedicine capabilities.
- Implement long-term work-from-home programs for all eligible staff members.
- Perform an IT review now to identify and clear roadblocks that might otherwise cause problems when volume picks back up.
- Update EHR and patient financial systems as necessary to accommodate new COVID-19 clinical coding and documentation requirements.
- Review compliance with cybersecurity and privacy guidelines.
- Make sure your organization is on track to comply with interoperability rules.

Moving from crisis to restart isn't an overnight event. In fact, a potential resurgence of the virus this fall could put many of our organizations right back in crisis mode. But keep in mind that you don't have to go it alone. The global nature of this crisis is creating a heightened need and opportunity for collaboration. Reach out to other healthcare organizations in your region and in other regions, as well as the advisors and associations that can help provide feedback on crisis management plans and strategies.

For the first time in our lives, everyone is fighting the same enemy. As we let our collective guard down and work side by side with organizations that we previously viewed as competitors, let's all consider how we can make this new level of collaboration effective and permanent.

About the Author

Christopher Jones, partner, CPA, CGMA, *is a Plante Moran healthcare practice leader, guiding a talented group of professionals, serving clients in the acute care, post-acute and senior care, physician practice, and other healthcare-related areas. Contact him at chris.jones@plantemoran.com or 248-223-3408.*

Matt Weekley, partner, CPA, *is a Plante Moran healthcare practice leader. With more than 35 years in this business, he's gained an intimate knowledge of the healthcare industry, which enables him to offer clients forward-thinking and pragmatic solutions during times of uncertainty. Contact him at matt.weekley@plantemoran.com or 614-222-9073.*

Don't Forget Gen X in Crafting Your Healthcare Payment Strategy

BY SUE CZUBALA, ACCESSONE CHIEF CLIENT SUCCESS OFFICER

"Don't you forget about me," the lead singer of Simple Minds, Jim Kerr, croons in a 1984 pop classic that could be an anthem for Generation X, often dubbed "the forgotten generation." But failing to craft a healthcare payment and affordability strategy with Gen Xers in mind would be a major mistake in healthcare.

That's because Gen Xers— sandwiched between baby boomers and millennials and far outnumbered by both—often are managing care for themselves, their families and their aging parents. They are also the most likely of any generation to put off care when they aren't sure how they'll manage the expense.

A recent survey of 1,000 consumers, with insights broken down by generation, shows:

- Sixty-nine percent of Gen Xers say providers' willingness to share price information prior to the point of service is a critical factor in determining where to seek care.
- Half of households with children—primarily Gen Xers and millennials—say they would switch providers to access affordable payment arrangements to cover their costs of care—including half of households with children.
- Forty-five percent of Gen Xers have shopped around for care based on price.

Given the importance Gen Xers place on affordability of care, transparency and price, how can healthcare providers craft payment strategies that appeal to this generation? Here are four approaches to consider.

1. **Share costs of care prior to the point of care.** Gen Xers—those born between 1965 and 1980—highly value price transparency: 69 percent want their healthcare provider to share costs of care before treatment. Gen Xers also are 50 percent more likely than millennials and twice as likely as baby boomers to delay care when they aren't sure how they will manage the expense. Survey results also indicate the point at which price becomes a concern for Generation X in seeking healthcare: 45 percent of Gen Xers

(continued on page 19)

are concerned about their ability to pay for an unexpected medical expense under $500.

2. **Gaining and retaining business from Generation X patients**—and, therefore, from the children and parents for whom they manage care—depends on providers' willingness to be open about healthcare costs. Make it easy for Gen Xers to obtain cost information by listing prices for common procedures or providing cost estimation calculators on your organization's website, and share the patient's anticipated out-of-pocket costs prior to the point of service. Leading organizations provide this information with consumers in their preferred communication format, whether by phone call, text (with a link to a secure portal), email or postal mail.

3. **Engage Gen Xers in patient financial conversations early in the encounter.** Survey results show 81 percent of Gen Xers believe the ability to discuss their ability to pay for their care with their provider is very important, compared with 75 percent of millennials and 71 percent of baby boomers. Providers can alleviate the stress of healthcare expenses not only by being prepared to engage in cost-of-care conversations, but also by initiating these conversations before patients reach the exam room. Initiate patient financial discussions at the point of scheduling or registration. Make cost information meaningful by sharing the patient's anticipated out-of-pocket costs, taking into account the amount of the patient's deductible met to date. Explore whether patients are concerned about how they will manage their out-of-pocket costs and assess whether a payment plan is needed.

4. **Offer flexible options for payment.** Gen Xers crave multiple options for healthcare payment. Sixty-one percent desire flexibility in healthcare payment according to their needs, and 43 percent are likely to switch providers for the ability to access low-interest or no-interest payment plans. They are also more likely to want to discuss financing and payment plans with their providers than any other generation (81 percent).

When it comes to healthcare payment plans, it's important to recognize that one size does not fit all. Offering a variety of payment plans, from low-interest to no-interest, enables Gen Xers with a greater chance to pay in full, no matter their financial circumstance. One best practice: Give patients the flexibility to adjust payment arrangements if the amount of their monthly payment becomes too much for them to handle comfortably.

Provide self-service options for account management and payment. This approach helps tech-savvy Gen Xers by providing them with the opportunity to self-manage their account. Consider offering self-service options through a patient portal and look for ways to allow Gen Xers to self-enroll in payment plans prior to service. Doing so empowers Gen Xers by enabling them to direct their patient financial experience— the first and last encounter Gen Xers will have with your organization.

Appealing to a Gen X Mindset for Payment

There are jokes about Gen X being the **forgotten generation**, but given that three-quarters of Gen Xers consider themselves the **primary health decision makers** for their parents and children, those that don't consider Gen X when crafting healthcare payment strategies risk lost loyalty and revenue. Taking steps to provide the level of price transparency and affordability Gen Xers desire will leave a better impression with this key generational segment, strengthening loyalty and providers' bottom line.

About the Author

Sue Czubala *is chief client success officer for AccessOne. In her 30 years of healthcare revenue cycle experience, she has transformed many mid-to large sized physician practices and healthcare organizations into models of efficiency. Her experience is in the academic and private practice environment as well as skilled nursing facility revenue cycle operations and several years at a large consulting firm.*

Revenue Cycle Staffing:
Moving Forward from the First Wave of COVID-19

BY MATT ELLIS, VICE PRESIDENT OF CLIENT SERVICES, ENABLECOMP

Revenue cycle leaders across the country are facing extraordinary staffing challenges as the economy begins to reopen. With accounts receivables worked down to the bare minimum and elective surgeries beginning to pick back up, hospital leaders are asking themselves: How do I staff for this? Based on predictions by industry leading clinicians, coupled with flu season, there will likely be a second wave of COVID-19 in the fall of 2020. The looming question is: How will this affect billing department staffing?

Traditionally, most middle to back-end revenue cycle departments have been moved off the main campus of the hospital. However, with many of the revenue cycle employees working from home, they are asking themselves:

- What does the fall of COVID-19 tidal wave of cases look like?
- Now that I have safety protocols in place according to CDC guidance, at what point is it safe to have all my staff back in-house?
- Will insurance companies have the ability to process the claims and bring their workforce back to their offices?
- What does my new staffing model for billing look like?
- How should I maximize vendor partnerships?

All these questions are weighing on leaders, and after multiple conversations with industry professionals, there have been a few things that stand true. Hospitals located in hot spots of COVID-19 are still in the process of protecting their employees' health and financial interests to the best of their ability, while making sure they support their business. Those hospitals not located in hotspots, typically in more rural America, are slowly bringing employees back to work but are seeing small waves in cases. Regardless of how heavily impacted their community was by the pandemic, revenue cycle leaders are still wondering what the new normal is and taking this opportunity to evaluate their current staffing models and vendors.

Part of developing a plan for the new normal is exploring all staffing options. This is an opportunity for hospitals to hit the reset button and explore potential restructuring of their billing departments. Leaders are reviewing and editing their "work from home" policies for their billers and collectors, while putting into place new incentive programs for their billing offices by creating a new "work from home" merit program structure. In speaking with industry leaders who moved most of their billing staff to their home offices, they have seen an overall increase in productivity during the COVID-19 pandemic. The biggest challenge to working from home was the IT infrastructure that hospital IT departments had to implement to set up work from home ques. With hospitals' PHI constantly at risk, they had to work closely with their employees to ensure the safety

of their patients' information. The IT security created to support this scenario has proven challenging, but also demonstrated to hospital leadership that it is possible to protect PHI and give employees a work from home incentive program a small victory for hospitals in a difficult time.

Another option a few of the hospitals are considering is the potential of moving some revenue service lines to specialty billing companies. Hospitals considering this see it as a way to combat labor costs due to a decline in volumes for complex claims. As a result of COVID-19, hospitals experienced an over 50 percent decrease in their workers' comp and motor vehicle accident claims. Those who already partnered with a contingency partner for this 2 to 4 percent of their claim volumes limited their cost exposure with these contingency based partnerships. This led to fewer lay-offs and furloughs supporting these areas. If there is no volume, there will be little to no expense. When considering this model, leaders should continue to evaluate those partners to ensure they can deliver the same standard of excellence expected at their hospital. Revenue cycle leaders should work with their IT leadership to ensure these partners comply with certifications such as SOC2 and HiTrust. Overall, a partnership like this will limit your cost exposure for a small revenue, but boast a high yield business line.

With the uncertainties we face ahead in tackling this virus, we know hospitals are being pushed to the max to ensure the safety of their communities, employees and patients. Our revenue cycle leaders are making difficult decisions, but at the same time hopefully exploring new staffing model opportunities. On behalf of EnableComp, I would like to say a BIG THANK YOU to those battling COVID-19 to ensure employee and patient safety across the state of Illinois.

About the Author

Matt Ellis *is vice president of client services at EnableComp. Contact him at MEllis@enablecomp.com or 601-540-7069.*

Leverage Robotic Process Automation to Accelerate COVID-19 Recovery

BY ANDREW WOUGHTER, NTHRIVE SENIOR VICE PRESIDENT, PRODUCT STRATEGY

Social distancing due to COVID-19 has forced health care industry leaders to rethink how work gets done. Traditional onsite employees are working remotely. Many are deployed to new roles in response to the pandemic. Now is the time to recognize these changes and reinvent processes, leveraging robotic process automation (RPA) to operate more efficiently now and in the future.

WHAT IS ROBOTIC PROCESS AUTOMATION?

While we are all accustomed to logging into software to get our work done, RPA can do it for us. Think of it as software programmed to log into a system and emulate a person, replicating what a human would do. For instance, a "bot," as RPA software is typically called, can enter a username and password, access an account, trigger application programming interfaces and operate directly on the objects within the system to parse information and complete work processes.

All of this happens in a matter of seconds versus minutes for human specialists, freeing them to work on more complex, human decision-making requirements. While RPA is addressing basic cleanup items such as eligibility mistakes or rejections, specialists can be focused on human interactions such as talking to patients about their itemized statements, something most people still want human interaction on.

HOW DO YOU GET STARTED ON RPA?

Because it is never a good idea to take a bad process and just do it faster, an RPA implementation should start by optimizing and assessing your existing processes. Once you've identified root causes of inefficiencies and deployed corrective actions, RPA can be utilized to emulate many of the clean-up tasks your staff currently does today.

WHERE IS RPA BEING USED TO LIGHTEN THE LOAD?

While there are many choices, common bot applications include:

- Managing denials
- Managing lock boxes to address and/or route correspondence
- Handling eligibility processes
- Submitting notifications on admissions
- Adding claims attachments
- Executing billing edits
- Translating Medicare codes to standard codes
- Automating authorization submission and tracking
- And many more

HOW HARD IS IT TO DEPLOY RPA?

That depends. If you decide to build your own bots, you'll need in-house resources both to create and maintain your bots.

Partnering with an expert resource can be much more efficient, especially if you are working with a vendor who understands health care revenue cycle processes and is committed to RPA for the long term. Look for a partner that creates bots using a "smart architecture" based on shared knowledge that is maintained across multiple users. Should something go awry, issues can be addressed rapidly to minimize downtime.

HOW MUCH DOES RPA SAVE?

The average labor savings from RPA is dramatic. One large, 50+ hospital that deployed bots for adjustment claims (XX7 type bill), eligibility denials and root cause (XX7 claims) eliminated between two and four FTEs per application, resulting in ROIs of as much as 583 percent! Smaller facilities can also benefit greatly for a quick win.

About the Author

Andrew Woughter *is senior vice president of Product Strategy at nThrive. Visit nThrive.com/covid19 to watch an RPA webinar. Contact info@nthrive.com to learn more about their RPA approach.*

Data Readiness in the Healthcare System

BY PETER K. ELIAS AND REBECCA M. SALTIEL

In the July 2019 "First Illinois Speaks" newsletter, we discussed the importance of data-driven insights for patient self-advocacy. By using a Personal Healthcare Portfolio (PHP), a patient can find the information necessary to make his or her own important healthcare decisions. Accurate and available information enables such a patient to select the right resources (at the right time and at the right price) and improve health outcomes. But, if the other healthcare stakeholders that generate and provide the data for the patient's PHP do not have robust processes for accurately identifying, storing and processing the data, these benefits will be lost.

Accurate and available healthcare data is invaluable to the other healthcare market participants as well. Clinical Intelligence (CI) supports quality improvement, care management and population health management, while Business Intelligence (BI) addresses the financial and operational aspects of healthcare systems, such as contract negotiation, facility management and cost analysis.

Effective data and IT infrastructure supports this intelligence gathering, while also preparing enterprises to handle unseen exigencies like those created by the recent coronavirus. Having the training, staff and infrastructure in place to handle an emergency like this can mean saving an enormous amount of future cost, and can be applicable to any number of crisis events, such as fire, extreme weather, active shooters, etc. Further, the COVID-19 crisis clearly separated those organizations that could migrate to a cloud environment versus those that could not. The ability to utilize cloud-based PHI is directly proportional to not just the use of technology, but also the ability of their users to utilize it. The idea that all organizations should do a data readiness assessment has become a critical activity.

However, not all organizations possess the tools and skill sets necessary to process information effectively and make the most of their data streams. That's where the Data Management Capability Assessment Model (DCAM®) can help. Originally created by members of the Enterprise Data Management (EDM) Council for use in the banking industry, DCAM was designed to assess a firm's capacity to effectuate a Data Management Program. Its various components easily apply to any industry where data management is important, and in this case, we will be applying it to healthcare information.

1 Data Management Strategy & Business Case

The first stage in the process is to define the *Data Management Strategy*. The data management strategy serves as the blueprint for coordinating the implementation of a successful data management program. Data elements which are to be collected, the means by which these data will be stored and accessed, and how the data are analyzed and used are all identified with the integral involvement of key stakeholders. Further, the funding, implementation and governance of the resulting information technology system must all be mapped out. It should align with the objectives of executive management, as well as the current IT infrastructure of the firm. As such, the data management strategy engages all components of the DCAM.

In order to justify the existence of the data management program, a Data Management Business Case must be defined. The CI and BI benefits of an effective data management program make a strong case for stakeholder commitment.

In the context of healthcare, CI can be used to:

- Assess population health to develop appropriate public health responses
- Predict which populations are at greater risk for which illnesses
- Identify individual care gaps
- Measure clinical outcomes
- Evaluate provider performance
- Measure and analyze variations in care
- Individualize plans of care and treatment regimens

BI can be used to:

- Identify and analyze financial gaps
- Allocate reimbursements
- Avoid referral leakages out of network
- Stratify risk
- Manage charity care
- Ensure that patients meet their financial responsibilities
- Determine staffing and operational needs

Long term, both CI and BI will be the backdrop toward artificial intelligence initiatives.

2 Data Management Program & Funding Model

This is the point where the data management strategy becomes realized as a data management program. The previous step should have already helped commit key stakeholders to supporting the program; the next step is to begin implementing what was discussed above. The program should be embedded in the current organizational structure and be capable of exercising the authority to enforce compliance. This will likely require the institution of an *Office of Data Management*.

How funding is secured to support the data management program depends on the revenue streams particular to your own organization. The amount that can be invested should be proportionate to the scope, and the value derived from the plan should be documented in order to ensure its continued support. It is important to keep investment in line with the ROI of the data management program. Better data does not always mean better insights, particularly if it goes unused and disconnected from enterprise objectives and business processes.

The value derived can be tracked through outcome measurements. In healthcare, examples of outcome measurements should include the CMS hospital rating measures of mortality, safety of care, readmissions, effectiveness of care, timeliness of care and efficient use of medical imaging. Other measureable benefits include improving the patient's care experience, improving the provider's experience in supporting patients, reducing staff burnout and reducing the per capita cost of healthcare delivery.

(continued on page 23)

 (continued from page 22)

3. Business & Data Architecture

Business Architecture is concerned with how the goals of the business are met and defining the processes critical to fulfilling them. *Data Architecture* is concerned with how the data is categorized, defined, utilized and distributed. The various contracts, reporting needs, and business requirements, among others, need to be properly modeled so that the right data is defined the correct way for the appropriate group of employees. Data that is useful for coding won't necessarily be useful for collections, and defining data differently across offices causes confusion and complexity.

Data architecture should be designed to feed data to the relevant business processes as defined by the business architecture. For example, a data management team stakeholder should be working on the Electronic Health Record (EHR) task force for an organization. A data control opportunity would be to ensure that EHR has the infrastructure to support registry reporting requirements. This would include the ability to isolate relevant patient populations by health condition, report as required and conduct appropriate data analytics.

4. Data & Technology Architecture

Also understood as *IT Architecture*, a roadmap should specify the various tools and platforms necessary to manipulate the data with optimal efficiency. Issues such as processing speed and scalability must be addressed at this stage, including scalability as the company grows. The technology implemented must also facilitate the governance of the data and minimize any operational risks.

Many facilities make the mistake of bypassing the data management program elements described above, instead skipping straight to data architecture and analysis and then questioning why patients or employees do not make use of their various data platforms. It seems that the current ethos for developing these platforms is the familiar saying, "If you build it, they will come." However, merely building the platform is not sufficient if you do not evaluate whether the end user is capable of using the tool, the quality of the data, the data architecture, the presence of controls, etc. Many projects fail because they have not considered these aspects when developing the data and technology architecture.

5. Data Quality Management

Perfect data – data that is easy to comprehend and simple to distill into clean and tidy reports is prohibitively difficult to come by. However, we can exercise due diligence by establishing a *Data Quality Management* Program that tries to ensure the data reflects reality as accurately as possible. This requires various data custodians to be in charge of data at multiple points such that various data quality metrics can be captured and problems can be resolved swiftly. An assessment of the quality of existing data is equally important because it can drive remediation in the form of future data quality protocols.

6. Data Governance

Effective governance requires clear rules and oversight to enforce best practices and permit the secure transfer of data, among other concerns. The program should be embedded in the current organizational structure and be capable of exercising the authority to enforce compliance, leveraging the capabilities of the new office of data management.

When properly designed, an office of data management can allow for enhanced data mining capabilities that are invaluable to satisfying business goals of all kinds. However, the office cannot be given such power that it would interrupt the normal business operations of the firm.

Internal controls on the substance of clinical data is an evolving discipline. The Association of Healthcare Internal Auditors (AHIA) is an excellent resource for the role of internal audit in data governance. Enhanced data mining activities can be illustrated in the innovative use of pharmacists in the primary care management of patients with chronic conditions. The Indian Health Services (IHS) has noted that the use of pharmacists in medication management has improved patient outcomes.

7. Data Control Environment

Many of the components of the DCAM call for your company's data to be auditable, transparent and well-documented. Taking account of the *Data Control Environment* verifies these qualities of your data pipeline and is aided by adapting the perspective of any potential auditors, regulators, etc. Having this component under control can mean that any RAC audits happen quickly and without unnecessarily disrupting your organization.

It is likely that your organization already has many elements of the DCAM in place. Regardless, there is always room for improvement. An organization's progress towards fully implementing/integrating any given component can be scored on a scale from Uninitiated to Enhanced. The DCAM goes into fine detail concerning how to bring your organization up to this point and can be of tremendous benefit to both freshmen and veterans of healthcare data management. As of May 2019, the DCAM has been updated to include emerging data topics such as Machine Learning (ML), Artificial Intelligence (AI), and Data Ethics. For more information on the DCAM Model and the EDM Council, please visit their website at https://edmcouncil.org/.

About the Authors

Peter K. Elias *is a senior data analyst at Medical Business Associates working towards Certified Specialist Business Intelligence (CSBI) and Certified Fraud Examiner (CFE) certification. He is also a student at Illinois State University pursuing his master's degree. Throughout his tenure with Medical Business Associates, Peter has leveraged his medical auditing experience and knowledge of statistical methodologies through legal and patient advocacy work, as well as various data analytics projects. He may be reached at pelias@mbaaudit.com.*

Rebecca M. Saltiel, RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA *is CEO, Medical Business Associates, an author of "The Cyber Patient, Navigating Health Informatics" 2019; "A Practitioner's Tool Kit for Patient Advocacy" 2017; "Leveraging Data in Healthcare: Best Practices for Controlling, Analyzing, and Using Data" 2016; "Healthcare Fraud Audit & Detection Guide" 2nd Edition 2012; "Electronic Healthcare Records, An Audit & Internal Control Guide" and "Personal Healthcare Portfolio" 2010. She may be reached at bbusch@mbaaudit.com*

[1] https://edmcouncil.org/page/aboutdcamreview

[2] https://www.medicare.gov/hospitalcompare/Data/Measure-groups.html accessed 10/15/19

[3] https://ahia.org/

[4] https://www.ihs.gov/pharmacy/

2020-2021 Officers & Board of Directors

OFFICERS

PRESIDENT	Bart Richards, CHFP
PRESIDENT ELECT	Richard Schefke, CPA, FHFMA
TREASURER/SECRETARY	Ann Peterson, CHFP
PAST PRESIDENT	Lana Dubinsky

BOARD OF DIRECTORS

- Ekerete Akpan, FHFMA
- Matt Aumick, CHFP
- Ryan Bell, CHFP
- Eileen Crow
- Nicole Fountain
- Lauren Gorski, CHFP
- Sue Marr
- Brian Pavona, FHFMA
- Tim Stadelmann

CONTACT INFORMATION

Click here to view contact information and other committee and program leads.

VOLUNTEER

Interested in learning more about volunteering within the chapter? *Click here*

hfma Your Challenge. Our Mission. 20-21

2020-2021 HFMA Theme

America's healthcare organizations: Their size, structure and services may differ, but they have a shared mission—improving the lives of the people they serve. In fulfilling their mission, these organizations have faced many challenges over the years, ranging from keeping up with technology to improving healthcare value and addressing social determinants of health.

Healthcare finance leaders have dedicated their efforts—often working behind the scenes—to supporting their organization's mission. To accomplish that, finance leaders must master the intricacies of our nation's complex payment system. At the same time, finance professionals must lead their organizations in preparing for the business models of tomorrow while adjusting to the accelerating pace of change and the ever-increasing complexity of contemporary healthcare.

HFMA has dedicated its efforts to supporting healthcare finance leaders in overcoming those challenges and more in order to achieve their organizational and professional goals. With a streamlined membership experience and a state-of-the-art digital platform, HFMA is well positioned to help its members navigate the unprecedented demands of 2020 and beyond.

Your challenge. *Our mission.*

Welcome New Members

Cerilda Aleck
Charge Master Specialist
OSF Little Company of Mary

Marianne Alt
Patient Access Associate
OSF Little Company of Mary

Brenda Anderson
Patient Access Associate
OSF Little Company of Mary

Jenessa Anderson
Patient Access Associate
OSF Little Company of Mary

Kate Aument
Advocate Aurora Health

John Baker
Senior Director,
Continuous Improvement
Strata Decision Technology

Dave Barker, CRCR
Senior Financial Analyst
AMITA Health

Brandon Bartol
Senior Financial Analyst
Northwestern Medicine

Arkela Beamon
Patient Access Associate
OSF Little Company of Mary

Stephanie Bell
Program Manager
Northwestern Memorial Hospital

Chantel Blair
Patient Access Associate
OSF Little Company of Mary

Michael Bosse
Senior Consultant, Guidehouse

Tiffany Boyd
Patient Access Associate
OSF Little Company of Mary

Cate Bracken

Tammy Bremer
Finance Manager
Northwestern Medicine

Jennifer Breuer
Partner, Faegre Drinker Biddle & Reath LLP

Marvette Broussard
Patient Access Associate
OSF Little Company of Mary

Kimtoy Brown
Billing Clerk
Northwestern Medicine

Teresa Cabel
Patient Access Associate
OSF Little Company of Mary

Cassia Carter
Advocate Aurora Health

Nicole Channell
Sr. Manager, Healthcare Advisory, BDO USA, LLP

Cynthia Chechang
Financial Assessor
Northwestern Medicine

Christopher Clark
Director of Healthcare Solutions
EPAM Systems, Inc.

Mackenzie Copeland, CRCR
Billing Clerk
Northwestern Medicine

Katherine Copia
Patient Access Associate
OSF Little Company of Mary

Soniece Curin
Accounting Manager
Amita Health

Tiffany Currie
Patient Access Associate
OSF Little Company of Mary

Robin Czajka
Vice President,
Customer Success
Premier Healthcare Alliance

Pamela Czyz
Patient Access Associate
OSF Little Company of Mary

Ashley Dear
Patient Access Associate
OSF Little Company of Mary

Joe Dominguez
Senior Vice President
HRE Capital

Disa Dordies
Patient Access Associate
OSF Little Company of Mary

Malorie Edwards
Patient Access Supervisor
OSF Healthcare System

Haithum Elhadi

Leslie Favela
Manager of Revenue Cycle Management Development
Regent Surgical Health

Christopher Fogle
Manager, Grant Thornton LLP

Erin Foley
Operations Coordinator
Northwestern Medicine

Alexander Forney
Senior Consultant
HealthScape Advisors

Tamra Franson
Patient Access Associate
OSF Little Company of Mary

Kathleen Free
Financial Analyst
Northwestern Memorial Hospital

Robert Jeffrey Gallagher
HIM Applications Analyst/ MBA Student
Rush University Medical Center

Nancy Gallo
Patient Access Associate
OSF Little Company of Mary

Tara Gilligan

Fusun Guder
Business Planning and Benchmarking Coordinator
University of Illinois Hospital & Health Sciences System (UI Health)

Stephanie Guinto
Director, Strategic Business Operations
Sinai Health System

DeAndre Hardy
Vice President, Senior Account Executive - Commercial Card Sales
Commerce Bank

Dominique Hawkins
Patient Access Associate
OSF Little Company of Mary

DeShawna Hill
Medical Program Director
Malcolm X College

Jennifer Holcombe
Finance Manager
Northwestern Memorial Hospital

Tatianna Hollingsworth
Operations Coordinator
Northwestern Memorial Hospital

Sally Hoppenrath
Patient Access Associate
OSF Little Company of Mary

Beth Houck
Financial Assessor Patient Account, Northwestern Memorial Hospital

Eva Hunt
Operations Coordinator-Billing, Northwestern Memorial Hospital

Amin Ibrahim
Associate Consultant
Cerner Corporation

Donna Jones
Pt Access Associate
Revenue Cycle
OSF Little Company of Mary

Donna Jones
Patient Access Associate
OSF Little Company of Mary

Rene Kezon
Patient Access Associate
OSF Little Company of Mary

Dominique Kilgore
Patient Access Associate
OSF Little Company of Mary

Brenda Knox
Patient Access Associate
OSF Little Company of Mary

Beverly Komers
Senior Financial Analyst
Amita Health

Jesse Kong

Patricia Kouba
Patient Access Associate
OSF Little Company of Mary

Jeet Koya, CSPPM
Merchandising Specialist

Deb Kozlowski
Senior Managing Consultant
BKD LLP

(continued on page 26)

Welcome New Members (continued from page 25)

Alison Kratowicz
Consultant
Strata Decision Technology

Matthew Laird
Healthcare Consultant
Crowe LLP

Alisha Lal
Sr Healthcare Consultant
Crowe LLP

Jenna Lambrecht
Senior Director, Revenue Cycle
Amita Health

Robert Lamont
Vice President of Finance
Amita Health

Martina Larue
Patient Access Associate
OSF Little Company of Mary

Renee Lee
Patient Access Associate
OSF Little Company of Mary

Jamie Levin
Associate, Faegre Drinker
Biddle & Reath LLP

Jennifer Logan-Porter
Compliance Analyst
RSM US LLP

Diane Maniaha Mouaha

Maria Martinez
Patient Access Associate
OSF Little Company of Mary

Daniel Mayer
Program Manager - Finance
Northwestern Memorial Hospital

Elizabeth McDermott
Financial Assessor
Northwestern Medicine

Gloria Melendez
Patient Access Associate
OSF Little Company of Mary

Dan Melillo
CEO, Odeza

Leslie Miggins
Financial Assessor
Northwestern Memorial Hospital

Dorothy Miller
Patient Access Associate
OSF Little Company of Mary

Amar Singh Minhas, CRCR
Healthcare Consulting
Manager Guidehouse

Juan Montealegre
President
Connect International LLC

Margaret Morris
Patient Access Associate
OSF Little Company of Mary

Ahmed Naguib
Associate Director
Guidehouse

Lynette Neal
Patient Access Associate
OSF Little Company of Mary

Arielle Nguyen
Healthcare Risk Consultant
Crowe, LLP

Denise Nowak
Patient Access Associate
OSF Little Company of Mary

Ryan Ogasawara
Manager, RSM US

Princess Okpaleke,
CRCR, CSMC
Patient Access Manager
Little Company of Mary

(continued on page 25)

Welcome New Members (continued from page 26)

Neil Olderman
Partner, Faegre Drinker Biddle & Reath LLP

Katherine Oleary
Analyst Financial
Ascension Health

Sheila O'Neil
Patient Access Associate
OSF Little Company of Mary

Michael Parker
Associate
Berkeley Research Group

Austin Pilotte
Director
Huron Consulting Group

Colisha Poston
Patient Access Associate
OSF Little Company of Mary

Angela Price
Patient Access Associate
OSF Little Company of Mary

Kari Proctor
Financial Assessor
Northwestern Medicine

Adeela Qamar, CRCR
Director
Avelead Consulting, LLC

Patricia Rabbitt-Dejnowski
Patient Access Associate
OSF Little Company of Mary

Deedee Raddatz
Patient Access Associate
OSF Little Company of Mary

Monica Rao

Leester Raymond
VP, HealthNautica

Rosa Razo
Patient Access Associate
OSF Little Company of Mary

Sharilyn Rittenhouse
Senior Financial Analyst
Amita Health

Letetia Roberson
Patient Access Associate
OSF Little Company of Mary

Ernst Robinson

Jason Rosenberg
Director - Operations - Immediate Care, Northwestern Memorial Hospital

Mary Roza
Patient Access Associate
OSF Little Company of Mary

Ryan Rozwat
Sr. Manager, BKD LLP

Mirella Ruiz
Financial Assessor
Northwestern Medicine

Lakeshia Rupert
Financial Accessor
Northwestern Memorial Hospital

Neehar Sachdeva
Healthcare Consultant
Crowe LLP

Linas Savickas
Financial Analyst
Northwestern Memorial Hospital

Justin Schroeder
Senior Associate
Kaufman, Hall & Associates

Jay Shah, CSBI

Jordan Shusterman
Manager, Engagement & Delivery
Premier Healthcare Alliance

Chaitra Sindhe
Analytics Consultant
Northwestern Memorial Hospital

Mary Sisto
Patient Access Associate
OSF Little Company of Mary

Bobby Skogsbergh
Administrative Fellow – EVP Ops, Advocate Aurora Health

Nikki Slowinski
Director, Leadership Development, Leadership & Organizational Development
Advocate Aurora Health

Tiante Smith
Director of Revenue Cycle
Familia Dental

Joon Song
Senior Manager
Ernst & Young LLP

Sandra Sperry
Principal, SPS and Associates

Lauren Swiderski
Patient Access Associate
OSF Little Company of Mary

Douglas Swill
Partner, Faegre Drinker Biddle & Reath LLP

Becky Tamayo
Sr. Financial Analyst
Northwestern Memorial Hospital

Alicia Tate Harris
Financial Assessor Patient Accounting
Northwestern Memorial Hospital

Annette Thompson
Patient Access Associate
OSF Little Company of Mary

Denise Truvillon
Patient Access Associate
OSF Little Company of Mary

Sheena Tubon
Patient Access Associate
OSF Little Company of Mary

Fatat Turkmani, CRCR
Patient Access, Representative II
Advocate Christ Medical Center

Ellen Plate VanBuskirk
Managing Partner
Vanbuskirk & Associates

Lyndsey Vanthournout
Access and Revenue Cycle IS Analyst, University of Illinois Hospital & Health Sciences System (UI Health)

George Vieu
Sr Dir-Finance MWF, Ascension

Aimee Villalobos
Patient Access Associate
OSF Little Company of Mary

Veronica Ann Villegas, CRCR
Patient Access Director
Conifer Health Solutions

Mary Wade
Patient Access Associate
OSF Little Company of Mary

Briana Walker
Financial Assessor
Northwestern Memorial Hospital

Phyllis Walker
Patient Access Associate
OSF Little Company of Mary

Rosemary Walker

Gina Walters
Patient Access Associate
OSF Little Company of Mary

Brett Warner
IHS Consultant
Faegre Drinker Biddle & Reath LLP

Nancy Whitaker
Lead, University of Wisconsin

Alison White
Director Finance
Northwestern Memorial Hospital

Adrian Williams
Patient Access Associate
OSF Little Company of Mary

Mae Wilson
Patient Access Associate
OSF Little Company of Mary

Maria Wilson
Clinical Quality Improvement Specialist
Loyola University Health System

Kelly Wirtz
Patient Access Associate
OSF Little Company of Mary

Nicole Wright
Patient Access Associate
OSF Little Company of Mary

Hagar Yeboah
Financial Analyst
Amita Health

Jami Youmans
Managing Partner
HealthEco

Elanna Young
Patient Access Associate
OSF Little Company of Mary

Lucy Zielinski
Managing Partner
Lumina Health Partners

Karen Zotti-Mitchell
Patient Access Associate
OSF Little Company of Mary

Karina Zuniga
Patient Access Associate
OSF Little Company of Mary

First Illinois Chapter Partners

The First Illinois Chapter wishes to recognize and thank our 2020 Partners for all your generous support of the chapter and its activities. ***Click here*** to learn more about the chapter's robust partnership program.

hfma™ first illinois chapter

Platinum Partners

BDO

BKD CPAs & Advisors

RSM

Silver Partners

AccessOne

Enhanced Medical Revenue, LLC

flywire Health

nthrive

Gold Partners

Bank of America Merrill Lynch

CLARO HEALTHCARE

experian health

HARRIS & HARRIS

POWERS + MOON HEALTHCARE REIMBURSEMENT LAW

rh Robert Half

Bronze Partners

enablecomp

plante moran

protiviti Face the Future with Confidence

SAC Law Offices of Stephenson Acquisto & Colman

salud revenue partners

Triage Consulting Group

WIPFLi CPAs and Consultants HEALTH CARE PRACTICE

First Illinois Speaks hfma
HFMA's First Illinois Chapter Newsletter

Publication Information

Editor 2019
Jim Watson ..... 847-410-5711 jwatson@bdo.com

Official Chapter Photographer
Randy Gelb ..... 847-227-4770 rgelb@mbb.net

Partnership Chair
Rich Franco Richard.Franco@nm.org

Design
DesignSpring Group, Kathy Bussert kbussert@designspringinc.com

First Illinois Chapter HFMA Editorial Guidelines

First Illinois Speaks is the newsletter of the First Illinois Chapter of HFMA. *First Illinois Speaks* is published 3 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 1,000-1,500 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 2020	September 1, 2020
March 2021	February 1, 2021
June 2021	May 1, 2021