hfma
first illinois chapter

October 2023

FIRST ILLINOIS SPEAKS

IN THIS ISSUE

To View the Fall Summit 2023 - Oct. 26-27 In-Person Event CLICK HERE

To Register for the Summit CLICK HERE

To View Message from Our Chapter President CLICK HERE

First Illinois HFMA
Fall Summit 2023

"Cost of Care: Overcoming the Gap"

October 26-27, 2023

Sheraton Lisle Naperville Hotel
3000 Warrenville Road, Lisle, IL 60532

Where Will You Be on October 26-27?

This year's event brings together healthcare industry executives and experts for a premier event, ***Cost of Care: Overcoming the Gap,*** in Lisle, Illinois. Education topics are focused on the healthcare industry, trends, and solutions.

You can see the full agenda **HERE.** A few highlighted sessions and their related speakers include:

- CFO Panel on Cost Effectiveness of Healthcare – *Vince Pryor, Ivan Samstein, Matt Flynn, Tim Heinrich, and Doug Welday, moderated by Brian Pavona*
- Innovation with Artificial Intelligence – *John Bennett, Manish Thakkar*
- Be the Best Part of Their Day: Supercharging Communication with Values-Driven Leadership – *Dr. David Schreiner, President and CEO of Katherine Shaw Bethea Hospital*
- Cost of Care, Overcoming the Gap – *Ann Jordan, President and CEO of HFMA*

While at the Fall Summit, you will meet thought leaders and gain the opportunity to expand your knowledge. Benefits of attending include:

- Networking Opportunities – Connect with healthcare financial professionals from organizations, such as Advocate, Ascension, NorthShore University HealthSystems, Rush University Medical Center, University of Chicago Medicine, and University of Illinois Hospital & Health Services System who have already registered. Scheduled networking opportunities include the Thursday morning New Member Breakfast, Thursday afternoon Networking Event *(celebrating First Illinois's 75th anniversary as a chapter)*, and more!
- Continuing Professional Education Credits – Throughout the 1.5-day event, 9 CPE hours are yours for the taking
- Sharpen your toolbox by visiting the conference's extension list of onsite companies to learn about the many ways they can support you in your day-to-day business operations.
- Building – The relationships you build through HFMA transcend work and allow you to grow both personally and professionally!

CLICK HERE to register today!

Message From Our Chapter President

Dear Friends and Colleagues,

The first quarter of our 75th year as a chapter has not disappointed. We started the year with SOLD-OUT attendance at our 9th Annual Women in Leadership (WIL) Retreat, held for the second year at the beautiful Morton Arboretum. The committee, led by Sue Marr, Nicole Fountain, and Ashely Teeters, continues to put on such a unique event that everyone attending leaves rejuvenated, connected, empowered, and ready to improve outcomes both in and out of the office.

The month of June continued with our Certified Healthcare Financial Professional (CHFP) Certification Practicum. The practicum was the second of the calendar year and the first in-person, post-Covid event where members who were unable to participate in January could prep for the exam and even take the first part on site. I encourage anyone interested in getting their CHFP certification to consider the training program that is held at least once a year. The team, chaired by Connor Loftus and Sara Weisenberg, does an amazing job at making sure our members are prepared for the exam.

To close out a busy first month, many of the First Illinois members attended the association's annual conference in Nashville. We were able to find time between the educational and networking events to gather as a chapter and catch up with one another.

In July we officially kicked off our 75th year as a chapter at our annual Transition Dinner, celebrating the success of not only the most recent fiscal year but of the last 75 and honoring what has been built to allow us to continue as a chapter today. Several past presidents were in attendance. I personally enjoyed talking to each one of them, some of whom I met for the first time, and several who mentored me into the president I am to the chapter today. It was truly a special event. Celebrating the volunteers of our chapter who work so hard for our members is inspiring and propels us for the work ahead.

As the summer came to an end, the chapter held its 29th Annual Executive Golf & Scholarship Event at the end of August. The weather was great, and the company was even better. If I only golf a few times a year, I am glad this event is one of them. Catching up with our executive providers and partners of the chapter outside of the office and the conference rooms is always a great time. Rich Franco has chaired this event for several years now, with great support from the rest of his committee in Rosalyn Ryan and Greg Burdett, and the administrative support of the chapter. All of this comes together to put on a great event year after year. This year, the event raised over $3,350 for our scholarship fund, and we look forward to adding to that throughout the year.

continued on page 4

First Illinois HFMA President's Message Continued

For the first time, in September, our Diversity, Equity and Inclusion (DEI) Committee put together a volunteer event with The Boulevard of Chicago, an organization that the chapter has partnered with for years on various support events and initiatives. This event allowed our members and volunteers to come together and do some landscaping and beautification efforts on the grounds of The Boulevard. This was both rewarding for our volunteers and The Boulevard, and we look forward to being back and having more members come out to support this partner organization in the future.

We have had an awesome start to our 75th year, and I couldn't be more excited for what's to come next. The chapter's premier education event, the Fall Summit, is October 26-27, and the chapter's official birthday, if you will, is also in October. We are on track to have our best event yet! Just a few highlights to mention, we have built a CFO panel that is sure to help us understand the key challenges we face today and what various teams are doing to overcome them. We also have Ann Jordan, the new president and CEO of HFMA who will share her perspective on what is going on nationally in our industry and what the focuses are in the near term. It's been exciting to see all the provider organizations who have already registered to attend. It's a testament to the Fall Summit Committee led by Greg Burdett on the great agenda they have built for our members. Don't miss it!

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Growth Fluidity: Achieving Growth to Bring Value

The same statement resurfaces whenever we face an economic downturn: healthcare is recession proof.

Unfortunately, that's more fiction than fact.

Just like other large organizations with workforce, supply chain and other fiscal concerns, healthcare organizations are impacted by economic conditions. However, it is true that the industry responds to economic downturns in unique ways. The downturn we are experiencing in 2022 is different in many ways than those that came before, especially because it's happening concurrently with an ongoing global pandemic that continues to destabilize the healthcare industry.

Healthcare leaders need to understand how the downturn could exacerbate issues brought forth by the pandemic and introduce new challenges.

In this article, we'll discuss both the challenges and opportunities that could lie ahead, categorized by healthcare providers' top fiscal priorities.

Patient Access and Experience

Challenges

- **Patients may start to defer care or continue to defer care** if they are already doing so. This may be due to high insurance deductibles, loss of health insurance due to unemployment, or less disposable income to pay for care. Deferred care could cause demand to drop, especially for elective services, and lead to worse long-term outcomes for patients with chronic conditions. Additionally, these worsened long-term outcomes may lead to negative performance for a provider's risk-based contracts, resulting in lower reimbursement and/or penalties for the care of those patients.
- **Quality of care may drop** as providers are pushed to do more with less and staffing issues persist at all levels, including nursing, allied health professionals, technologists and more.
- **Older patients may have fewer care options.** Many of these patients are dependent on pensions or fixed incomes and will struggle to afford assisted living and memory care. Over time, inability to fill these facilities could lead to cutbacks in services and ultimately permanent closures.

Opportunities

Prioritize patient-centric innovation.
You may need to reprioritize investments. Think about what innovation projects will bring the greatest benefits to your patients right now. Longer-term ROI projects may need to be deferred to preserve precious capital. This can help address potential access challenges.

Streamline your referral system.
It's important that you streamline the referral process to reduce hurdles and improve patient care coordination. Consider exploring how maximizing the value of your EHR system can facilitate a cleaner referral process.

Optimize your digital front door.
Your digital front door should make it easier for patients to schedule appointments, manage their health and understand the cost of their care.

Proactively monitor patient acuity and outcome measures.
Work with the applicable payers to negotiate potential modifications to reimbursement and penalties of risk-based contracts to address the negative trend.

Financial Health

Challenges

- **Demand decreases could lead to reduced revenue.** This is especially true for discretionary services. Providers may have to cut certain services due to both concerns with financial sustainability and staffing shortages.
- **Insurance coverage gaps** could lead to lower reimbursement rates for providers, particularly as more patients find insurance through the marketplace or Medicaid.
- **Bad debt will likely increase,** making it more difficult to collect payment for services rendered.
- **Days of cash on hand will likely decrease,** leaving less liquidity for healthcare providers to work with and potentially triggering debt covenants.
- **Bond ratings may go down** as debt covenant violations increase, resulting in higher interest rates.
- **Costs are likely to increase,** especially labor and supply costs. In addition, due to pandemic pressures, there will likely be fewer options to reduce expenses compared to previous recessions.
- **Providers may struggle to make contractual payments** such as lease payments. This is especially true for providers in the elder care space, such as skilled nursing facilities.
- **Private funding is likely to decrease.** In particular, we could see reductions in private grant awards in the coming months.

Opportunities

Assess your key financial metrics. Across the healthcare industry, many organizations struggle to achieve economic stability while embracing value-based models of care. As organizations are evaluating

continued on page 6

Growth Fluidity: Achieving Growth to Bring Value (continued from page 5)

their ideal systems of care, service line growth, financial affordability, and overall sustainability, **growth fluidity** is the capability that will help drive these goals forward. While growth is defined differently by any given organization, 79% of health system executives believe regionalization and comprehensive network design will be the primary drivers to increasing their long-term financial sustainability.1 Addressing sustainability will require healthcare

In the fee-for-service model of care, a hospital's profitability is driven by enhancing services related to emergency room volume, surgical case volumes, inpatient admissions, and outpatient visits. Value-Centric Enterprises improve profitability by understanding how to diagnose patients and direct them to the appropriate center of care across the organization's health system. Increasing accessibility for patients in terms of how, where, and when patients need care will generate future revenue. As the traditional motivators of the fee-for-service model decline, healthcare leaders find new ways to support a new value-based equation focusing on access, quality, and engagement. This will be most important for systems of care supporting non-acute, pre-, and post-acute care systems.

Regionalization

Incorporating horizontal and vertical growth channels will allow healthcare organizations to achieve greater relevance across a broader geographic region with a consolidated services strategy. More than expanding across a physical geographic area, however, regionalization is about incorporating a pre- and post-acute strategy that covers an entire patient population. Consolidating skills, resources, and knowledge will enhance the value of care but also the financial sustainability of an organization while transitioning from the incentivization of quantity to quality.

New & Emerging Technologies

Technological innovation in the healthcare space has skyrocketed in recent years. COVID-19 placed a premier focus on telehealth and at-home care, but innovations like biosensors and remote patient monitoring have and will continue to change how we think about healthcare. These industry disruptors are outpacing the transformation to value. Organizations need to invest in emerging technologies and integrate them within a system of care where they can share these resources across a larger platform.

Many of the largest conglomerates in the industry increased both their revenue and cost savings by investing in new technology, like artificial intelligence and machine learning. Implementing these solutions can help healthcare providers identify opportunities for improvement while reducing costs associated with variations in care and administrative tasks.

Four of the critical capabilities essential to becoming a Value-Centric Enterprise—strategic agility, value-centricity, change clarity, and financial sustainability—are all powered by the fifth capability: growth fluidity. Executing strategic and value-based initiatives will not be possible without organizational growth, whether it be horizontal or vertical, organic or inorganic. The ability to adapt quickly as needs arise will be paramount to creating a comprehensive network of care that meets the needs of an organization's patient population.

About the Author

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Safeguards around patient data are key to continuity of care: Summer 2023 Industry Outlook

Safeguarding the integrity of patient information is key to mitigating potential issues in the care provided to consumers. Integrity issues such as quality and continuity in patient data may increase malpractice risk and negative patient outcomes, which can harm an already pressured bottom line for many beleaguered hospitals. When patients lose confidence in an organization or provider, they will seek care elsewhere.

Transparency leads to several positive outcomes

Health care organizations can create a competitive advantage by taking several steps to improve data integrity, ensuring that the data they collect and maintain is accurate, complete and reliable. As patient information becomes transparent across various health care organizations, this can lead to positive outcomes for the delivery of care to patients.

Organizations should focus on building a committee of leaders with knowledge of health care compliance frameworks that will oversee data quality and then adopt a framework with protocols in place for continuous improvements. When patient data, such as comprehensive medical records that include past treatments, medications and allergies, is transparent and easily accessible across the health care ecosystem, providers can make more informed decisions about patient care, administrative time can be reduced, and physicians can focus their efforts on providing optimal, patient-centered care.

In addition, patients with access to their own health data become empowered to take an active role in their health care. When patients can view their medical records, test results and treatment plans, they gain a better understanding of their conditions, which facilitates informed decision making and promotes engagement in their own care. Patient empowerment could lead to improved adherence to treatment plans, better self-management of chronic conditions and increased patient satisfaction.

At the same time, it is essential to maintain patient privacy and confidentiality when implementing transparency initiatives. To protect patient information and ensure that sensitive data is accessed only by authorized individuals or entities, organizations must put strict data security measures in place and adhere to legal and ethical guidelines.

Ensuring data credibility

In health care, several data integrity models are commonly used to ensure data accuracy, consistency and reliability. Here are a few examples:

- ACID (atomicity, consistency, isolation, durability): The ACID model is a set of properties that guarantee reliability and consistency in database transactions. Atomicity ensures that a transaction is treated as a single unit of work, either fully completed or fully rolled back.
- CAP (consistency, availability, partition tolerance): The CAP theorem states that it is impossible to achieve all three properties referenced in its name simultaneously in a distributed data system. In health care, where data consistency is crucial, the CAP model guides organizations in making trade-offs between consistency and availability in distributed environments.
- DICOM (digital imaging and communications in medicine): DICOM is a standard for transmitting, storing, and sharing medical images and related information. It ensures data integrity by defining protocols, data formats and metadata standards that allow for the accurate and reliable exchange of medical images across different health care systems and devices.
- HIPAA (Health Insurance Portability and Accountability Act): While not a data integrity model, HIPAA establishes privacy and security standards for protecting patients' health information. Compliance helps ensure data integrity because the rules require safeguarding against unauthorized access, maintaining data accuracy and implementing security measures to prevent data breaches.

These models and standards play a significant role in maintaining data integrity within health care systems and applications, enabling the accurate and reliable exchange of health information while ensuring patient privacy and security.

Looking forward

Overall, data integrity is essential for the continuity of care, as it promotes accurate diagnosis, safe transitions between health care providers, effective care coordination, and evidence-based decision making. By maintaining data integrity, health care organizations can enhance patient safety, improve outcomes, and provide high-quality, uninterrupted care throughout a patient's health care journey.

Looking forward, generative AI has the potential to improve data integrity in health care by augmenting and enhancing the quality and completeness of existing data sets. It's important to note, however, that while generative AI techniques hold promise in improving data integrity, careful governance, validation and verification are necessary to ensure the reliability and accuracy of generated data.

Companies now have access to more data than ever before, and while collecting data is no longer a problem, getting the right data remains challenging.

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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-effective 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 – {design: state location of 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.

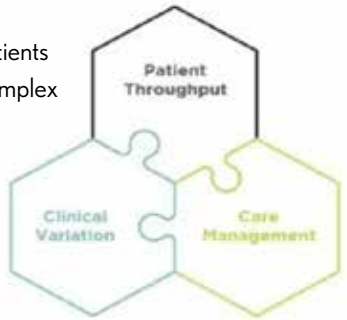
Best practices in optimizing patient time in the hospital

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.

Factors involved in efforts to reduce acute care hospital length of stay

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

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



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

continued on page 11

Hospitals face increased need amid pandemic to improve patient throughput (continued from page 10)

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. Confirming 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 effectively 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.

Team process steps for patient throughput in an acute care hospital

Each daily throughput process allows for a continuous flow of patient information to ensure efficient 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 efficient 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 effectiveness

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.

continued on page 12

Hospitals face increased need amid pandemic to improve patient throughput (continued from page 11)

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.

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.

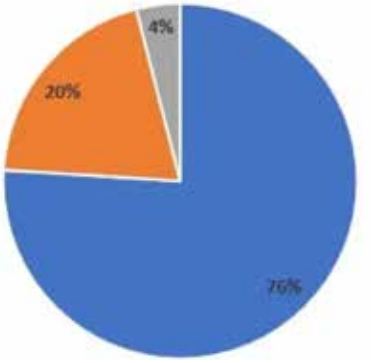
Implications of reduced LOS

Efforts to reduce LOS have both financial and quality implications. For payers that pay per a diagnostic-related 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 beneficial 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 hospital-acquired conditions and other complications. These are negative quality indicators for the hospital, 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.

Discharges from short-term acute care hospitals by disposition

Percentage of total discharges



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

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The Trifecta in Revenue Cycle

There is a trifecta at work in revenue cycle today. Technology, teams, and time are all factors that impact a provider's ability to achieve their revenue cycle goals. When one or more of these elements is weak, a provider may struggle to weather the current healthcare crisis storm. Poor revenue cycle management can cause quality to suffer or lead to a discontinuation of services, the closing of hospital units or the shuttering of facilities altogether. Ensuring strength and stability in the revenue cycle trifecta can help hospitals and healthcare systems overcome barriers to financial health so providers can focus on patient care.

Technology

As we all know, artificial intelligence (AI) is finding its way into every nook and cranny of healthcare. Payers have already embraced its technology and the results can be detrimental to both patients and providers. Nearly gone are the days of humans applying nuance to understand the unique condition of each patient and provider. Insurance companies have implemented AI to process claims at break-neck speed using algorithms, which has led to a significant uptick in claims denials. According to a recent Crowe RCA benchmarking analysis[1], denials rose from 8% in 2021 to 11% in 2022. That means the average healthcare system was saddled with approximately 110,000 unpaid claims last year alone.

For providers, technology can play a key role in improving revenue cycle performance. Optimizing this technology may involve implementing new systems and processes, integrating existing systems and improving staff proficiency with technology. But revenue cycle technology can be complex, costly, and constantly evolving. Identifying and implementing the right technology solutions as well as managing and maintaining these systems can be daunting.

Team

While the pandemic may have waned, the impacts are long lasting, notably in the healthcare industry. Staffing shortages and reduced operating revenue have led to increased workloads and employee burnout, and revenue cycle staffing is not immune. Recruiting and retaining staff with the knowledge and expertise to successfully navigate the revenue cycle complexity is becoming increasingly difficult and costly.

An analysis published by CWH Advisors[2] revealed that 63% of providers were experiencing revenue cycle staffing shortages and that accelerating cash flow and improving predictability of revenue streams were top goals. Without adequate revenue cycle staffing to mitigate claims denials and manage the backlog of unpaid claims, healthcare systems will continue to see the claims denial rate skyrocket, contributing further to cash flow challenges.

Time

Without the proper technology and team in place, time becomes a rare commodity. The increase in workloads means less time to recruit and train revenue cycle staff and less time to implement and maintain technology. It's a vicious circle where each element of the trifecta directly impacts the other elements. With less time to identify and correct claim errors, analyze contracts and reimbursement issues, and appeal denials, providers are left with a growing number of open claims or inappropriately closed claims, which ultimately leads to increased revenue loss and patient debt.

Data released by the Centers for Medicare and Medicaid Services[3] reveal that only a miniscule 0.2% of denied claims are appealed. That leaves the patients carrying the burden of paying out-of-pocket for services that should have been covered through their insurance. And when patients experience financial hardships, they often avoid adding to their debt by abstaining from or postponing necessary healthcare services. Even worse, more patients are being denied medical care because of existing debt. It is a compounding problem that adds to the crisis.

So, what can providers do to stop the vicious circle and strengthen their revenue cycle trifecta?

For one large urban hospital system in the Midwest, conducting zero balance reviews helped to identify $5.5 million in potential underpayments over just a few months, of which $3.9 million made the cutoff for appeal. Most of the underpayments and cash collections came from Medicare and Medicaid managed care plans and a large commercial plan. In many cases, the denial was related to eligibility, and correct coverage updates resulted in the hospital receiving retroactive payments.

Another 10-hospital health system was able to identify and recover $10 million in the first year of outsourcing its zero balance reviews. By leveraging the revenue cycle service provider's advanced tools and tactical teams, the health system not only recouped lost revenue, but they were also able to fix issues to prevent future losses. As each system hospital was added, a review of coding, billing and write-offs fixed a host of broken processes.

Instead of focusing on reducing expenses, providers should turn to zero balance reviews to find a new source of revenue. However, it takes a lot of sophistication to figure out if money has been left on the table, and providers need technology, time, and the right team to manage this process effectively.

For some healthcare systems, recovering funds through zero balances reviews is just the first step. When broken processes continue to plague the revenue cycle, additional help with coding and accounts receivable may be required to bridge the gap and help improve processes to avert future revenue losses. Providers may find outsourcing to be their best option as they can leverage the advanced technology, expert team, and dedicated time that revenue cycle service providers can offer.

About the Author

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2024 Healthcare Hiring and Compensation Trends

Demand is expected to remain high through 2024 for administrative and financial professionals employed by healthcare organizations. Competition for many of these workers continues to be fierce, however. To build a strong foundation for the future, providers and payers need to stay up to date on hiring trends and remain continually on the outlook for skilled talent.

The 2024 Salary Guide from one of the leading talent solutions firms offers a look at employment trends in seven professional fields, including healthcare, along with the projected 2024 salaries for hundreds of positions. Following are some insights taken from the guide.

Organizations need to hire, but talent shortages persist

The hiring market is still primarily candidate-friendly, with more job openings than job seekers. The result is an environment where the vast majority of healthcare managers (98%) say it's challenging to find the skilled professionals they need. When they do identify job candidates, employers need to streamline their hiring process or risk losing their top choices to competitors making job offers faster.

Managers say their hardest-to-staff roles include (in order of hiring difficulty) administration, office services, medical billing and collections, and revenue cycle specialists. These are also the areas where employers use contract talent most often. In addition, demand persists for administrative professionals with experience in medical coding, medical data entry and patient services.

Salary transparency can give healthcare organizations a hiring edge

The strong salary growth we saw beginning in 2022 is generally steadying, but many managers continue to increase compensation to retain key staff and better compete for top talent. 52% of healthcare managers say they're increasing starting salaries to attract and hire skilled candidates. 38% say they're adding new benefits and perks.

Employers that are upfront about a role's salary range can improve their hiring prospects. Almost half (49%) of healthcare workers say the lack of transparency about pay or benefits is their No. 1 frustration when looking for a new job. Providers and payers are apparently listening: 91% of healthcare managers say their organization includes compensation information or a salary range in its job postings.

continued on page 15

2024 Healthcare Hiring and Compensation Trends (continued from page 14)

Contract professionals keep work on track

Healthcare managers are relying heavily on contract professionals to help them address talent shortages and heavy workloads, with 70% saying they plan to increase the number of these workers in the second half of 2023. Many interim workers are being offered permanent roles, increasing the rate of contract-to-hire conversions compared to recent years.

Healthcare managers say they most often use contract talent in these areas, listed in order of usage frequency:

- Administration
- Billing and collections
- Payment processing
- Office services
- Revenue cycle
- Claims processing

The fast pace of work in the healthcare field often leaves managers with little time for recruitment. Many are working with talent solutions firms to find both the permanent and contract professionals they need.

Some managers also consider less-experienced candidates who show high potential for on-the-job training. 31% of healthcare managers say they're loosening job requirements related to education, skills or experience.

Accreditations matter

Organizations prefer professionals who have attained certifications in their area of focus. For those employed in administrative and financial roles at hospitals, medical offices and insurance firms, these accreditations include:

- Certified professional biller (CPB)
- Certified professional coder (CPC)
- Electronic medical records systems (Cerner, Epic)
- Registered health information administrator (RHIA)
- Registered health information technician (RHIT)
- Workday

Remote and hybrid work model still very popular

While remote work is not possible for most clinical healthcare workers, offering remote and hybrid options can help bring in top administrative and financial specialists.

A third of healthcare managers say they are offering remote and hybrid work arrangements, and 36% say they're evaluating candidates outside the organization's geography and allowing new hires to live anywhere. This not only attracts job candidates but, once hired, keeps them on board.

Remote-friendly positions may include medical billing manager, medical coding manager and medical data entry specialist to name a few.

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Making Financial Benchmarks Actionable with DRG Performance Insights

Benchmarking and distributed data sets have been available for years, yet many healthcare teams continue to struggle with adoption and usefulness of this data. According to a new report, operating margins are experiencing a recent downturn, for the first time since they rose back to the black in March 2023. Many healthcare organizations are focused on real, tangible ways to expedite their performance improvement efforts. any healthcare organizations are focused on real, tangible ways to expedite their performance improvement efforts.

The first step is identifying the right data. Often because the source of a metric's "target" carries distinct importance, finding the right target for cost improvement can be the first challenge that leaders face. In addition, while internal benchmarks provide direct comparisons, these efforts often overlook systemic internal practices which drive up costs across all encounters. For example, you might see very little variation case by case, physician to physician, but what if your costs are still X% higher than your peers? What might have been an overlooked opportunity is now brought back into focus. For a true measure, most leaders know that external benchmarks are valuable however using them to drive change has proven challenging due to data distrust or limited acumen.

In my career, I have worked directly with healthcare organizations who are using a healthcare-specific enterprise performance management tool and helped deploy both tools and workflow improvements to strengthen their financial outcomes. This has provided a unique lens into how leading health systems adopt and use data for improving financial performance, highlighting the need for tailored benchmarking and in-depth analysis. Now with a network of over 200 healthcare organizations, our tool's data-sharing solution addresses these needs with a benchmarking and comparative analytics platform that delivers normalized cohort data to empower leaders with actionable insights. However, while data is critical, healthcare teams also know that improving performance is not as straightforward as simply putting that data into people's hands - the effort needed to interpret and analyze the data in order to find the resolution is another barrier to change. One solution is a customized benchmarking data set coupled with expert insights, giving your teams validated findings and a clear path forward.

With our recent DRG performance insights package, teams can approach their financial improvement efforts in a focused and efficient manner, prioritizing actionable findings and speed to value. This solution brings cost and margin trends across a comparative data set, organized by primary DRG. To address the nuances of each organization and the uniqueness of its data, the report data is customized for the organization's DRGs, comparison cohorts, and various internal/external cost benchmarks. This partnership between the health system and Strata's experts continues from report design through data analysis, which then allows teams to move swiftly from analysis to action. For example, learning not just that supply costs are increasing in a DRG grouping, but specifically what factors are causing costs to go up.

For the hospitals and health systems with which we partner, the key to making financial benchmarks actionable is in identifying metrics that provide valuable insights through several crucial angles, and to make those insights stand out using simplified data visualizations. In our work, we see hospitals find success by targeting a few key metrics for insights:

1. Cost containment: hospitals can fairly easily identify their cost-per-case, especially when leveraging a strong cost accounting tool. But to make that information actionable, you must be able to find the cost drivers and components that contribute to the overall cost per case. Our DRG performance insights report provides a heat map that shows, by DRG, an organization's percentile rank compared to their desired cohort, as well as a deeper look into cost-per-case by contributing

continued on page 17

Making Financial Benchmarks Actionable with DRG Performance Insights (continued from page 16)

component or cost driver. These insights can identify more generalized costing variation, as well as focused, clinical variation-caused insights.

2. Clinical consistency: to take action and establish clinical consistency, hospitals can examine their "safe picks" compared to the more "risky ones," i.e. which DRGs are the most consistent, with minimal "spread" across case-by-case cost. Knowing how predictable costs are from one case to another can provide helpful insights, but gaining access to a benchmark overlay can help you better understand the story your data is telling against a comparison group.

For example, while examining your own data you may see a certain patient type has limited variability. What if, while this patient type may appear consistent case by case within your organization, it is actually less consistent and/or more costly compared to the cohort benchmark?

3. Insights by omission: exploring benchmarking insights starting from the top line instead of the bottom line can help identify omitted insights. Comparing a grouping of like DRGs by percentage with or without major comorbid conditions against the desired cohort can help you unearth possible coding insights. For example, if an organization has a DRG Grouping where 23 percent of patients have a comorbidity or complication, but for that same DRG grouping, their peer cohort's percentage is 52 percent, could there be an opportunity to review patient charts?

4. Quality excellence: bringing clinical quality to the topic of financial stewardship, this metric hones in on the rates and added costs tied to certain hospital acquired conditions (HACs). Quality excellence reflects a client's HAC incidence and prevalence rates, while also providing those "avoidable cost" insights.

Faced with continued margin compression, healthcare leaders must be efficient in how they deploy resources for cost savings. Many are quickly realizing that the data they use must be trustworthy and the insights must be specific and defensible to incentivize changes in behavior. Leaning on the combination of our new DRG performance insights report, along with services to pull actionable opportunities from your organization's data, delivers this with speed to value, so that leaders can focus on building a broader ecosystem to strengthen accountability.

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Delivering Fast, Convenient, Cost-Effective Patient Refunds

Healthcare providers are issuing a growing number of refunds driven by rising patient financial obligation for care, expansion of preservice cost estimates with upfront collections, and complex payer reimbursement policies. Refund management is often inefficient, costly, and detracts from the patient financial experience.

Fortunately, meaningful opportunities exist to improve the situation. This article briefly explores the primary issues and highlights a solution to address them.

Key issues.

Multiple sources produce the cost and productivity issues in healthcare refund programs:

- Volume-related. Patient refunds totaled an estimated $3.1 billion in 2022[1] Many involve small dollar amounts that require as much administrative effort as larger ones. Overall volume is challenging to manage and frequently creates mounting backlogs.
- Process-related. Many steps in the process remain manual, consuming staff time and adding cost. Integration of information systems and workflows is often lacking. Further complexity arises from variations required in processing both patient and insurance company refunds as well as the detailed document attachments that frequently accompany payments.
- Payment-related. Checks continue to be pervasive. One study indicated that 82% of patient refunds are in the form of checks.[2] Escheatment exposure is another element in the equation. Many small checks are never cashed, and staff time is expended executing state regulation and reporting requirements.

These problems have larger implications. They impede progress toward two major objectives shared by health systems, hospitals, and practices. One is the imperative to cut costs. An analysis concludes that "inflation and pricing pressures are leading to significant cost increases in goods and services" and producing "relatively flat margins … likely to continue in the near term."[3] Hospitals have been "forced to take aggressive cost-cutting measures."[4]

The second goal impacted is improvement of the patient financial experience to address growing consumer-centric, technology-forward competition as well as patient demands. A Harris Poll found that 61% of consumers "would like their healthcare experience to be more like the customer experience of an online convenience service app."[5]

The core need in refund management.

All providers require solutions that let them deliver refunds and other payment adjustments to recipients quickly, conveniently, and cost-effectively. The right solution will consistently optimize the experience for all participants.

continued on page 19

Delivering Fast, Convenient, Cost-Effective Patient Refunds (continued from page 18)

The solution.

A digitized B2C payments platform can assume the complete life cycle management of a provider's refunds to patients and insurers. Patient interaction is facilitated by a well-designed application that does not require setting up a password-based account and is accessible on computers or smartphones. Individuals exercise choice in how they receive payments: direct to debit card, direct deposit, electronic check or paper check. Digital payments are increasingly favored, growing at almost 23% annually in healthcare.[6]

The workflow is encrypted, automated and streamlined for convenience and efficiency. When a provider's system triggers a refund request, the digital payments solution electronically communicates with the patient to gather account data. The system issues payment in the patient's chosen mode and returns reconciliation information to the provider.

A few of the many features show how an innovative B2C payments solution meets today's IT and user requirements:

- Integration with EHRs and financial systems via Application Programming Interface (API) or file transfer options. Specific prebuilt data extracts ensure synchronization with numerous healthcare software and service systems.
- Patient account setup not required.
- Strong security and confidentiality. Customer data is stored behind the firewalls and relies on multifactor authentication. All workflows conform to HIPAA requirements.
- Branding flexibility. Solutions can be adapted to the provider's branding "look and feel."
- Payment reconciliation and reporting.

An array of benefits.

An inventive, digital B2C payments solution benefits patients and organizations alike. Patients can elect the payment method best suited to their needs and offering the fastest receipt of funds. Transactions are conducted easily on a smartphone or computer. The bottom line is a better experience: choice, convenience, consistency.

For health systems, hospitals, and practices, these improved options can generate cost and time savings through greatly reduced staff involvement in all aspects of the refund process. Fewer paper checks are issued. Customer satisfaction is enhanced, boosting competitive strength.

Conclusion.

A modernized B2C payments platform is a timely solution amid today's financial and operational challenges. It offers demonstrated success, is easy to implement, and generates a rapid return.

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Disclosures:

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Combatting Margin Erosion with Margin Improvement

The past few years have significantly destabilized the healthcare industry's financial footing. According to a recent 2023 Healthcare CFO Outlook Survey, 60% of healthcare CFOs could not meet the terms of their bond or loan covenants in 2022–up from 41% in 2021.

As unfavorable economic conditions continue to pressure healthcare, providers must act to prevent further margin erosion and financial insecurity. Unfortunately, many providers are struggling with margin erosion dynamics that show no signs of resolving on their own. According to Fitch Ratings, it may take years for healthcare margins to recover to pre-pandemic levels.

To improve margins and achieve greater financial stability, healthcare providers must first understand what's causing margin erosion. Below is a summary of the key drivers of margin erosion and their impact on the healthcare industry:

- **High Labor and Contract Expenses:** These expenses, which have trended upward over the past several years, have plateaued but show no signs of falling. Even with costs plateauing, April 2023's performance showed a 3% increase in labor expenses.
- **Supply Cost Increases:** Supply costs continue to rise due to geopolitical disruption and lack of geographic diversity in supply chains.
- **Interest Rate Hikes:** The Fed's recent interest rate hikes have increased the cost of borrowing. We could see further increases to the cost of capital as economic indicators like the better-than-expected May 2023 jobs report and wage increases may cause the Fed to bump rates up again later this year to cool ongoing inflation.
- **High Inflation:** High inflation increases costs in healthcare. May 2023's jobs report and wage rate increase data may prompt a Fed rate increase to offset ongoing inflationary pressures that, for example, have contributed to mortgage rate increases being their highest since November 2022.
- **Low Capacity:** Shifts in case mix are driving higher bed utilization. Hospital stays are also trending longer, due in part to heightened acuity resulting from delayed care during the pandemic. Furthermore, staffing shortages are contributing to a lack of capacity and a reduction, in some cases, of elective services.
- **Decreasing Commercial Coverage:** Providers face lower reimbursement rates as coverage by nongovernmental organizations declines. This problem will worsen as an aging U.S. population leads to greater numbers of people covered under government programs, which provide lower reimbursement rates. An unfortunate outcome of the debt ceiling resolution is increased restrictions around employment requirements that may actually reduce the number of insured Americans, which will also extend to the Food Stamps program.
- **Changing Sites of Care:** Patients are increasingly seeking care from non-hospital sites of care that pull volume and revenue from provider systems that subsidize many physician groups and practices.
- **Competition from Non-Traditional Entrants:** Non-traditional entrants like retail and tech providers are taking market share away from traditional facilities.
- **Underperforming Assets:** Underperforming service lines or specialty facilities can take a disproportionate amount of capital to maintain for very little ROI.
- **Underperforming Real Estate:** Real estate represents a high fixed cost that can quickly become a financial burden in the event of underperformance.
- **Lingering Impacts of COVID-19:** Providers are catching up financially after COVID-19, with some still waiting to receive COVID-era payments and reimbursements.
- **PPP Repayments:** Some organizations planned poorly for Paycheck Protection Program (PPP) repayments and are facing unplanned cash impacts.

Some will say this list of the key challenges for healthcare providers to address is unprecedented and growing. The challenges are certainly many, requiring a focused, action-oriented approach for the near term and the long run.

Margin Improvement Requires a View of the Long Game

Many providers are tempted to solve margin erosion by cutting costs. Margin improvement, however, requires a long-term strategy, and cost-cutting without a growth strategy is a shortsighted approach. While it may generate some immediate bottom-line improvement, it's unlikely to strengthen your financial foundation. On the other hand, developing a margin improvement strategy allows providers to gradually make structural changes that yield long-term results – and greater stability.

Need to establish a margin improvement strategy but not sure where to start?

At BDO, we suggest you look at this both wholistically–what you want to build in the long term from where you are today, and in a phased approach---to initiate immediate action, develop traction, and expand.

continued on page 22


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.
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Five suggested Phases for Margin Improvement:

PHASE I:
Identifying Cost and Revenue Opportunities

Benchmark your costs in the following areas against industry standards:

- Provider and clinical support staffing in pharmacy
- Perioperative and procedural in supply chain
- Vendor management
- Selling, General & Administrative (SG&A)
- IT

PHASE II:
Reviewing Balance Sheets

- Identify your priority strategic initiatives and determine the capital requirements to support them.
- Conduct a property, plant, and equipment (PP&E) assessment to determine if any assets should be sold, leased, or disposed of.
- Identify opportunities to deploy or reinvest working capital.
- Reevaluate your debt structure to assess your organization's current financial risk level.
- Determine whether you have any unclaimed property and, if so, review your state's regulations around reporting and refunds ahead of balance sheet transactions.
- Assess your management of assets, such as technical systems and medical equipment, to identify gaps and inefficiencies.
- Identify opportunities to capitalize on R&D tax credits.

PHASE III:
Accelerating Digital Enablement

- Explore opportunities to leverage data and machine learning to reduce preventable readmissions.
- Offer expanded consumer-centric self-service tools with the side benefit of shifting work into the hands of patients.
- Assess your EHR platform to determine if it is properly integrated with your other systems and can support data-driven predictions.
- Evaluate the potential of new technology systems to impact or disrupt clinicians and administrative staff prior to introducing them.

PHASE IV:
Exploring Partnership Opportunities

- Consider opportunities to partner and collaborate for functions such as IT, contact centers, and supply chain.
- Explore outsourcing and managed service arrangements to achieve efficiencies in core business operations.
- Critically evaluate mergers and integration opportunities to ensure that they are patient-centric and focus on improving care at lower costs.

PHASE V:
Developing Your Workforce

- Consider how you can enable remote work opportunities to expand your talent pool.
- Invest in continuous learning to promote employee retention and satisfaction.
- Integrate advanced practice providers (APPs) across service lines.
- Invest in recruiting and training licensed practical nurses (LPNs) and medical assistants (MAs).

Moving Forward with Margin Improvement

Designing and deploying a margin improvement strategy is a serious undertaking that requires the right experience and support. Healthcare organizations must transform operations and improve margin performance leveraging internal and external resources for short-term financial turnaround and long-term financial sustainability.

The phased approach outlined above allows healthcare organizations to start wherever they feel will provide the best launch and move vertically and horizontally from there. However and wherever you choose to start your Margin Improvement journey, know it's worth the effort toward continuing the mission.

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First Illinois Chapter HFMA News & Events

This year's June 8 Women in Leadership (WIL) Retreat took place at the Morton Artoboretum and offered a full day of highly interactive learning sessions and great networking.

SAVE THE DATE – 2024

Marks our 10th anniversary

Mark your calendars now to join us on June 13, 2024 at Cantigny Park in Wheaton, Illinois as we celebrate the 10th anniversary of the Women in Leadership Retreat. Cantigny is the 500-acre former estate of Colonel Robert R. McCormick, the longtime editor and publisher of the Chicago Tribune. Registration opens later this year - check First Illinois Chapter's webpage.

First Illinois Chapter HFMA News & Events

2023 Golf & Scholarship Event

This year's Golf and Scholarship Event on August 25 raised over $3,200 for the First Illinois Chapter's Scholarship Fund. Closest to the Pin winners were Frank Carozzi and Liz Simpkin while Joe Quass and Kristen Refness took the prize for Longest Drive. First Place Team Scramble went to Joe Quass, Michael Suazo, and Kevin Smothers.

First Illinois HFMA Diversity, Equity and Inclusion Committee Gives Back

Twenty-nine years ago, The Boulevard founders witnessed thousands of people with medical injuries entering shelters across Chicago with nowhere else to go. To break the cycle of homelessness, these individuals needed a place to recover and the opportunity to move on to stable housing. The Boulevard was founded in 1994 to answer this critical need. Today, The Boulevard is one of the original medical respite care facilities in Illinois serving men and women experiencing homelessness with a full range of resources for holistic human healing.

On Saturday, September 9, the First Illinois Chapter's Diversity, Equity and Inclusion (DEI) Committee hosted a volunteer landscaping event at The Boulevard. The volunteers were HFMA members from Harris & Harris, Medix, Real Partners Consulting, Trinity, UChicago Medicine, US Acute Care Solutions, and Vanderbilt University Medical Center.

Together, the team cleared out weeds from the raised vegetable beds and flower gardens, readying the property for the fall. They participated in the effort with leaders from The Boulevard. The weather was beautiful, and the networking was fantastic. Several then concluded the day by having a celebratory volunteer lunch sponsored by Harris & Harris.

The committee plans to have future volunteer efforts and would love to have you join them. If you are interested in participating as a volunteer at an upcoming event, please contact Ashley Teeters at Ashley.Teeters@uchicagomedicine.org. As HFMA members, everyone is involved in some way in healthcare so supporting philanthropic efforts to make our communities healthier is something everyone can feel good about doing.

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.

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In recognition of your efforts, HFMA members who have articles published will receive 2 points toward earning the HFMA Founders Merit Award.

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