First Illinois Speaks
HFMA's First Illinois Chapter Newsletter
October 2018

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Evolution of Health Care: Bridging the Clinical, Administrative and Financial

BY FRAZER BUNTIN, PRESIDENT, VALUE BASED SERVICES & KATE ROLLINS, VICE PRESIDENT, CLINICAL PROGRAMS AND PERFORMANCE, EVOLENT HEALTH

The new skills required to operate a value-based care business successfully are vast, and the financial return becomes viable only if a provider can go at-risk for enough lives to scale their investment. This reality is a major inhibitor to providers who want to move up the risk continuum and for those who tried and failed. Unfortunately, many value-based care (VBC) initiatives fall at the lower end of a spectrum of accountability, amounting to little more than glorified pay-for-performance tasks that check the box for bonus dollars. This doesn't drive accountability into the care delivery system in the same way that taking on both upside and downside risk does. To effect lasting change, providers are moving up this continuum of risk-taking through mechanisms that allow them to capture more of their generated savings, but also hold them financially accountable for losses—such as Next Generation ACO or Medicare Advantage for Medicare populations.

Providers making the move toward risk are balancing the in-sourcing of new skill sets with outsourcing to third parties. Those who are seriously committed to VBC as their path forward are looking for partners that can help them rethink and redeploy their clinical model for effective population health, get technology in place to enable clinicians and administrators to operate effectively, and, for the most sophisticated, run the back-office administrative components that are culprit cost drivers, but which providers must own if they want to capture the maximum financial gain from the value they're creating.

The way the industry is evolving, and where providers are innovating in the space, is bridging the clinical, administrative and financial:

1. Clinical:

- CARE TEAM PERFORMANCE: Using a care team to support high-risk patients is not a

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new concept, but has traditionally been challenging to directly measure impact/ROI. Having a concrete process and key performance indicators for care managers helps providers identify exactly what tasks correlate to improved health outcomes and lower costs. It also helps identify high and low performers so teams can replicate the best practices of the highest performers and deploy skills training for those who need coaching. Getting smarter on how to orient expensive clinical resources and directing that attention where the care team can make the biggest impact is a different construct than yesterday's disease management programs.

- COMMUNITY HEALTH WORKERS: In one program, a provider deployed Community Health Workers as part of an extended care team for Medicaid populations. In a preliminary analysis of the impact on the care team's workload and productivity, early data suggest that care managers can nearly double their case loads after successful introduction of Community Health Worker support. This could have major implications for how the industry thinks about creating capacity for both doctors and nurses, what roles are needed in the healthcare workforce at large, and the benefits of a community-centric approach to operationalize and deliver care. It also has implications for avoiding physician burnout. The more productive the care team is that supports that primary care practitioner (PCP), the more that PCP can trust that patients are followed and continually engaged outside of the point-of-care office visit. This helps them succeed at population health without taking essential time away from other practice areas, and sets them up for a better relationship with the patient when they're face-to-face.

- CLINICAL PROGRAM INNOVATION: The same provider is also engaged in a partnership with in which some of their partners are piloting new clinical programs for targeted populations. One in particular is a pilot to prevent chronic kidney disease from escalating to end-stage renal disease. What's interesting about this partnership is that the provider is helping their partners take the best academic models and determine how to operationalize them on the front lines. The provider is working to iterate, test and titrate at the population- and disease-specific level to drive better patient experience and health outcomes. The goal is to refine the approach and then scale it to the provider's numerous national partners nationwide.

2. Administrative:

- THIRD-PARTY ADMINISTRATOR (TPA) CAPABILITY: To capture the value that providers can create through clinical impact and savings, they need to be able to administrate claims, run effective utilization management and pharmacy benefits management, and in some cases support member

Evolution of Health Care: Bridging the Cinical, Administrative and Financial (continued from page 2)

services with call centers and staff. These aren't traditional areas of expertise for a provider, but helping them take on these administrative services is beneficial.

- POWER OF CLAIMS PLUS CLINICAL: One provider successfully integrated its claims administration platform into Identify , its core population health data analytics technology, last year. This means that their partner now has claims processing and data operating on the same scalable platform as their clinical and financial workflow tools. Claims traditionally have months of lagtime before they can be used to help identify patients who may need care management support. With the stratified clinical platform, knowledge about which patients may be high risk for an acute event can be quickly spread across the care continuum, and lead to accelerated conversations with the patient and her PCP. This helps achieve the ultimate goal of intervening before a medical event occurs.

3. Financial:

- FINANCIAL METRICS ARE DIFFERENT FOR VBC: When providers effectively learn the new clinical and administrative skills they need to be successful in risk, it drives financial performance, as well. Providers benefit from having reporting and analytics on the same infrastructure as their clinical and administrative tools. In the value-based care world, they need to be able to track, report and manage based on contract terms that work differently than fee-for-service.

- FINANCIAL PERFORMANCE READINESS: Providers participating in Next Generation ACO are faced with a complex financial situation. They need to monitor performance on clinical outcomes for a specific group of Medicare beneficiaries throughout the year to know if they're on track to achieve savings or not. Knowing the financial trend of the value business early on creates opportunity to change approaches mid-year for a better chance at achieving savings targets. However, to do this effectively, providers need to get started before their performance year begins with CMS. They can deploy tools several months prior to the performance year to start analyzing and assessing the probable risk of their Medicare panel, get people in early for preventive care, and jump start the clinical program design process so that the entire care team can make a difference on day one of the performance year.

KEY TAKEAWAY: Any given provider could pull all of these levers and still not see an ideal return if they're only doing it for a few thousand patients. Once infrastructure and process are in place and there's a roadmap for success via a smaller population test case, providers are then ready to place more risk lives under management. How they accomplish this depends uniquely on the dynamics of their local markets, which drives the wide variety of business strategies across the country. For instance, some take their PSHP to new geographies to get more membership; some create alliances with other provider groups to get more patients attributed to a successful ACO; some have immediate scale if they're granted the opportunity to manage hundreds of thousands of Medicaid beneficiaries. Regardless of which strategy providers choose to navigate the shift to value-based care, it's clear that they're on the right track to serving a common goal of improving health.

Frazer Buntin is the president, Value Based Services, and Kate Rollins is the vice president, Clinical Programs and Performance, at Evolent Health. They can be reached at FBuntin@evolenthealth.com and KRollins@evolenthealth.com.

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

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The BDO Center for Healthcare Excellence & Innovation

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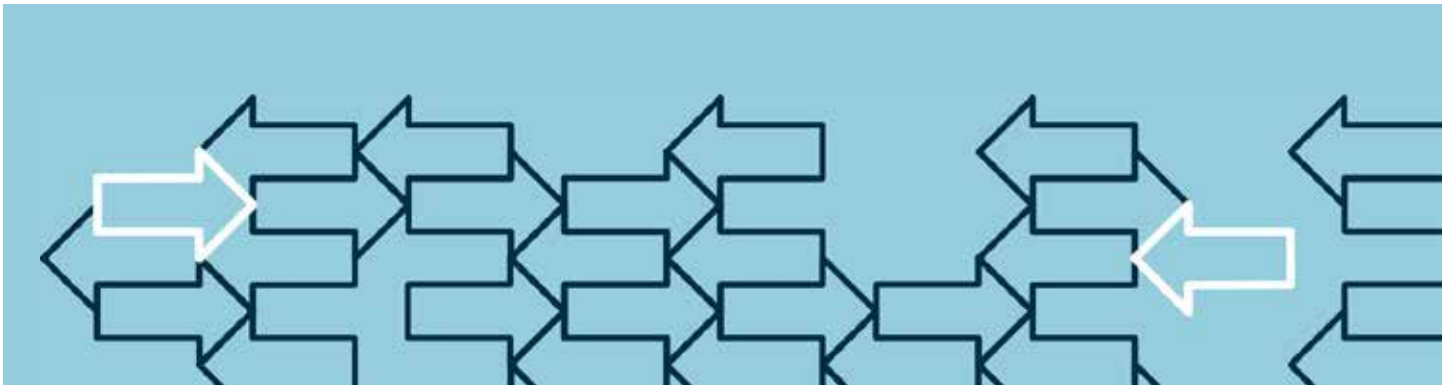
Using Big Data in Healthcare: Start Small to Drive Results

BY ATUL GANDHI, MARK HERBERS AND BORIS LUZHANSKY, ALIX PARTNERS, LLP



For healthcare providers today, survival is often the first item on the agenda. As costs keep rising, operating margins keep shrinking. According to Moody's, for example, average operating margins at U.S. public hospitals dropped from 3.4 percent in 2014 to 2.7 percent in 2016.

By starting with something relatively small and manageable, teams should be able to score quick hits that go straight to the bottom line.

When confronted with the new realities of U.S. healthcare, many providers launch full-scale transformation efforts to address everything from cost-savings and treatment protocols to public health management and changing organizational cultures. In many cases, the sheer size of the endeavor is too huge for time-strapped healthcare professionals to make much progress. As a result, it often loses much of its steam after only a few months.

Data is one of the biggest roadblocks. Providers have information systems that capture clinical and operational data to support individual patient encounters and assure accurate billing. But that body of data is so vast and fragmented that providers have an extremely difficult time gleaning useful insights from it.

Electronic medical records also pose analytical challenges. They put clinical data into a single source database record that replaces the traditional paper file. However, much of the data is maintained in memo fields in the form of written notes (unstructured data) from physicians and nurses, which is also very difficult to analyze and use to create physician scorecards and other rankings. Providers will also have more access to big data emanating from wearable devices and patient care monitoring devices. If easily accessible and actionable, this data can be powerful during routine physicals and to identify early warning signs of potentially dangerous conditions.

By starting with something relatively small and manageable, teams should be able to score quick hits that go straight to the bottom line.

The end game is to bring all of this data together so healthcare providers can develop a holistic view of their operations and patient populations. Once they gain that perspective, providers will be poised to reap the rewards of a new environment that demands cost reductions while maintaining and increasing the quality of care.

Where to start? Well, we know from our experience that trying to boil the ocean isn't where to begin. Instead, healthcare providers need to start small, reap the gains, and then systematically move forward.

Starting Small in the OR

Given the daunting challenges, not all U.S. healthcare providers have cost reduction initiatives in place. Many of those that do have set fairly modest goals, some as low as 1%.

But if organizations start with manageable efforts, they can usually achieve much stronger results. Consider, for example, the operating room (OR) of a large urban hospital where surgeries are a key revenue stream. However, OR revenue is below what it should be and is causing profitability concerns. Bottlenecks throughout the process increase wait time and reduce the number of patients that can be treated. If that is not enough, the hospital's data is voluminous and stored in multiple systems, even though gathering it could be a straightforward exercise, since they know what they need an where it is.

If this hospital has sufficient resources, with a reasonable effort they could examine all the process data over a two-year period—for example, when a patient's operation started, when anesthesia began, when the first incision was made, when the procedure was finished, when the patient went to the post care unit and when he or she returned to the patient room.

The hospital team could then analyze the actual time intervals for each process step and compare them to benchmarks. This could help them discover that communication problems are the root cause of process steps that take too long (which often is the case, in our experience). For example, if a patient is ready to go to post-operative care but transport isn't receiving timely notification, the patient will have to wait in the OR, delaying the start of the next procedure.

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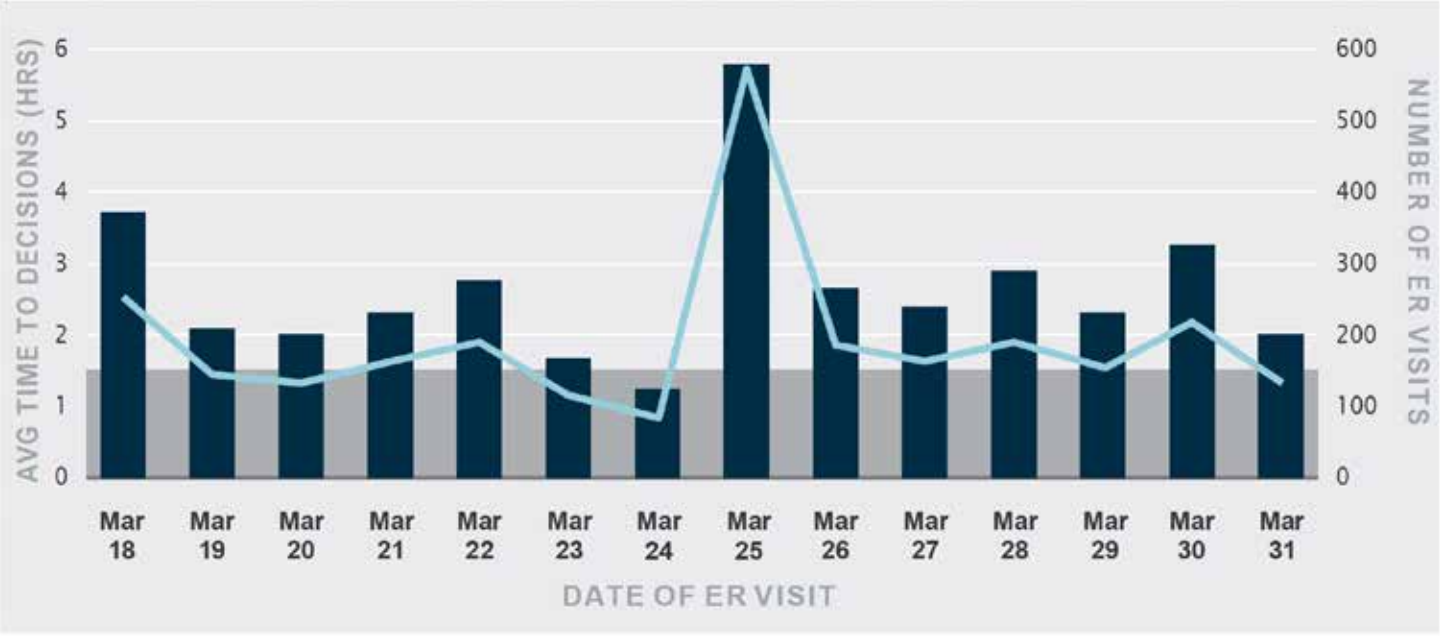
FIGURE 1: SAMPLING OF ER VISITS OVER TWO WEEKS



Source: Illustrative example based on fictional data, representing what could be done with ER data

To fix the problems, the hospital could install a communication system detailing where all patients are at any given time and when each employee needs to take their respective actions to keep the patient flow moving. For example, in analyzing and improving the flow of patients, an organization we worked with was able to increase its case load by 10% with the small additional cost of a communication system.

The hospital also could use the data to improve scheduling by leveraging historical insights and building improved predictive models. For example, hospital leaders could see the average amount of time each physician spends to perform a given procedure and what might be the expected time for the procedure in the next few days or weeks. That would allow the OR team to schedule much more accurately.

By starting with something relatively small and manageable, teams should be able to score quick hits that go straight to the bottom line.

Improving Patient Flow in the Emergency Department

The emergency department (ED) has a similar dynamic and opportunity. They are essentially custom job environments where traditional methods of quality control, cost accounting, and industrial engineering (which primarily addresses repetitive processes) don't offer much benefit. However, emergency rooms still struggle with patient wait times such as time to triage, waiting to be seen, waiting for tests, and being admitted or discharged.

> By starting with something relatively small and manageable, teams should be able to score quick hits that go straight to the bottom line.

Again, hospitals have considerable timestamp data that can be straightforward to collect and analyze. For example, data tied to billing systems clock everything from time of arrival and registration to time of physician interaction and time of discharge.

By mapping out the processes, ED professionals can identify sources of delay and inefficient uses of resources. The hospital can start building basic analytical models to predict ED load and assessment. With those insights, patients can be triaged more efficiently, generating better service ratings and reducing ED crowding.

Healthcare providers can also use the data to create a simple new customer service KPI called 'time to decision.' The customer service KPI would measure the optimal process from arrival to physician interaction. It would ensure that patients are seen quickly by the right clinician resources who are aware of the patient's situation. Providers opting for such a KPI must be sure their benchmarks and follow-up on variation is 100%. That could avoid—and often prevent—any legal issues that arise due to wait times.

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Using Big Data in Healthcare: Start Small to Drive Results (continued from page 6)

Billing and Collecting More Smoothly

As providers know, billing is a critical and complex process. It requires the accurate completion of more than 30 activities before the provider can submit a bill and collect payment.

Provider systems and databases have metrics for each of these activities, including total cost to collect, reimbursement rate by payer and denial rate by payer. Once consolidated and mapped to the patient journey, healthcare providers can identify significant opportunities for efficiencies that improve net revenue. For example, payment integrity and auditing review processes mandated by payers and governance authorities add considerable burdens to billing and administrative personnel. They must respond to daily queries about payment accuracy and these responses can waste time and also result in denied claims and/or delayed payments.

The Path Forward

Starting small can produce quick wins. Those wins can improve communication and coordination between various stakeholders, lower costs, or increase revenue and drive support for additional projects, resources, and capital spending.

Eventually, companies will be able to leverage the latest analytics technologies and learning algorithms, and providers can map patient journeys and identify patterns that can optimize various business processes. A tactical revenue improvement focus on the emergency department, operating room, and/ or billing department represent potential quick wins. The goal is higher patient satisfaction, more complete clinical documentation, and quality care provided at lower costs.

In the future, a more collaborative, transparent and secure view into each patient's health through blockchains will further revolutionize patient care quality while lowering costs with an end-to- end mapping of the patient journey. To get there, healthcare providers should only bite off as much as they can chew and then use those successes as part of a step-wise progression and the basis for moving forward.

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About Us:
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How Medical Necessity Disputes Cause Hospitals to Leave Revenue on the Table - Proper Documentation Before Claim Denials is the Only Antidote

BY KAREN MEADOR, MD, MANAGING DIRECTOR AND SENIOR PHYSICIAN EXECUTIVE, BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

Medical necessity disputes are causing hospitals to leave revenue on the table.

Hospitals are already facing increased financial pressures as care moves outside of facility-based models and more of them adjust to value-based reimbursement. Added to that, payers under financial pressure themselves because of rising healthcare costs are scrutinizing claims through increased medical necessity denials with hospitals.

Providers and health systems denied reimbursement for care by a payer can successfully appeal or ultimately litigate such disputes in many cases. But internal costs and legal and consultant fees in support of the appeals and litigation process can be costly, and revenue can be degraded during the appeals and litigation process. Providers and health systems can take steps, however, to reduce the frequency of care ending up in dispute—and proper documentation before litigation is key.

Incomplete or ineffective documentation is a frequent cause of denials. It has often been said in healthcare, "If it wasn't documented, it wasn't done." That's true. But perhaps even more relevant in today's healthcare world, "if it wasn't documented, it may be considered medically unnecessary," resulting in denied payer reimbursement. In fact, CMS could even consider billing for that service to be a false claim. Furthermore, poor documentation provides a weak defense in medical liability cases.

We have learned valuable lessons from evaluating thousands of medical records—including hundreds that have risen to the litigation phase. The following checklist can guide clinicians and their leaders in good documentation practices. At a minimum, providers should ensure that they clearly document the following elements for each hospital observation or admission.

1. While EMRs have automated and created prompts for many documentation requirements, a resulting new problem has been the increased lack of distinctive patient notes. Therefore, it is essential that providers avoid the overuse of templates and make sure they have typed information that clearly distinguishes notes between patients.
2. The order for observation or admission must include the diagnosis and be signed by a physician with a legible signature or electronic signature and with a date and time.

3. Orders for labs, procedures and medications must be signed by a physician or midlevel (as the scope of practice allows in the particular state) with a legible signature or electronic signature and a date and time.
4. All notes must be legibly signed, dated and timed by the provider with regular evidence throughout the hospitalization of physician oversight documented in physician signed notes.
5. The admit note must clearly describe the patient's condition and document the reasons for hospitalization, the particular level of care required and the expected length of stay. If the patient is hospitalized as a full admission, the expectation of the patient requiring a stay crossing two midnights needs to be documented. Or, on the rare occasion that a patient in a highly acute situation requires inpatient or even intensive-level care but possibly not needing to stay past two midnights, this must be explicitly documented.
6. Daily progress notes must be sufficiently detailed to clearly show the need for the continued hospitalization and the reasons for each service provided. Providers should ask themselves if a third-party provider would agree that the hospitalization and services are needed based on documentation.
7. Nursing, respiratory therapy, physical therapy and other care team notes also contribute to the story of what care is provided and the reasons for it. However, the notes by the physicians or midlevels need to be able to stand alone in supporting the need for continued hospitalization.

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How Medical Necessity Disputes Cause Hospitals to Leave Revenue on the Table - Proper Documentation Before Claim Denials is the Only Antidote (continued from page 8)

8. Discharge notes should again clearly articulate the reasons for admission, as well as the key services provided during the hospitalization that required the patient to remain hospitalized up until the time of discharge.

Health system leadership needs to ensure that their providers know the expectations for documentation, that the EMR system prompts the key documentation items without creating too much duplication and that compensation incentives align with goals for appropriate documentation with fewer denials.

Annual training sessions with regulatory and compliance updates equip and remind the providers about documentation requirements. Regular internal chart sampling and reviews prior to claims submission to the payer are also educational to the providers in actively guiding better documentation in the future. They can also allow the immediate correction of inadequacies of documentation prior to claims submission so that denials are reduced.

Engaging an external team with expertise in clinical documentation and reduction of claims denials can ease the burden on leadership and staff and often will identify areas of needed improvement that may be overlooked when doing an internal evaluation.

When ongoing documentation education and reviews are done internally, an external team should conduct an annual risk assessment and chart documentation audit. A feedback session should follow with a detailed action plan to correct the identified deficiencies in documentation and to enhance the processes that support good documentation.

Learn more about issues facing hospitals here.

Karen Meador is managing director and senior physician executive in The BDO Center for Healthcare Excellence & Innovation. She can be reached at kmeador@bdo.com.

FALL SUMMIT 2018

First Illinois HFMA

OCTOBER 23-24, 2018

Here's a sneak peek at some of the 2018 Fall Summit keynote speakers and topics we have lined up to inspire you to explore, discuss and jumpstart your creativity in problem solving.

Catherine A. Jacobson, FHFMA, CPA
President and CEO
Froedtert Health, Wisconsin, IL

Leadership in a Time of Disruption and Uncertainty in Healthcare

Healthcare is an industry ripe for disruption due to continued concerns about cost and value as well as the rising expectations of consumers. Learn about the forces driving healthcare disruption and what leaders need to do to prepare their organizations for this change.

Patrick Carroll, MD
Chief Medical Officer/
Divisional Vice President
Walgreen's Healthcare Clinics, Deerfield, IL

What Are You Doing to Be a Consumer-Facing Organization?

Eager to learn about strategies to maximize consumer-facing healthcare access points, including virtual visits, retail health, urgent care and pharmacy as must-haves for consumer-focused health systems? During this keynote session, you will come away with ideas on how to build your patient access strategies utilizing all of the access points, as financial risk for health care is shifted to consumers. The presentation will also highlight the necessity of developing an on-demand care strategy as well as the steps needed to develop a robust patient acquisition strategy.

Craig Richmond, CPA
Executive Vice President and CFO
The MetroHealth System, Cleveland, OH

Thriving Not Surviving: A Story of a Resilient Organization

MetroHealth System is succeeding (and thriving) in a challenging market with their delivery of health care for the next generation despite escalating odds. Due to its spirit of innovation and adaptability, its laser focus on delivering quality care at lower cost, and its unwavering commitment to its mission, the 180-year-old system has set the goal to become one of the most admired public health systems in the nation and is on course to actualize that goal through revenue growth, new job development and an ambitious physical transformation made possible by securing nearly a billion dollars in funding from the capital bond market. Through factual information, you will learn how to implement strategies to overcome challenges to create your own thriving organization.

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Kevin Brown
Keynote Motivational Presenter

The Hero Effect™: Creating a Culture of Heroes at Every Level
Renowned motivational speaker Kevin Brown will focus on the principles of leadership through his presentation of The HERO Effect™. Kevin has a simple philosophy when it comes to leadership. He believes that you are "a leader of one or a leader of none." He believes that leadership begins with mastering self along with the daily habits required to become world class leaders, mentors and coaches to the teams we live and do business with. The foundation of this program can be summed up in one powerful idea: we reproduce what we are! The role of leadership in an organization is to create an environment where people can be the best version of themselves. That is what serves a brand well and stands out in a crowded marketplace.

Concurrent Sessions

In addition to our keynote presenters, the two-day 2018 Fall Summit offers over 20 concurrent sessions on revenue cycle, compliance initiatives, healthcare finance, mergers and acquisitions, and federal and state legislative and regulatory updates. Sessions include:

Where Do I Go from Here: How to Find Your Next Great Job and Preparing for Your Future Financial Wealth Management
This session will have relevance for all career stages.

First Illinois Chapter Is 70 Years Young
This October, the First Illinois Chapter is 70 years young. First Illinois enjoys the distinction of being the first chapter created when the Healthcare Financial Management Association (HFMA) then known as the Association of Hospital Accountants was founded. The chapter is the second largest of HFMA's 68 chapters and the largest metropolitan chapter, serving over 1,150 members in the Chicagoland area. Celebratory festivities at the 2018 Fall Summit include a luncheon to honor past presidents and a fun-filled Casino Night networking event.

Email: What to Do When You Just Don't Get It! –
Rescuing Your HFMA Communications from Junk Filters - reprinted from Notes from National (NfN) June 2018
Email offers a way to communicate quickly and efficiently—if it reaches the recipient's mailbox.

As inboxes become clogged with unwanted offers and scams, junk filters have become more aggressive. It can wreak havoc with communications.

Often, you don't know you have a problem until you've already missed something important, so we turned to the sleuths who help us when members report that they are not receiving HFMA emails. Below is their step-by-step guide on troubleshooting problems if you are not receiving HFMA emails.

- Check your junk or quarantine folders to ensure that these haven't been filtered to these locations.
- Add hfma@hfma.org (for emails from HFMA National) and education@firstillinoishfma.org (for emails from First Illinois) to your safe senders list through Outlook by following the steps below:
  - Select Actions from the toolbar at the top of the screen (if your toolbar doesn't have an Actions option, you can right click on any email message, then select Junk from the drop-down list).
  - Select Junk Email (ignore this if you are following the right click option).
  - Select Junk Email Options.
  - Click the Safe Sender tab.
  - Click Add.
  - Type in the email addresses you wish to add to your safe sender list.
  - Click OK.
- Contact your IT department and ask them to look for the messages by one of these four pieces of information:

From HFMA National
- Assigned IP Address: 209.18.70.21
- Prepend Domain: http://www.mmsend98.com
- Return Path: return@mmsend98.com
- The From: hfma@hfma.org

From First Illinois Chapter
- IP Addresses: 205.201.128.0/20 198.2.128.0/18 148.105.0.0/16
- Domain: http://www.firstillinoishfma.org/
- Return Path: education@firstillinoishfma.org
- From Address: education@firstillinoishfma.org

Once your IT department is able to find the message in the quarantine, they should be able to allow the emails to go through their server.

FI HFMA Partners:

Our First Illinois partners will be on site both days and provide opportunities to learn about the latest tools and resources they offer to help you in your job and career. Watch your emails for registration information or check our website events calendar at http://firstillinoishfma.org.

Managed Care Program

Feb 7, 2019

University Club
76 E Monroe St.
Chicago, IL 60603

To register online please visit:
http://firstillinoishfma.org/events/

REVENUE CYCLE 101 SEMINAR 03.25.19

hfma first illinois chapter
healthcare financial management association

Prentice Women's Hospital
250 E Superior St. Chicago, IL 60611

To register online please visit:
http://firstillinoishfma.org/events/

Earn up to **7.5 CPE credits!**

Message From Our Chapter President

BY RICH FRANCO, PRESIDENT, FIHFMA

On July 19, 2018, First Illinois Chapter HFMA celebrated another chapter year at our annual "Transition Dinner." This year's location was aboard the Odyssey for a Lake Michigan dinner cruise. On this beautiful July evening, over 100 chapter leaders and guests shared and celebrated this year's chapter successes and memories.

The evening began with a social hour and appetizers, followed by the dinner and program. As has been a tradition for over 10 years now, FIHFMA awarded scholarships to college students who were selected after an application and interview process. This year, FIHFMA awarded $15,000 in scholarships to these final winners selected from over 200 applications:

Abigail Rooney	$5,000	Columbia University
Rachel Marr	$4,000	Oklahoma City University
Christopher M. Breuer	$2,000	Emory University
Claire E. Swiatek	$2,000	Saint Louis University
Allison Yunker	$2,000	University of Iowa

Following the Scholarship Awards, the Annual Chapter Awards were presented. The chapter received a total of five awards for 2017-2018:

- Gold Award of Excellence for Certification
- Four Helen M. Yerger Special Recognition Awards: One each for Innovation, Education, Improvement, and Member Communication

***Innovation:* FIHFMA Women in Leadership**: The First Illinois HFMA (FIHFMA) held its 3rd Annual Women's Golf Outing as part of the Women in Leadership Initiative, on Monday August 14, 2017. Previously, the outing was to provide a networking opportunity and an introduction to golf. For this event, we further promoted the Women in Leadership Initiative by (1) providing education outside of the traditional healthcare financial learning, (2) inviting inputs from local healthcare executives, and (3) increasing provider participation.

***Education:* 2017 Fall Summit:** The Fall Summit was developed a few years ago as a two-day education event which contains education tracks and has been our chapter's largest and premier education program. Based on prior evaluation feedback and several volunteer discussions, the program planning team determined various operational changes were needed to improve marketing, attendance, CPE certification and evaluations.

***Improvement:* Moving from Sponsors to Partners, an Essential Shift in How FIHFMA Funds Our Chapter:** The First Illinois Chapter identified gaps in the chapter sponsorship/partner strategy and effectively developed solutions for each of the identified gaps. In doing so, we created a more positive experience for our partners, improved partner ROI and increased partnership funding for the chapter.

Member Communications: FIHFMA was awarded a Yerger Award for its enhanced efforts at member communications throughout the 2017-2018 chapter year.

Last but not least, we had the annual Officer & Board Transition Ceremony, recognizing this year's leaders and officially installing the 2018-2019 chapter year leaders.

Brian Katz, FIHFMA president 2017-2018, introduced the 2018-2019 FIHFMA chapter leaders:

PRESIDENT, Rich Franco, FHFMA, Richard.Franco@nm.org
PRESIDENT ELECT, Lana Dubinsky, lana.dubinsky@sbcglobal.net
TREASURER/SECRETARY, Bart Richards, FHFMA, brichards@clarohealthcare.com
PAST PRESIDENT, Brian Katz, brian.katz@rsumus.com

2018/2019 Board of Directors

Eric Brodsky, ebrodsky@epoxyhealth.com
Eileen Crow, CAE, ecrow12@yahoo.com
Kevin Fitch, FHFMA, CPA, kevin.fitch@advocatehealth.com
Lauren Gorski, CHFP, lgorski@clarohealthcare.com
Sue Marr, swmarr610@sbcglobal.net
Analise Masciola, analisemasciola@gmail.com
Jim Porter, FHFMA, CPA, mr.jimporter@yahoo.com
Bob Rosenberger, robert.rosenberger@presencehealth.org
Rich Schefke, FHFMA, rschefke@nch.org
Pete Stille, p-stille@sourcing-results.com

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Message From Our Chapter President (continued from page 13)

Annual Transition Dinner Photos

Eileen Crow, Rich Schefke

2018-2019 FI HFMA Board Members Present: Rich Franco, Rich Schefke, Lauren Gorksi, Analaise Masciola, Eileen Crow, Brian Katz, Pete Stille, Bart Richards, Lana Dubinsky

David Pareja, Mar Treacy Shiff

Dan Yunker, Brian Katz

Giovanna Losacco, Rich Franco

Karen Yunker, Allison Yunker, Dan Yunker

Marcia Rooney, Abigail Rooney, Jeff Rooney

Women in Leadership Initiative:
4th Annual Women's Golf Outing

BY SUE W. MARR, CHAIR, FIHFMA WOMEN IN LEADERSHIP COMMITTEE

Maggie McNelis, Andrea Dreher, Deb Spencer, Haley Schumaker

Winners of Prize Golf Balls

Candice Richmond, Amy Kraft, Sara May, Becky Smith

Brittany Sanchez, Donna Jansen, Nikki Kelleher

As part of the Women in Leadership Initiative Series, the Fourth Annual Women's Golf Outing was held on Monday, August 20, 2018, at Eagle Brook Country Club in Geneva, Illinois. There were over 60 attendees with golfing skills ranging from collegiate golf athletes to ones who haven't held a club for years. The participants were a great mix of FIHFMA members and associates. There were representations from hospitals, healthcare providers and vendor partners, including Advocate, Northwestern Medicine, Presence, Rush, Palos Community, BDO, BKD and many more. We had a number of familiar faces from previous outings and many first-time attendees. Ladies were looking very stylish in the official event golf polos.

The course was beautifully manicured, and the greens were rolling well. The forecasted downpour did not dampen golfers' enthusiasm, and with a close watch of the radar, the ladies were able to complete the golf before any significant raindrops fell. Golfers had the option to play a game of scramble or attend a "Golf Clinic." At the clinic, professional golf instructors provided a tutorial on golf strokes and course etiquettes, and then led the attendees through three holes on the course. A lot of competitive edges were demonstrated on the course with various on-course games and proximity contests, and fun was had by all. Following lunch, the education session led by Tina Naizer, "Drive Your Destiny!" challenged attendees to dedicate themselves to something greater by passionately pursuing their visions for success. Discussions and exercises were done to guide individuals to realize personal and professional success by starting with a vision, creating a deliberate plan and executing the plan. The day concluded with awards and social hour back in the clubhouse.

The format of the event allowed attendees the opportunity to network, learn and relax in the beautiful surroundings of the Eagle Brook Country Club. Additionally, a raffle was held with the proceeds going to the chapter scholarship fund. Everyone's generosities will greatly benefit and be appreciated by scholarship recipients who are First Illinois HFMA members and their children pursuing higher education. There were numerous promises of returning next year and spreading the word about the event.

Here are the winners ~~we~~ had several scratch golfers among us!

Eagle Division

- **Longest Drive:** Brittany Sanchez
- **Longest Putt:** Anna Diemoz
- **Closet to Pin:** Nikki Kelleher
- **Lowest Score:** Karen Williams and Anna Diemoz

Birdie Division - Clinic + 3 hole

- **Longest Drive:** Baylee Walters
- **Closet to Pin:** Deb Kozlowski
- **Golf Trivia Game:** Michele Kohout
- **Scholarship Raffle:** Kristen Snowden

It is never too early to plan; please SAVE THE DATE for the 5th Annual Women's Golf Outing to be held on Monday, August 19, 2019, at Eagle Brook Country Club.

I will leave you with a quote from Dr. Bob Rotella, the world's preeminent sports psychologist and performance coach, "Golf is about how well you accept, respond to, and score with your misses much more so than it is a game of your perfect shots."

Welcome New Members

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VP Treasury & Chief Investment Officer

Nicole P. Serna
Mercy Hospital and Medical Center
Patient Financial Services Manager

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Jaidev Jayakumar
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Shawn Albritton
UI Health
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Alexis Amato
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Vivian Elam
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Amanda Geraty
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Howard Paskin
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Jean Corban
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Emily Smith
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Area Director

Kerry Kim
University of Illinois
Business Administrative Associate

Debnita Talapatra
Claro Healthcare
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Ashley E. Price
Claro Healthcare Analyst

Darrwin Perkins
Boa Vida Healthcare, LLC
Strategic Operations/Business Development

Claudia Burchinal
Erie Family Health Center
Senior Director, Patient Benefit Services

Melissa Fradkin

Eric Swanson
Heath Financial Systems
Medicare Specialist

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Welcome New Members (continued from page 17)

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John Diamond
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Director - Client Services

Mary L. Williams
Experian
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Jacquelyn Harris
Experian Health
Customer Care Specialist

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Total Home Health
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Care Services

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Garrett Young
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Teri Reed
ACCESS Community Health
Director of Revenue Cycle

Thomas Szmelter
Ventas, Healthcare Analyst

Jason Simmers
Ventas, VP

Justice Hammers
Claro Healthcare
Analyst

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Welcome New Members

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Chi-Matic
Head of Innovation and Client Success

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LUMC, Analyst

Poonam Desai
Loyola University Health System
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Alexa Stephenson
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Kelly Carney
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Will DeMille
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Priyanka Joshi
Cerner, Solution Designer

Ronald L. Hirsch
R1 RCM, Inc.
VP Regulations & Education

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Welcome New Members (continued from page 19)

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Physician Advisor

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

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

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Publication Scheduling

Publication Date	Articles Received By
January 2019	December 1, 2018
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July 2019	June 1, 2019
October 2019	September 1, 2019