hfma
first illinois chapter

June 2023

FIRST ILLINOIS SPEAKS

IN THIS ISSUE

To celebrate FIHFMA's 75 Years at the Annual Transition Dinner CLICK HERE

To View the Messages From Our Outgoing CLICK HERE & Incoming CLICK HERE Chapter Presidents

To Meet Our 2022-23 Officers & Board of Directors CLICK HERE

Exciting is hardly the word. **Let's all get ready for the FIRST IN THE NATION party for HFMA's original chapter!** As a former chapter president, I invite all members and their significant others to this event, which includes the annual transition from one leadership team to the next.

The event will be held at Carlucci's Restaurant in Rosemont on Thursday July 20, 2023, beginning at 5:00pm.

CLICK HERE to register today!

This event includes cocktails and appetizers at 5:00pm; followed by dinner and a ceremony from 6:00-8:30pm. Enjoy networking and a few cocktails on the outdoor patio. Dinner will be served inside.

If you have never attended a chapter event, I highly recommend it. You will meet groups of strangers who, it is very likely, will become some of your newest, best friends. No lie. Having been a member for 48 years, I can confidently state that some of my deepest lifetime friendships began at any number of HFMA events such as this. These are your peers. They understand your likes, your hates, your anxieties, your concerns.

Take this opportunity to loosen up, unwind, and engage a new set of acquaintances. While you are at it, consider volunteering for any of the many committees that help the chapter explore new and existing opportunities for you, your peers and your community. And 48 years from now, you too can look back and know that engaging in the HFMA chapter experience was one of the very best things you ever decided to do in your life.

Steven Berger, FHFMA
2000-01 FIHFMA President

Message From Our Outgoing President

BY BRIAN PAVONA , FHFMA, CPA, 2022-23 PRESIDENT

Dear FIHFMA Chapter,

Congratulations on the end of the Public Health Emergent (PHE) which ended on May 11, 2023. It's been a very long three years!!

The entire industry gets our heartfelt thanks and deserves a huge break. This includes the front-line workers who showed up every day, putting themselves and their loved ones at risk for the greater good. As a chapter, we learned more about exactly what our front-line caregivers endured while reading and discussing *The Emergency: A Year of Healing and Heartbreak in a Chicago ER*. Having the author, Dr. Thomas Fisher, facilitate a discussion with chapter members was one of the many meaningful moments shared over the past year.

And our thanks extends to you - the healthcare finance leaders who showed up (whether in person or remotely) to keep our healthcare systems operating during this unprecedented time. Together, we:

- Quickly deployed a work-from-home strategy to keep the revenue cycle, reimbursement, procurement, and payroll functions churning while also revising budgets, applying for relief funding, and reporting results timely
- Searched the globe and acquired personal protective gear, ventilators, and other necessities for the frontlines
- Pursued, obtained, utilized, and maintained compliance with Provider Relief Funds and other COVID-19 relief monies
- Supported the many new needs of the healthcare organizations in our community

All the while, you continued the very important work on what I believe is the most important and fundamental healthcare issue of our time… Addressing healthcare inequities. Whether through enhanced patient access, communicating and tracking charity care and community benefits, collaborating with community organizations, implementing diverse workforce initiatives, or collaborating on financial structures to support behavioral health and other critical programs, you rose to the challenge to make this issue a top priority in our community.

The FIHFMA Chapter was here to support you in all these initiatives. At the beginning of the chapter year last June, I summarized a vision for the year and along with chapter President-elect Katie White, Immediate Past President Rich Schefke, and Secretary/Treasurer Matt Aumick, we vowed to support you in the following ways:

Health Equities: We said First Illinois HFMA would help by continuing to educate its membership on the root causes of healthcare inequities, would host safe environments for dialogue and set goals to help our providers tackle the significant challenge. Update and Results – Over the past year we:

- Convened our 2nd and 3rd book clubs as a chapter this year, including hosting author and ER physician Dr. Thomas Fisher (Thank you Ashley Teeters)
- Featured Rush University Medical Center (Rush) CFO, Patti O'Neil and others in several forums to discuss how organizations like Rush are working to address healthcare inequities and workforce diversity
- Hosted our 9th Women in Leadership event to date, the largest in the chapter's history (Thank you Sue Marr and Nicole Fountain for your leadership!)
- Included DEI items on the agenda for all critical meetings and events throughout the year
- Enhanced our support and involvement with The Boulevard - a not-for-profit organization in Chicago that provides high quality, cost-effective respite care, holistic support, and housing services to help ill and injured homeless adults break the cycle of homelessness, restore their health, and rebuild their lives

Financial Acumen: We said First Illinois HFMA would help by continuing to bring innovative speakers, case studies, panels, and ideas to our providers to help them seize opportunities. Update and Results – Over the past year we:

- Featured dozens of CFOs and VPs of Finance, VPs of Revenue Cycle, Treasurers, Controllers, Internal Audit & Compliance professionals and other healthcare finance leaders on panels, webinars and other learning opportunities. A special thank you to Brian Kirkendall, Shelby Burghardt, Kim Wedster, Eileen Crow, and many others for your commitment to first in class programming throughout the year!
- Hosted hundreds of advisors, partners and subject matter resources in case study, panel and other forums

Workforce Matters: We said First Illinois HFMA would enhance opportunities to connect, network, and develop soft and hard skills together. Update and Results – Over the past year we:

- Hosted five chapters in an incredible 2.5 day Region 7 Fall Event. A special thank you to the Region 7 Committee and especially Stu Schaff, Rich Schefke, Brian Kirkendall, Laurel Davis, Kim Wedster, Meagan Edgren and Eileen Crow for representing our chapter on the Region Event Committee and knocking it out of the park!
- Held monthly events to bring the members of the industry together to network, learn, connect, mentor, and grow. A special thank you to Megan Edgren and Greg Burdett for enhancing our membership committee and membership experience!
- Continued to support the certification of members and recognition of awards throughout the year

What a year! Thank you for offering me the opportunity to serve!

Now, the new chapter year is here! I'm so excited to see what's in store for 2023-24. We have an amazing board and executive committee focused on raising the bar further to help our membership continue to develop, connect, and achieve together.

Brian Pavona, FHFMA, CPA
2022-23 FIHFMA President
Partner-Healthcare Audit and Advisor at FORVIS
Brian.Pavona@FORVIS.com

Message From Our Incoming President

KATIE WHITE , FHFMA, CPA, 2023-24 PRESIDENT

THANK YOU! It is truly an honor and privilege to serve as President of the First Illinois Chapter, and to top that, during our momentous 75th year as a chapter, the longest running chapter of the Healthcare Financial Management Association (HFMA). It is a responsibility that I couldn't possibly deliver on without the great leadership that has come before me, along with the current leadership and board of directors who support our chapters goals and efforts as we serve our membership.

My Legacy

A question that gets asked of every president before they begin their role is what is the legacy you want to leave for your year as President? It was only fitting to hear that question asked of me by our incoming Regional Executive, Dan Yunker, the same person who got me involved in HFMA 10+ years ago and showed me the importance of being involved in HFMA, a mentor who has asked me this same question at different points in my career.

Community: We are a community, a group of healthcare professionals with diverse characteristics, experience, and background. I want to see us come together even more as a chapter this year, in support of each other in forms of collaboration and mentorship. To not only educate our members but bring together our membership to support our community and all the great initiatives our local hospitals, health systems, and providers are actively working on. Making public health equality our focus in education, community involvement, and as a supporting organization.

Collaboration: The financial picture our industry faces continues to be a tough one. Inflation has had its impact everywhere in the industry and our chapter isn't immune to that. We not only need to get more creative with how we provide education and community to our membership, but we also need to collaborate more within the healthcare community: partnering with providers and health systems to put on affordable education; working with like organizations to promote content that is meaningful to our members and providers; and promoting other HFMA chapter events. Success will not require compromise, but flexibility.

Connection: The recent COVID-19 pandemic has taken so much from all of us. Some lost friends, family, and loved ones. Its devastation has run deep. What continues to linger beyond the quarantines and the masks is the loss of connection and how plentiful it once was. I want this to be a year of connecting for our chapter and fellow HFMA chapters. I personally have set a goal to connect with at least three fellow HFMA members monthly in various settings, and I hope you have a similar goal as well. Over the years, my HFMA community has brought me friendship, mentorship, and networks. I look forward to growing those connections deeper and wider with the HFMA community.

In closing, I am very much looking forward to the year ahead, as we all continue to grow in our careers, our connections, and our benefit as a chapter to the healthcare communities we serve.

Katie White, FHFMA, CPA
2023-24 FIHFMA President
VP, Finance & Performance Strategy
Innovista Health Solutions
kwhite1@innovista-health.com

Moving Out of the Red – Achieving Financial Sustainability for Healthcare Providers

As we look forward to life beyond COVID-19, healthcare organizations are facing a myriad of difficult decisions driven by margin pressures. In 2022, approximately half of U.S. hospitals finished the year with a negative margin due to increased expenses in labor, supplies, and pharmaceuticals. As we open 2023, provider operating margins are largely still in the red. However, we are seeing margins begin to rebound slowly for those who have disciplined expense management and revenue cycle best practices. Tackling this financial crisis with any hope of reaching a sustainable financial future will require ingenuity and perseverance as organizations seek solid footing, enabling continued service to their communities. However, financial sustainability is not simply about wiping out the red in the margins. Research conducted by Becker's concluded that healthcare CFOs defined financial sustainability as an organization's possession of sufficient financial resources to serve its community, while also making strategic decisions and capital investments over some time.

Essential Business Objectives

The road to financial sustainability has two lanes—cutting costs and generating revenue. To help rebuild balance sheets and achieve the stability and prosperity needed in healthcare, focus on the following business aspects:

Expense Management: Supplies, purchased services, and employee benefits showed double-digit increases for many providers over the last two years. Pharmaceutical costs showed the highest percentage of growth since 2019, impacting both self-funded health plans and patient care costs. Surfacing potential savings for rebates inside of pharmacy benefits management (PBM) contracts and redesigning benefit packages to manage high-cost claimants are complex and typically beyond the capabilities of internal HR. Brokers can help navigate these complexities if commission-based compensation from carriers will not influence recommendations. However, benchmarking spending data to other hospitals in similar markets is the most objective way to help identify savings and negotiate from a position of strength. For 2023, providers should consider benchmarking the following:

- Pharmaceutical costs
- PBM rebates
- Ancillary benefits such as life, AD&D, and LTD
- Stop-loss insurance
- Medical supplies and implantable devices

Workforce Productivity: Faced with increased staffing and financial demands, as well as the need for an efficient labor force, the capabilities of most healthcare organizations regarding staffing are significantly challenged. The need for contract labor has decreased substantially from the early days of the pandemic; however, hourly rates for regular employees have risen on average 15% from pre-pandemic levels and must be accounted for. Post-pandemic labor ratios (comparing labor expenses to total revenue) are ranging from 50% to 60% on average. Healthcare systems could not operate without clinicians and administrative professionals to deliver patient services, which is why it is important to calculate labor ratios and identify inefficiencies that need to be addressed and efficiencies that can be converted to potential savings. Departmental benchmarks for productivity should be re-evaluated and measured regularly to help create an efficiency culture driven from the bottom up. Site-of-care transitions from inpatient to outpatient settings also must be considered as new cost structures must offset reduced reimbursement.

Insurance Claim Denials: In the past six years, the average rate of healthcare insurance claim denials has risen by 33%. According to Healthcare Finance, a single denied medical claim costs approximately $118, or $4.9 million per hospital annually. With such a high price tag, reducing insurance denials is a top priority for the majority of healthcare providers. This process is complicated by the increasing volume of healthcare reimbursement changes, such as the No Surprises Act that will go into effect this year. The time and money that go into managing claim denials can have a huge, negative impact on an organization's net revenue and margins and are exasperated by revenue cycle staffing challenges, insurance claim denial and write-off visibility, and regulatory audit "denials."

Managed Care Assessment

Understanding existing payor contracts and reimbursement terms is key to developing an overall managed care strategy. The managed care assessment provides insight into an organization's current payor relationships and evaluates potential opportunities to enhance those agreements. In evaluating these relationships, organizations can potentially find new revenue-generating opportunities and position themselves for long-term success.

Conclusion

Margin improvement is an ongoing effort to identify and implement cost savings and revenue-generating opportunities. As the level of complexity continues to accelerate in healthcare, organizations will need talent, technology, and best practices to keep pace with insurance companies, suppliers, and vendors seeking a stake. Receiving help from industry professionals can help fill talent gaps, supply technological advancements, and accelerate efforts to rebuild margins.

About the Author

***Eric M. Rogers**, is Principal/ Healthcare Performance Improvement at FORVIS. You can reach Eric at Eric.rogers@forvis.com*

Moving FORward requires VISion

Brian Pavona, AICPA Health Care Entities Expert Panel

It's hard to stand out in a crowded space, but your forward vision has you in the spotlight—and it's time to celebrate. FORVIS is proud to recognize Partner Brian Pavona on his appointment to the AICPA Health Care Entities Expert Panel.

FORVIS ranks among the nation's top 10 public accounting firms, helping unlock the potential of our clients, people, and communities. We deliver an Unmatched Client Experience™ with assurance, tax, and advisory services that reflect our exceptional capabilities and uncommon commitment to excellence. Discover how our forward vision can help you prepare for what's next.

FORVIS™

ASSURANCE / TAX / ADVISORY

forvis.com

4 Key Plays for Maximizing Incentives in Value-Based Care

As providers transition to value-based care over the next several years, they will take on a lot of risk that they're not used to. Fear of poor return on investment may loom large as they gain their footing in this new paradigm.

As value-based care continues to grow, practices will have no choice but to face these types of challenges head on. So, the question becomes: What do practices need to do to succeed in this new medical landscape?

There are several ways to foster financial success in value-based care, but providers should prioritize four key plays to truly maximize incentives.

Coding Accuracy

HCC codes create an overall risk score, which the Centers for Medicare & Medicaid Services (CMS) use to predict future healthcare costs. This determines how much money CMS will allocate for the care of each patient based on the complexity of their case, risk of future disease, and estimated cost of care.

Inaccurate coding can lead to compensation that's not aligned with risk. Financial implications can be huge and dramatically impact a practice's success.

To ensure accurate coding, routine, in-depth audits are a must. Audits identify areas of improvement in billing, coding, and documentation, and help educate practices on ways to close coding gaps.

Practices also need systems in place to track where they succeed or miss the mark. This type of reporting provides a clear picture of year-over-year differences in revenue as it relates to coding.

Partnerships with value-based/managed service organizations can help, by conducting various audits and compiling reports that provide valuable insights to physicians and administrators.

Quality Improvement Via Annual Wellness Visits

The best way for practices to improve quality metrics is to close care gaps. By leveraging the annual wellness visit (AWV), providers stand to maximize incentives in more ways than one.

continued on page 8

4 Key Plays for Maximizing Incentives in Value-Based Care

(continued from page 7)

AWVs Close Care Gaps

An analysis of Medicare claims from 2011-2014 showed that 62% of people who got an AWV went on to receive other preventive care services. Research shows that patients who have AWVs are more likely to close care gaps by undergoing preventive screenings such as mammography, Pap smears, prostate and colon cancer screening, and bone density scans.

Screenings also can help providers maximize incentives by driving down medical costs. Some estimates show early cancer diagnosis can save $26 billion in healthcare spending per year.

AWVs Ensure Accurate Risk Score

The AWV is a standardized way for practices to collect data about patients that can be used to assess risk.

Within the AWV, providers should use the most specific HCC codes to document the appointment, which offers a highly accurate representation of patient health so that they are compensated appropriately.

AWVs Provide Added Revenue

Providers receive on average $168 for an initial AWV and $111 for repeat AWVs.

AWVs can also include a discussion of advanced care planning. This is a separate billable service, offering the ability to generate additional revenue within the AWV.

Despite all the benefits of AWVs to patients—and the incentives they provide to practices—research shows only about 24% of eligible Medicare beneficiaries get one.

To proactively get patients in the door for AWVs, practices should consider using techniques such as seasonal scheduling.

Comprehensive Care Management

Care management uses real-time data and predictive analytics to identify high-risk patients who could benefit from more extensive care and provide support for them along the care continuum.

One of the biggest components of care management that drives incentives is transitional care management (TCM).

Thirty-day hospital readmissions are an enormous healthcare expense. In 2018, there were 3.8 million 30-day hospital readmissions, with an average cost of $15,200 each. TCM employs a set of actions to ensure coordination and continuity of care so that the patient stays on the path to recovery without readmitting to the hospital unless necessary. One study showed an 86.6% decreased odds of emergency department readmission among those who had TCM.

When partnering with a managed care organization, practices have full access to care managers who interact with dozens of patients daily to ensure their TCM and other health needs are met.

Technology

Technology serves the dual purpose of helping patients take a proactive approach to their healthcare while enabling providers to maximize incentives.

Without data, it's difficult to succeed in value-based care. That all-important data is captured using innovative technologies designed to find trends so that providers know where to focus their efforts.

To help providers realize gaps in coding and care—the biggest incentive driver—technologies such as point-of-care EMR overlay can help. When they're with a patient, doctors can see real-time coding/care gaps and suggested actions. This allows them to not only improve outcomes for that patient, but also achieve incentives by closing care gaps and improving risk score through coding gap closure.

The Bottom Line

Since payment structures in value-based care are so different than traditional fee-for-service models, learning how to maximize incentives is one of the most important challenges providers need to overcome.

By focusing on the plays discussed here, they have the best chance of succeeding, and thriving, in value-based care.

About the Author

Larissa Long *is Content Marketing Manager at Innovista Health Solutions. You can reach Larissa at llong@innovista-health.com*

Health Care Faces Financial Challenges

Health care providers across the country have been challenged with rising costs for medical supplies, drugs and labor while also facing poor performance in the financial markets. Collectively, these trends decimated operating margins for 2022, arguably the worst financial year on record for hospitals. As the pandemic's toll continues into 2023, hospital leadership is being forced to identify innovative ways to continue to provide high-quality health care services to the communities their facilities serve. In 2023, some key financial trends hospitals are experiencing include the following.

High workforce cost

The high cost of labor remains top of mind for providers, given that labor is the most significant operating expense for many hospitals. During 2022, many higher-cost traveling nurses returned to permanent jobs as contracts came to an end. Many hospitals subsequently spent less on travelers as a percentage of total labor expense. However, the cost of labor in health care continues to rise and has been on an upward trajectory since pre-pandemic days. According to a recent report from Kaufman Hall, total labor expense for providers of all bed sizes is still significantly higher through February 2023 as compared to 2020 and in some cases by as much as 24% higher. This is directly contributing to negative operating margins.

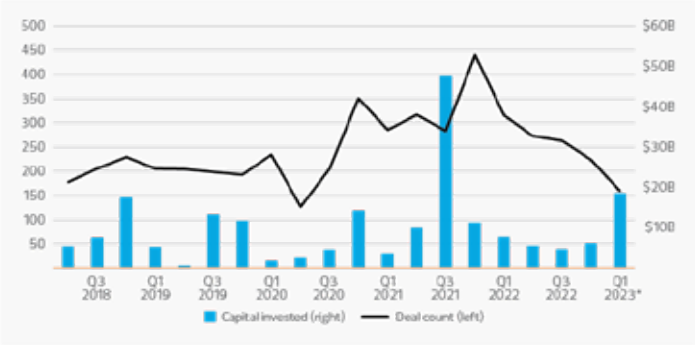
Strategic workforce reductions

Attracting and retaining talent is still a priority for providers, but many are making strategic workforce reductions. Becker's Hospital Review reported that "health care, which includes hospitals and health care products manufacturers, overall has announced a total of 16,482 job cuts this year. That is an 85% increase from the 8,928 cuts announced during the first two months of 2022." We believe this trend will continue as providers streamline operations to focus on core services by removing layers of leadership and consolidating operational structures.

High workforce demand

Despite a modest unemployment rate increase to 1.4% in February 2023 from 1.2% in December 2022, according to the U.S. Bureau of Labor Statistics, as well as strategic workforce reductions, demand for clinical hospital labor continues to remain high and surpassed pre-pandemic levels late in 2022. There is no evidence to suggest that this upward trajectory will reverse anytime soon, and it may indicate that more nurses and other employees who left health care soon will be returning.

Health care services buyout activity has cooled to more normal levels



Source: PitchBook; RSM US LLP

*Several large deals affected Q1 2023 capital investment.

In a report released in February this year, the Health Financial Management Association found that the industry can expect to continue to see health care staffing shortages across every category of worker. During the pandemic, nearly 20% of health care workers quit their jobs; up to 47% plan to leave by the end of 2025. Two out of five nurses and nearly one-third of physicians are reporting physical, mental and emotional exhaustion due to the stress of their jobs, an indicator that burnout is taking a toll on the industry.

Higher patient volumes

We're seeing patient volumes increase in health care systems, but this increase is not keeping pace with the rise in expenses due to inflationary pressures.

Poor investment performance

Last year saw poor performance in the financial markets. The S&P 500 dropped more than 18%, according to Slickcharts. Poor market performance significantly reduced available liquidity and operating margins for health systems across the country.

Solutions to consider

To continue to provide high-quality care to the communities they serve, providers should consider taking steps to manage operating margin and other challenges facing the industry.

Creation of a sustainable workforce

Demand for health care service providers will continue. Organizations should identify creative opportunities to attract and retain talent such as investing in nursing programs offered at colleges and universities to provide the resources needed to expand enrollment.

continued on page 10

Health Care Faces Financial Challenges

(continued from page 9)

Continued technology investment will be critical to bridge the gap between the need for health care services and the available labor resources to provide them. In addition, providers must train and educate their constituents in the use of this technology for it to be effective in achieving established goals.

TAX TREND: Workforce

Developing a sustainable compensation philosophy centered on total rewards instead of just cash salary may help health care organizations balance costs with offerings that match workers' preferences. Retirement programs, equity compensation, education opportunities or assistance, health savings accounts and subsidized transportation benefits are just a few of many common offerings with tax implications.

Margin improvement initiatives

Margin improvement may encompass a variety of pillars to reduce cost and improve net revenue, including revenue cycle, managed care strategy, clinical operations, pharmacy strategy and supply chain. Successful integration throughout the pillars, which is imperative for margin improvement, relies on the following:

- A collaborative team of operational and technical subject matter experts with a robust knowledge of current regulatory demands
- A vision for identifying technical opportunities for optimization and automation, as well as analytics to drive data-guided decisions and create transparency in performance
- Support of financial integrity with accurate documentation and severity capture to report the true acuity of a patient and capture appropriate reimbursement

Providers must take the time to analyze the people, process and technology associated with all the pillars to maximize margin.

TAX TREND: Cost management

Tax departments in middle market organizations are commonly strained by a variety of challenges, including difficulty finding qualified professionals and new compliance requirements resulting from frequent regulatory changes. A company that outsources or co-sources its tax function can augment the strengths of its in-house resources with manpower and secure technology without having to add full-time employee.

Supply chain management

Organizations should identify opportunities to close gaps and boost efficiency within their supply chain. Consider engaging a professional to conduct a comprehensive rapid assessment in order to gain an independent perspective. Reviewing every facet of the supply chain and aggregating the information into one holistic view is important. Once you have gained this high-level, comprehensive perspective, implement the changes necessary to reduce costs and fortify supply chain resilience using solutions and frameworks that precisely fit your needs.

TAX TREND: Supply chain

As supply chains evolve, the transfer pricing implications can be out-sized, leading to tax planning opportunities and risk management needs. More immediately, the increasing permanence of supply chain disruptions may necessitate organizations to update their transfer pricing more frequently than in previous business cycles. A company that understands the transfer pricing life cycle can tackle its numerous complexities—including data management, analyses, documentation and implementation—to ensure compliance and tax efficiency.

About the Author

Lori Kalic *is partner and a Health Care Senior Analyst at RSM US LLP. You can reach Lori at lori.kalic@rsmus.com*

Hospitals Face Increased Need Amid Pandemic to Improve Patient Throughput

reprinted from hfm

An acute care hospital cannot begin to be able to deliver cost-e6ective care if it lacks a fully coordinated approach for moving patients from admission to discharge.

Lower admissions. Higher patient days. Longer-than-average length of stay (LOS) in acute care.

These are among the significant challenges U.S. acute care hospitals face as a result of the COVID-19 pandemic. This problem is in part a consequence of the processes and protocols hospitals put in place to keep patients and staff safe throughout the pandemic. But it was exacerbated by the unanticipated challenges of personal protective equipment (PPE) shortages and significant increases in agency staffing and associated costs. Amid these challenges, it has become critical for hospitals to find ways to reduce LOS and enhance patient throughput. Only through such effort can they ensure their future financial and operational success and fully realize their mission of caring for the patients in their communities.

The struggle to deliver timely care

Since the start of the pandemic, hospitals have struggled to deliver care to patients in a timely manner. Dealing with longer stays in the hospital has cut into their inability to accept transfers. Meanwhile, patients face long waits in the emergency department (ED), as operational constraints have made it extremely difficult for hospitals to achieve the four-hour turnaround time for patients in the ED recommended under Medicare guidelines.

Moreover, patients who await discharge to a post-acute care setting can expect to spend significantly longer in the hospital than those awaiting discharge to the home-care setting. There are three fundamental reasons for this difference:

- An increased number of payers require prior authorization for discharge to post-acute care.
- Staffing shortages in care management departments make it more difficult for hospitals to prepare patients for discharge to the post-acute care environment.
- Most communities have limited resources to meet the increased demand for post-acute care facilities, given that both hospitals and post-acute care

facilities are contending with the same staffing challenges.

These barriers, combined with supply shortages and rising input costs on labor, make maintaining effective patient throughput in short-term acute care facilities an operational puzzle for administrators of these facilities.

Hospital finance leaders have a meaningful role to play in solving this puzzle. But to fulfill that role, they must clearly understand what is involved in patient throughput, including the people and processes that are needed to ensure patients do not encounter bottlenecks on their journey from hospital admission to discharge. These considerations are addressed in the sidebar. With this understanding, finance leaders can begin to advocate best practices that can enable a hospital to optimize patient throughput, thereby ensuring patients have a positive experience with their hospital care.

continued on page 13

Hospitals Face Increased Need Amid Pandemic to Improve Patient Throughput

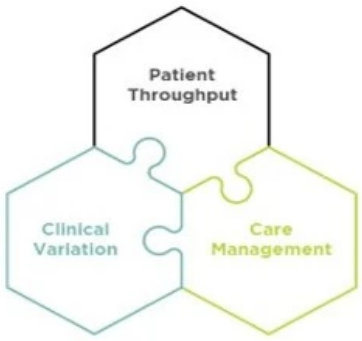
(continued from page 12)

Best practices in optimizing patient time in the hospital

There are many solutions for addressing the barriers that arise throughout a patient's hospital journey. Reducing LOS and improving patient throughput requires attention not only to the basic process steps involved with moving patients through the hospital but also to considerations around clinical variation and care management. These interlocking factors are depicted in the exhibit below.

Patient throughput

- Observation versus inpatient admission
- Multidisciplinary rounds (MDRs)
- Emergency department throughput
- Bed placement
- Ancillary wait times
- Day-of-discharge performance
- Inpatient rehabilitation
- Early ambulation program



Care management

- Patient status determination
- Utilization management
- Physician adviser involvement
- Discharge planning
- Care progression
- Executive escalation meetings
- Coordination with attending providers
- Post-acute care management
- Readmissions

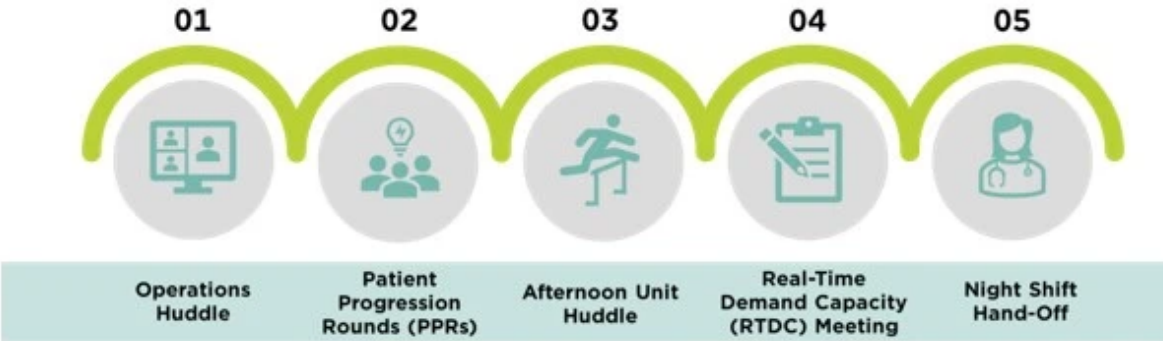
Clinical variation

- Clinical pathways
- Evidence-based practices
- Provider consensus
- Timely identification of at-risk patients
- Management of patients with complex acute conditions

The foremost concern is ensuring the patient receives the right care. Patients who have been assigned the wrong status may experience delays in treatment because of requirements imposed by their payers or because the diagnosis on which the patient's status is based is of lower priority than the diagnosis that more appropriately describes the patient's condition. ConCirming that the patient is in the right status at the right time allows for the appropriate treatment to begin at the right moment. Moreover, ensuring the patient is in the right status from the point of entry helps to prevent confusion over copays, deductibles and out-of-pocket expenses once the patient leaves the hospital, regardless of the setting.

It is important to see throughput as a journey, not a destination. Although clinicians must take the lead, the ability to e6ectively address throughput challenges requires a team-based approach involving participation by the care team, operations, finance and transport.

Finance leaders can play an important role by advocating for adoption of five leading practices that efficient hospitals use daily to promote effective throughput, described below and depicted in the exhibit below.



continued on page 14

Hospitals Face Increased Need Amid Pandemic to Improve Patient Throughput

(continued from page 13)

Each daily throughput process allows for a continuous flow of patient information to ensure elicient hospital flow

1 Operations huddle. The house operations huddle should be held in the morning, after shift change. Executives should attend this huddle for escalation purposes, while directors from all departments report out constraints they expect for the day, assess house-wide bed availability and address staffing shortages and safety and quality issues.

2 Patient progression rounds. The next step in the throughput cycle is for care team members to participate in unit-based patient progression rounds, with the goal of reviewing each patient's treatment plan, discharge objectives and barriers to discharge. The entire care team must participate in this process to ensure patients will appropriately progress through their care while also being prepared for discharge. Once the day's rounds are completed, the care team will be able to identify how many patients will be discharged that day and mitigate any barriers to those discharges.

3 Afternoon unit huddle. In the afternoon, care teams should gather for unit-based afternoon check-ins. This huddle gives each team an opportunity to quickly follow up on the action items from rounds, touch base on discharges expected later in the day and inform unit leaders of specific discharge barriers requiring their intervention.

4 RTDC meeting. Once the unit leaders have resolved the barriers to the extent possible, the larger team gathers for a second house-wide huddle, called the real-time demand capacity planning meeting (RTDC). The goal of the RTDC is to communicate where the remaining bottlenecks to patient throughput are and immediately address them with the appropriate leaders. Unit-based leaders should report out remaining discharges for the day, to enable transport managers to appropriately schedule the discharges and ensure requisite staff will be available. Outstanding constraints from the morning bed-huddle should be followed up during this meeting. Staffing should be addressed, test results expedited and preparations for morning discharges begun as well.

5 Night shift handoff. At end of the day, during shift change, discharge directives must be incorporated into handoff. Identifying a discharge readiness assessment and/or process into shift change continues the throughput cycle from day into night. The better the night shift understands throughput and feels the urgency to plan for discharge, the more efCicient the hospital will be in continuity of its throughput. Although it may seem that a great deal of time is being spent on managing the movement of patients, it is time well spent, because next to patient safety, it is the care team's most important responsibility.

Other steps for promoting cost electiveness

In addition to these proposed solutions, hospital Cinance leaders should devote attention to other ways that hospitals can reduce LOS and streamline throughput, including:

- Focusing on improving care of patients with complex conditions who typically have long LOS
- Advocating for reducing clinical variation through development of pathways and protocols for standardized disease states
- Collecting data to track and trend discharge barriers, to continuously work toward the removal of common barriers to discharge

These solutions and leading practices are just a few pieces to the larger puzzle that hospitals must solve to improve operations and efCiciencies. Success in managing throughput will remain elusive, however, without the understanding and support of the entire organization, where everyone is working toward a common goal. The pandemic may have made this truth more evident, but it remains fundamental to the success of our healthcare system under all circumstances.

Patient throughput: What it means and who is responsible for it

Patient throughput in the hospital is more than just admission to discharge for each patient. It also is everyone's responsibility in the hospital setting. And it poses a particular challenge when one considers that patients can arrive at any of multiple portals of entry, each with their own admission protocols.

Consider the following scenario of a medical inpatient.

This patient arrives in the emergency department (ED). The emergency medicine providers determine the patient will be admitted as an inpatient to a med/surg floor – technically, this patient's inpatient throughput timer begins when the provider writes the admission order.

Once the patient is transferred to the inpatient unit, hospitalists and specialists begin working to determine a diagnosis and projected prognosis for the patient. At the same time, the case management/discharge planner is learning about patient's circumstances and the extent to which family support is available, while the therapy team is assessing the patient for additional discharge needs.

continued on page 15

Hospitals Face Increased Need Amid Pandemic to Improve Patient Throughput

(continued from page 14)

Once a preliminary diagnosis is assigned to a patient chart, the diagnosis corresponds to an expected geometric mean length of stay (GMLOS) per CMS. The care team continues to work together toward an expected discharge date, which should align with the expected LOS. It is important to note that a diagnosis may not be assigned to the patient until they are nearly two days into their stay. It therefore is crucial for the care team to know how long a typical patient stay would be based on the projected diagnosis, to proactively plan for discharge when no GMLOS is available.

A critical process

Throughput is the backbone for hospital LOS. It is critical to have systemwide, multidisciplinary buy-in to throughput, with all care team members being focused on treating the patient and transitioning them to the next level of care. A hospital's ability to get patients in and out of the hospital is critical to hospital operations. In today's environment, hospitals are experiencing a high demand in the ED as well as for elective procedures that were postponed during the pandemic and transfers requiring a higher level of care. Without efficient processes and operational support to help drive throughput, hospitals will experience significant constraints.

Implications of reduced LOS

Efforts to reduce LOS have both Cinancial and quality implications. For payers that pay per a diagnosticrelated group schedule, that payment amount reflects the patient's expected level of care based on their diagnosis. Meeting the expected LOS ensures the payment will cover the cost of caring for the patient, and it will create capacity that ultimately allows the hospital to continue delivering care to other patients in the community.

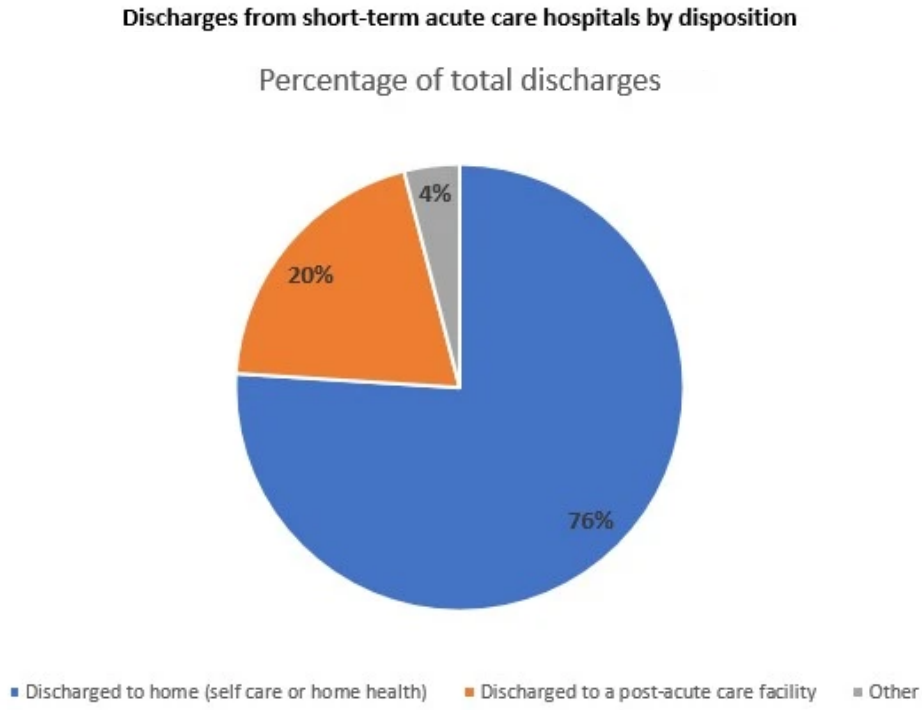
Reduced LOS also is beneCicial to the patient receiving care. Research shows that the longer patients stay in the hospital, the more susceptible they are to unsafe conditions, putting them at risk for hospitalacquired conditions and other complications. These are negative quality indicators for the hospital,

continued on page 16

Hospitals Face Increased Need Amid Pandemic to Improve Patient Throughput

(continued from page 15)

as well. Efficient patient care, coupled with clear communication, are paramount not only to moving patients efficiently from admission to discharge, but also enhancing the overall patient experience. As the exhibit below shows, short-term acute care hospitals in the 20th percentile in terms of quality are able to discharge a high percentage of patients to home or self-care.



Based on top 20 percentile from Medicare Provider Analysis and Review data, 2020

About the Authors

Brooke Balster *is a senior manager at Claro Healthcare, LLP, Chicago. You can reach Brooke at bbalster@clarohealthcare.com*

Larry Volkmar *is a managing director, Claro Healthcare, Chicago. You can reach Larry at lvolkmar@clarohealthcare.com*

Teri Wicker *is a senior manager at Claro Healthcare, LLP, Chicago. You can reach Teri at twicker@clarohealthcare.com*

Impacts to Work Comp and VA Claims Since Passing the Federal Spending Bill (HR2617)

Unless you spent your holiday season reading the almost 4200-page appropriations bill that Congress passed in December 2022, you may have missed the changes soon to be impacting your Work Comp and VA reimbursement. Nestled between funding all Federal Agencies and the whole of our government are provisions directly affecting providers that receive Work Comp and VA reimbursement. Specifically, the following bullets are now law:

- A Medicare reduction schedule for this year was postponed until 2025
- Medicare states especially would be impacted by the reduction
- Decision makers can adjust the uplifts to accommodate the potential drop before 2025

Let's take a deeper dive into the implications for each service line and what providers should potentially prepare for:

Workers' Compensation Reimbursement

Critical provisions in the bill delayed cuts scheduled for 2023. These cuts were specifically targeted for Workers' Compensation reimbursement in states with Medicare based fee schedules. A scheduled 4% (8.5% for Physicians) Medicare payment adjustment was postponed until at least 2025. States like California or Texas, who use Medicare as its base for Work Comp reimbursement, would have been directly impacted by this Medicare payment adjustment. In most cases, Medicare based states are on the lower end nationally for Work Comp reimbursement, making the average margins on these types of claims very small.

Using California as an example, we can see how this adjustment could greatly impact revenue. Outpatient Work Comp claims in California are calculated via Medicare rates, with around an 18% uplift, which is one of the lowest nationally. In 2019, the average payment in California for an outpatient Work Comp claim was under $3k compared to over $10k in other states (Louisiana and Wisconsin for example). Texas, another Medicare based state, was under $4k. In states like these, it is already difficult to cover the cost of treating a Work Comp patient, especially OP/PT/OT, and an additional decrease only magnifies the issue. The well-timed delay could allow decision makers in these types of states to adjust to their fee schedules to mitigate the impact.

On a positive note, there are waivers within this appropriations bill that extend Work Comp telehealth services and hospital-at-home programs for an additional two years. Telehealth usage in Work Comp skyrocketed during the pandemic. According to the state of Florida, the state treated 116,427 Work Comp claims via telehealth services between 2019 and 2022. This is more than a 4,500% increase compared to less than 2,500 total the three years prior.

Year over year, the rise of virtual care has proven to not only help drive down healthcare costs, but it has also simultaneously aided in the increase of overall patient satisfaction. Telehealth has paved the way for other programs to emerge. Nationally, many providers expanded upon their virtual care programs, experimenting with "hospital at home," as well as allowing patients to receive a wider range of care via telemedicine – for the same cost as an in-person visit. While telehealth usage normalizes across the country, the extension of these waivers will continue to encourage virtual healthcare and allow the hospital industry more time to innovate within the virtual healthcare field.

For the Workers' Compensation world, knowing your state's rules and regulations around telehealth will be important over the next few years, and beyond, as it becomes more of a standardized form of treatment.

Veterans Administration

With today's reimbursement for Veterans Administration claims, which are based off CMS rates (100% of Medicare in most cases/70% of Medicare for Millennium Bill claims), hospitals and healthcare systems dodged another bullet in payment reduction. We will continue to see increased volumes from the PACT Act (passed in late 2022), but we should not see a reduction in reimbursement until 2025. While the VA is used to CMS rates fluctuating, the magnitude of this reduction should be on every provider's radar as we approach 2025. The pandemic waiver extensions should impact VA as well. Since the pandemic, the VA has slowly made attempts to integrate telehealth into its programs. The extension will hopefully allow Veterans and the VA the opportunity to utilize and expand on telehealth services over the next few years.

While this bill relief is something to celebrate for hospitals, we have found that many are not prepared for the 2025 proposed cuts in regard to complex claims. Work Comp and VA are often an afterthought when it comes to legislation like this, but the impact targets places that you least expect. Awareness is key! Tracking these bills and working with decision makers in your state could be vital to your success and profitability.

About the Author

Zachary Schultz, CSMC, CRCR *is Sr. Director of Managed Care and Gov't Relations for EnableComp. For more information about how EnableComp can help, contact Rick Roos, Vice President of Client Services at rroos@enablecomp.com*

Changing Lanes: Switching to a Value Based Path

Few things cause more anxiety among healthcare leaders than the words "value-based care." Whether you're the C-suite concerned with global impact to your organizational mission and its bottom line, a provider concerned with the impact on your patients and your practice, or an operational leader concerned with what "business as usual" will look like, value-based care and downside risk seems daunting. In practice, though, what it can be is better: Better for patients, better for providers, better for care teams, better for your bottom line, and better for the organization. If you find yourself wondering how to navigate your organization to this "better," here are a few key "lane changes" that you should consider making:

Change the narrative from volumes to value

Organizations that continue to focus solely on inpatient and procedural volume growth will suffer in the value-based arena. This doesn't mean leaders should cease a focus on growth of market share – it means they should consider changing focus to expansion and growth of service lines that align with outpatient offerings, disease prevention, and chronic condition management. Take a hard look at your organization. Do you effectively promote preventive screening and patient engagement in health initiatives? Do your service lines strongly promote outpatient management of conditions, testing, and treatment? Do you excel at chronic condition management? If you hesitated when answering any of these questions, a strong and independent assessment of your strategic footprint and operations is in order. Investing the time and resources in an in-depth assessment will help identify the specific needs of your populations, potential collaborations within your community, and opportunities to help your patients achieve better outcomes in an efficient and cost-effective way – all of which promote success in a downside risk arrangement.

Shift your operations to a proactive gear

In the shift from volume to value, there is no more important component than your operational team. No matter what disease, measure, or patient, it's the operational team that is going to "make or break" your success. It's also the area organizations tend to ignore when readying for value-based arrangements. Make time to visit your frontline. Are they using standardized and aligned processes to see and reach patients or have they created individual workarounds for their daily tasks? Are they working to true capacity or are clunky processes causing overtime? Are your registration and preassessment processes effective at capturing needs and other social determinants of health? Are preventive screenings a focus or are they the "plus one" as your team focuses on the patient's most recent concern? Does the team leverage all forms of telehealth to

continued on page 19

Changing Lanes: Switching to a Value Based Path (continued from page 18)

proactively reach their patient panel on an ongoing basis or are you dependent on patients reaching out to you?

These inquiries will, no doubt, unearth a host of opportunities, and that's exactly the intention. To succeed in a value-based context, you need to ensure your operations support providers in proactive identification and management of chronicity. It's no longer enough to say your ambulatory operations see enough patients each day – they need to be seeing the right patients, using strong, aligned workflows, and capturing those factors that impact overall health, promote effective diagnoses, and ensure effective management for optimal outcomes and reduced costs.

Align providers with the value-based system

Many of us are old enough to recall the concerns about "cookbook medicine" when evidence-based protocols came into existence. It took time, effort, and physician-to-physician insight to align all providers with the idea that protocolized care was in the best interest of their patients. Value-based care is no different. Providers rightfully remain the staunchest and most effective advocates for patients. It is imperative that they understand the value-based system, and especially how the hierarchal condition coding system can drive outcomes of care – through proactive identification of disease risk, diagnosis and management of chronic conditions, and minimizing condition progression and complications. Simply put, providers must recognize that the value-based system empowers them to overwhelmingly promote the best and highest quality of life for the patients they treat.

Identify champions among your providers to share this message. Once providers are engaged, they will become your single most effective weapon against inefficiency and opportunities that can cause patient impact, and they will help you identify ways to make your care processes more effective and less costly. Listen to their insights and act on them.

Kick your EHR analytics into high gear

"What gets measured gets managed." Never was this truer than in the value-based context. Success in the value-based world means being able to respond quickly to issues and to measure the impact of operational improvements, risk capture activities, and leading indicators of disease management. Each and every one of these will have a revenue cycle component. Without effective and strategic analytics, you'll be "flying blind" when it comes to performance, and you risk setting your organization up for significant and unforeseen failure. Take the time to assess your EHR's functionality, along with your analytics team's skill set and abilities and their software. If you don't have the capability or skills to produce real-time analytics that can help you identify visits, diagnostic capture, and utilization down to the provider level, you need to engage resources to assist. Whether it's an assessment or enlisted help to build and streamline your analytic platform, the investment will pay dividends when your team needs to make rapid improvements to respond to patient needs and succeed in value-based measures.

Strive toward value-based "better"

Though the shift to value-based "better" may be daunting, it's one that is worth making for patients, providers, and our organizations. It's also one that none of us will be able to avoid. Taking the time to understand the chronic and coded disease-specific needs of your patient population and strategically invest in the infrastructure and operations to successfully manage their chronicity will drive toward "better" care, clinical outcomes, patient engagement, and financial performance.

About the Author

Tammy Schaeffer, BSN, RN, JD *is a principal within Plante Moran's healthcare consulting practice. You can reach Tammy at tammy.schaeffer@plantemoran.com*

Navigating the Medicaid Redetermination Process: A Guide for Healthcare Financial Managers

The recent passage of the Consolidated Appropriations Act of 2023 has initiated a significant shift in Medicaid enrollment. With an estimated 15 million patients being dropped from Medicaid, healthcare providers face new challenges in ensuring patient care and maintaining revenue streams. Healthcare financial managers must prioritize patient advocacy in this transition and implement practical steps to navigate the Medicaid Redetermination process effectively.

The Role of Patient Advocacy in Medicaid Redetermination

Patient advocacy is critical during this period of change, as millions of Americans face the uncertainty of losing their healthcare coverage. Providers must prioritize the needs of their patients while ensuring the financial stability of their organizations. By implementing comprehensive patient advocacy strategies, healthcare financial managers can help maintain continuity of care for those affected by the Medicaid Redetermination process.

Understand the Redetermination Timeline and State Specific Requirements

Each state has its own timeline and procedure for Medicaid Redetermination. To effectively support your patients and organization during this transition, it is crucial to familiarize yourself with your state's guidelines. Understanding when and how your organization will be affected is the first step in developing a comprehensive patient advocacy strategy.

Begin by researching the specific requirements for patients to re-enroll in Medicaid or find alternative coverage in your state. This information will help your team better support patients as they navigate their options. Additionally, stay informed about any updates or changes to the Redetermination process in your state by monitoring relevant news sources, regulatory updates, and government announcements.

Develop a Proactive Communication Strategy

Inform patients about the upcoming changes as early as possible. Develop a communication plan that includes letters, emails, phone calls, and social media updates. Ensure that your messaging is clear, concise, and compassionate, emphasizing the resources and support available to patients throughout the Redetermination process.

Train Staff on Patient Advocacy and Enrollment Procedures

Ensure that all relevant staff members are well-versed in the Medicaid Redetermination process and equipped to guide patients through enrollment. Offer ongoing training sessions that cover topics such as eligibility requirements, application procedures, and alternative coverage options. Empower your team to serve as knowledgeable advocates for patients in need.

Collaborate with Community Partners

Collaborate with community organizations, such as local health

continued on page 21

Navigating the Medicaid Redetermination Process: A Guide for Healthcare Financial Managers (continued from page 20)

departments, social service agencies, and nonprofit groups, to support patients during this transition. Establish referral networks and share resources to ensure patients receive comprehensive assistance in navigating the Medicaid Redetermination process.

Implement a Financial Counseling Program

Develop a financial counseling program to help patients understand their coverage options, potential costs, and financial assistance programs. Offer one-on-one sessions with trained financial counselors, either in-person or via telehealth. By providing patients with tailored guidance, your organization can help them make informed decisions about their healthcare coverage.

Monitor and Track Progress

As you implement patient advocacy strategies, regularly assess the effectiveness of your efforts. Track metrics such as patient satisfaction, re-enrollment rates, and changes in revenue. Use this data to identify areas for improvement and adjust your strategies as needed.

Advocate for Policy Changes

Work with local and national organizations to advocate for policy changes that protect patients from losing access to care. Engage with policymakers and government officials to share the real-life impact of the Medicaid Redetermination process on your patients and organization.

Identify a Reliable Partner

Find a trusted partner with the necessary tools and solutions to help your organization navigate the redetermination and re-enrollment process. A reliable partner can positively impact your bottom line by streamlining operations and alleviating the burden associated with Medicaid unwinding of members.

In a time of change and uncertainty, healthcare financial managers must take a proactive approach in supporting their patients while maintaining revenue streams. By focusing on patient advocacy and implementing the outlined strategies, providers can effectively navigate the Medicaid Redetermination process and continue to deliver quality care to those in need.

About the Author

Mark Starr *is Executive Vice President at CURAE/Patient Financial Care. You can reach Mark at mark.starr@curae.com*


What's Next?
Business resilience is being tested daily.
It's time for an urgent script for healthcare. To survive in today's environment, healthcare leaders must identify ways to improve financial, clinical and digital performance. But it's not enough for your organization to just keep pace.
BDO stands with you to address your current situation, performance opportunities and future growth scenarios, helping you anticipate what's next and transform data into actionable insights.
Accountants and Advisors
www.bdo.com/healthcare
@BDOHealth
© 2021 BDO USA, LLP. All rights reserved.
BDO

First Illinois Chapter 2023-24 Officers and Board of Directors

Officers

Katie White, FHFMA, CPA,
President

Matt Aumick, CHFP, CPA,
President-elect

Sue Marr
Secretary/Treasurer

Brian Pavona, FHFMA, CPA,
Immediate Past President

Board of Directors

Meagan Appleby (Edgren), CHFP, CRCR

Greg Burdett

Shelby Burghardt, CPA

Nicole Fountain

Brian Kirkendall, CHFP, CPA

Connor Loftus, FHFMA, CRCR

Ashley Teeters, MBA, CRCR

Greg Burdett

Board of Directors: Term of Office 2023-2025

Greg is a manager at FORVIS with six years of experience focusing on providing audit and financial accounting advisory services to healthcare organizations, including FQHCs, behavioral health clinics, physician practices/clinics, ambulatory surgery centers, and related nonprofit organizations. He has experience auditing and advising clients on critical allowances and reserves, revenue recognition, lease accounting and adoption, business acquisitions/combinations, debt financings, and grant accounting. He has been a member of the First Illinois Chapter HFMA for four years and is currently serving as a member and co-chair of the Membership/Social Committee and a member of the Golf Committee. Greg has enjoyed meeting other local healthcare finance professionals through HFMA and is looking forward to progressing the chapter's visions and goals as a member on its Board of Directors.

Meagan Appleby (Edgren), CHFP, CRCR

Board of Directors: Term of Office 2023-2025

Meagan is a Senior Financial Analyst in Net Revenue and Reimbursement for Rush University Medical Center. She primarily works on hospital net revenue, Medicare Cost Report, governmental audits, and other reimbursement related items. She has been a member of the First Illinois Chapter HFMA for six years, has served as a member and co-chair of several chapter committees, most recently co-chairing the Membership/Engagement Committee. Meagan has enjoyed meeting other healthcare finance professionals and is honored to serve the chapter's members on its Board of Directors.

Shelby Burghardt, CPA

Board of Directors: Term of Office 2023-2025

Shelby is a senior manager at RSM, working exclusively in the health care industry. She has over 15 years of experience serving health care and nonprofit clients. She has contributed as a member of several chapter specific programming committees and now serves as co-chair of the Programming Committee for the First Illinois Chapter HFMA. Shelby has enjoyed meeting other local health care professionals through HFMA and looks forward to serving the chapter's members on its Board of Directors.

Ashley Teeters, MBA, CRCR

Board of Directors: Term of Office 2023-2025

Ashley is an executive director of revenue cycle at University of Chicago Medical Center. She has been in healthcare for over twenty years, working with both payer and provider organizations. Ashley has been a member of the First Illinois Chapter HFMA for 2.5 years, joining as soon as her career brought her to Illinois. She has established wonderful connections and collaborations with chapter members. Ashley has been a part of the FI HFMA Women in Leadership Committee, moderated several HFMA events and is chairing the FI HFMA DEI Committee. She looks forward to serving on the chapter's Board of Directors because time spent with HFMA empowers her to be a stronger healthcare advocate within her community.

First Illinois HFMA Transition Dinner

Join us as First Illinois celebrates its 75th anniversary as a chapter! Since its charter in October 1948 as the first chapter of the newly formed American Association of Hospital Accountants (aka today's Healthcare Financial Management Association!), First Illinois Chapter has enjoyed exceptional growth and outstanding successes thanks to the dedication and leadership of chapter volunteer leaders and members.

The evening festivities begin with networking cocktails and appetizers followed by dinner. During the evening, there will be presentations of Chapter Member Achievement Awards, Annual Scholarship Awards, and Installation of the newly elected 2023-24 First Illinois Chapter Board of Directors. **CLICK HERE to register today!**

First Illinois Chapter Invitational Executive Golf and Scholarship Event 2023

Friday, August 25, 2023
8:30 am Shotgun Start

Willow Crest Golf Club
Oak Brook, IL 60523-2573

Join us for golfing, camaraderie, and good eats in support of the First Illinois Chapter's scholarship fund. Annually, the First Illinois Chapter awards $15,000 in scholarship monies to college-bound students of chapter members. The August golf event is the chapter's only golf event of the year and the largest source of funding for this worthy cause.

Located adjacent to the Hilton Chicago Oak Brook Hills Resort and Conference Center, the 18-hole, 6,433 yard par 70 Willow Crest Golf Club offers premiere course conditions combined with a spectacular natural setting for a memorable golf experience.

CLICK HERE to secure your golf foursome and/or explore unique golf sponsorship opportunities.

First Illinois HFMA Women in Leadership Committee Gives Back

For those not familiar with the Northern Illinois Food Bank, it is a location and mission worth checking out. Since 1983, the Northern Illinois Food Bank has been providing nutritious food and resources to a diverse community. The food bank provides food and staples throughout a 13-county area. They truly live their mission to provide food and resources to everyone in Northern Illinois.

On Saturday, March 11, the First Illinois HFMA Women in Leadership Committee volunteered at Northern Illinois Food Bank in the western suburb of Geneva. Our volunteers consisted of 20+ HFMA members and their families. We had representation from Advocate Aurora, Forvis, Harris & Harris, Northwestern Medicine, Plante Moran, QRC Analytics and UChicago Medicine.

Together, our team packed 7,725 pounds of food, thus providing 6,021 meals for 274 families in Northern Illinois.

We would love to continue our volunteer efforts and have you join us in our next event. If you are interested in participating in an upcoming event, please contact Ashley Teeters at Ashley.Teeters@uchicagomedicine.org to be sure you are notified of our next volunteer opportunity. As HFMA members, we are all involved in healthcare so supporting philanthropic efforts to make our communities healthier is something we can all feel good about.

About the Author

Ashley A. Teeters, MBA, CRCR *is Executive Director, Revenue Cycle, UChicago Medicine. She is a member of the First Illinois Chapter's Board of Directors and co-chair of the Chapter's Women in Leadership Committee.*

2023 Spring Symposium
Drury Lane Conference Center, Oakbrook Terrace, IL

May 18, 2023

Over 150 attendees from across Chicagoland healthcare finance, accounting, reimbursement, treasury, and revenue cycle operations participated in the full day of education and networking.

First Illinois Chapter Partners

The First Illinois Chapter wishes to recognize and thank our 2023 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
FORVIS
RSM

Gold Partners

Bank of America Merrill Lynch
CLARO HEALTHCARE
INNOVISTA HEALTH SOLUTIONS
POWERS + MOON

Silver Partners

CommerceHealthcare
CURAE™ Patient Financial Care
enablecomp
Great Lakes MEDICAID, Inc.
HARRIS & HARRIS
rh Robert Half®
SYNTELLIS

Bronze Partners

ELEVATE PATIENT FINANCIAL SOLUTIONS®
plante moran
protiviti® Face the Future with Confidence
SAC Law Offices of Stephenson Acquisto & Colman
!salud revenue partners

FIRST ILLINOIS SPEAKS

Publication Information

Editor 2023-2024

Jim Watson
jwatson@bdo.com

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.

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 2023	September 1, 2023
February 2024	January 2, 2024
June 2024	May 1, 2024