Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

April - August
2009

President's Message

by Grant Baumgartner, President

Looking Forward To A Great HFMA Year!

We have an extraordinarily unique Chapter…what other Chapter can boast of a geography containing 727,728 square miles, 46 active volcanoes, 3 time zones, and having another country in between its two parts? We are a strong Chapter with over 900 members, of which more than 140 have received Merit Awards and more than 40 have become Certified.

Over the many years I have been actively involved in the Chapter, I have been impressed by the many extraordinary and unique professionals who are as unique and diverse as the organizations and geographies they represent. From the rural areas Bethel, Alaska to Colfax, Washington; from the urban areas of Seattle to Spokane to Anchorage; our Chapter is rich in the quality of its people. It is the quality of our people, that has made our Chapter thrive for 56 years.

As I begin this HFMA fiscal year as Chapter President, I can't help but be reminded of the great legacy of our Chapter and take comfort in the rich quality of our people. Each one of you have already made a significant impact in the past and/or in getting our Chapter ready to advance our value to our Chapter membership and the healthcare financial management community this coming year.

MAKING IT Count

Our National Chairman's theme in the 2009-2010 fiscal year is, "Making It Count." Making it count depends on leadership of individuals who are willing to take an extra step, take a chance, speak up, or make a difficult choice because

continued on next page...

Contributing Writers

Grant Baumgartner
Susan Haseley
Matthew Jackson
Marc Krimen
David Morgan
Robert Witter

THANK YOU!!!

...continued from previous page


Richard Clarke
HFMA National
President & CEO

they believe their actions will help a patient, better their community, improve their organization or bring about a needed change. As a result of our Chapter Planning meeting in February, the Washington – Alaska Chapter has several key initiatives underway this year, to make it count.

We are working on improving the connectivity of our members through a new web site. This new site will give our members expanded Chapter information, technical and educational resources, ideas exchanges and social networking.

We are working on better access to Chapter meetings and educational events through new web casting capabilities. This will help respond to our member's budgetary and geographical challenges and still provide efficient, quality educational opportunities.

We are providing more support and access to members to achieve their HFMA Certification. Starting with our September 2009 meeting, we will provide access to members to sit for their certification exams at each Chapter meeting. In addition to access, the Chapter will loan exam study guides to members and has initiated a new program to reimburse for passed certification exams.

We are providing more opportunities for CFO's to interact with each other on current issues. Our new July Summer Healthcare Summit will provide a CFO panel presentation as well as a CFO-only roundtable break-out session following. We will continue to do this throughout the year.

I look forward to working with you this year to make it count and continuing to move our Chapter toward being *the* indispensable resource for healthcare financial management! ■

ANI Brings HFMA and Friends Home

by Robert Witter | Providence Health and Services

Several months ago when Greg Terreson asked for volunteers to work at the 2009 ANI here in Seattle I did so, not following the sage military advice of never volunteering. In retrospect volunteering at ANI proved to be an exciting five days. During the "chair drops" in the early morning and our meals together I enjoyed getting to know the HFMA staff and the other volunteers from Washington, California and Tennessee. Having relocated to Seattle only three years ago having the ANI here was as if HFMA had brought many friends and former colleagues from throughout the country home for me.


Al Gore

At the ANI the keynote speakers former Vice President Al Gore and Patrick Lencioni were excellent to listen to. Mr. Gore addressed the issues related to the climate and what the future holds. It would have been quite interesting to hear his views on the proposed health care reform that has become such a prominent issue. Mr. Lencioni described steps that health systems both large and small should consider in taking to move towards being a high performing system. In the more informal breakout session he offered many suggestions on conducting meetings that are efficient and productive. The regular breakout sessions I attended also were highly informative and educational. Having been to many educational sessions over the years it can be very disconcerting when the sessions are not informative and useful.


Patrick Lencioni

Overall I would have to say that a good time was had by all. ■

Alaska Healthcare Watch

This column is intended to share and inform the Chapter Members about Alaska healthcare financial news

by David Morgan,
Director of Reimbursement
Southcentral Foundation

At the Federal level the process of healthcare reform is a whirlwind. The President has been pushing a moderate plan, for example the Massachusetts health reform plan which kept the private health insurance industry in place, but required that all have health insurance provided by their employer, directly purchase insurance or enroll in the State's healthcare plan. How should you keep track of the national outcomes for the citizens of Alaska?

The most dependable source is Deborah Erickson's periodic summaries of national health reform issues, which can be located on the Alaska Health Care Commission web site http://hss.state.ak.us/healthcommission. Senator Hollis French recently established a health reform information service that is updated biweekly with articles and analysis of recent actions. To request information you should contact Senator French's office by e-mail at Senator.hollis.french@legis.state.ak.us or by telephone at (907) 269-0234. From a national point of view the Commonwealth Fund Health Reform web site is a great resource.

Alaska Health Care Commission Update:

The Alaska Health Care Commission has met several times since the appointment of its members, with a critical 2-day meeting in February that laid the foundation for the activities, roles, and goals of the Commission. A compete narrative on the comprehensive meeting notes taken from the meetings held on February 27-28, March 18, March 25 and May 26 for this year can be found on the Commission Web Site:http://hss.state.ak.us/healthcommission.

The next face-to-face meeting of the Alaska Health Care Commission, originally scheduled for July 13-14, has been postponed to August 25-26 in Anchorage (exact location TBD).

continued on next page...

...continued from previous page

The Department of Health & Social Services is in the midst of some major staff transitions, two of which have a significantly impact the Commission and has precipitated this hopefully minor delay. Dr. Jay Butler, formerly the Chief Medical Officer for DHSS, who served as Chair of the Commission, just left the department and the state to begin an assignment with CDC in Atlanta running the H1N1 vaccine program. Beverly Wooley, the Director of the Division of Public Health, will be leaving her position on July 1. Deborah Erickson has been appointed Acting Director of the Division of Public Health effective July 2, 2009.

Commissioner Hogan has assumed the role of Chair of the Health Care Commission. The Commission's website will be updated soon to note all these changes including new contact information.

2009 Legislative Update Wrap Up:

A total of 440 bills were introduced in the Legislature, only 61 passed both chambers. A few key health-related bills passed, but the majority of bills sit in committees. Work on un-passed bills won't resume until the House and Senate reconvene next year on January 19. 2010.

The Legislature is under no obligation to hear and pass any legislation, except the state budget. The Legislature passed a $9.7 billion operating budget and a $1.8 billion capital budget. Confusion surrounding the federal economic stimulus funds available to Alaska, and what to accept based on whether or not strings were attached, complicated the budget process.

SB 139 related to incentives and loan repayment and SB 13 expanding Denali Kid Care were bills impacting the outflow of state dollars and did not receive a hearing in the Senate Finance Committee. With the low oil prices and fiscal uncertainties, many lawmakers were hesitant to push through these two bills due to their fiscal impacts.

HB 26 did pass the Legislature to remove the June 30, 2009 Adult Dental Medicaid program. The passage of SB 133 will qualify Alaska for funding from the recent federal stimulus package, which would provide significant matching funds for the Alaska e-Health Network project.

Alaska Medicaid Regulation Update:

Several Medicaid Regulations need comments in the next 60 days.

- Integrated Behavioral Health Services – Date of Notice of Proposed Regulations 6/04/ 2009. The proposed regulation changes in Title 7, Chapters 29, 71 and 43 and adopted new regulations in Title 7, Chapter 135 and 160 of the Alaska Administrative Code, dealing with a new integrated approach to behavioral health services by addressing substance abuse treatment, community mental health services, and Medicaid coverage and payment regulations. Comments due by July 16, 2009.
- FASD/SED Waiver Services – Date of Notice of Proposed Regulations 6/26/2009. The proposed regulation changes in Title 7, Chapters 29, Chapter 43 of the Alaska Administrative Code, dealing with FASD/SED Waver Services requirements, enrollment and disenrollment, plan of care, mentor services, transition services, and supported employment services. Comments due by July 31, 2009.
- Integrated Behavioral Health Services – Date of Notice of Proposed Regulations 6/04/ 2009. The proposed regulation changes in Title 7, Chapters 29, 71 and 43 and adopted new regulations in Title 7, Chapter 135 and 160 of the Alaska Administrative Code, dealing with a new integrated approach to behavioral health services by addressing substance abuse treatment, community mental health services, and Medicaid coverage and payment regulations. The changes described in the June 4, 2009 notice, and set out in the proposed regulations. Comments due by August 20, 2009.

continued on next page...

...continued from previous page

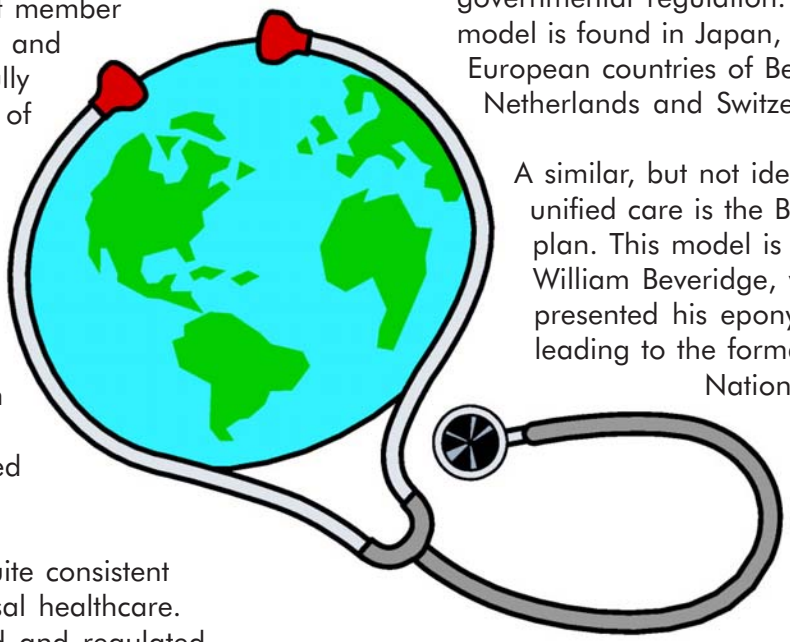
You may comment on all of the proposed regulation changes by submitting written comments to Mark Haines-Simeon, Division of Behavioral Health, 3601 C Street, Ste 878, Anchorage, Ak 99503: Email: Sandra.warren@alaska.gov.

Preparing to Celebrate National Health Center Week: Alaska's CHC will be celebrating national Health Center Week on August 9-15 Alaska's CHC will join Community Health – for more information contact Regan@alaskapca.org. Alaska Economic Trends June 2009 (Volume 29 Number 6) details some great information on Alaska's Direct Care Jobs and data on Alaska Migration and U.S. Economy you can find this data at laborstats.alaska.gov. ■

The Myriad of Formulas that Make Up Universal Healthcare Worldwide

by Marc Krimen | International Revenue Recovery Group

The US State Department recognizes 194 independent countries. Add Taiwan, a formerly but not present member nation of the United Nations, and that number reaches 195. Fully understanding the intricacies of these nations' healthcare systems is a daunting, if not impossible task. This overview will summarize some of the more significant healthcare models found among these countries in an effort to reach a greater understanding of how healthcare is approached around the globe.



The European nations are quite consistent in their adaptation of universal healthcare. These government-sponsored and regulated basic healthcare plans may be augmented by supplemental insurance for non-covered services, which vary from country to country. Universal healthcare countries include Austria, Belgium, Bosnia and Herzegovina, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Russia, Serbia, Slovakia, Spain, Sweden, Switzerland, Ukraine, and the United Kingdom.

Most notable, perhaps, is Germany's system in that it is the original model for universal healthcare. It is also known as the Bismarck Model, named after Prussian Chancellor Otto von Bismarck. Dating back to 1883, Bismarck's Health Insurance Act mandated health insurance to low income workers and has since expanded to cover virtually all residents of Germany (there is an income ceiling to which participation is mandatory, above which high-income residents may opt for private insurers outside of the program, of which some may provide coverage in the US). The Bismarck system utilizes insurers financed by employers and employees, typically through payroll deductions, except for the unemployed for which funds are derived from unemployment insurance. Bismarck plans cover all who apply, and are non-profit with tight governmental regulation. The Bismarck model is found in Japan, as well as the European countries of Belgium, France, the Netherlands and Switzerland.

A similar, but not identical approach to unified care is the Britain's Beveridge plan. This model is named after William Beveridge, who in 1942 presented his eponymous report leading to the formation of Britain's National Health Service in 1948. The NHS utilizes tax-based financing under which most hospitals are government owned and physicians receive

continued on next page...

...continued from previous page

their compensation directly from the government. Similar to the Bismarck System, NHS providers are tightly regulated, thereby minimizing fees. The NHS is currently considering plans to partially bifurcate, allowing patients who are financially able to supplement their treatments at government –owned hospitals with privately-paid drugs and services, concerning some that this will lead to a degradation of services and the formation of a two-tier health system. The NHS offers reciprocal coverage to 56 countries, typically limited to the level of coverage offered by the foreign sovereign to their residents. The United States is not included.

In Canada, perhaps the most familiar form of single payer system exists, and is effectively a hybrid of Germany's private healthcare provider/multi-payer model and the British NHS government-run insurance system. Based upon the Canadian Health Act enacted of 1984, it is a government funded system which provides universal coverage to permanent Canadian residents. Under the Act, the individual provinces administer and finance health plans which, while varying somewhat, must meet the five essential elements of the Act. They must be available to all eligible residents, be comprehensive in their coverage, be accessible, be portable between the provinces(with partial reimbursement for out-of-country services), and be publicly administered. Privately run health insurance plans are available for services not covered by the Canadian "Medicare" program. Canada's Medicare is also known to be challenged by excessive wait times, but recent legislation and funding is aimed to reduce this problem, increase system capacity, and improve medical technology. South Korea, one of the world's fastest developing industrialized nations, has followed the Canadian model of national health insurance, as has Taiwan.

In the Americas, Brazil and Peru have varying forms of universal health care, and Mexico has recently enacted legislation providing such coverage for children and pregnant woman, as well as pledging to achieve full universal coverage by 2011. On the Asian continent, China, Hong Kong, India, Israel, Singapore and Thailand have implemented versions of universal healthcare.

Universal healthcare, in the myriad of formulas found worldwide, is the dominant form of healthcare system. Whether the United States adapts such a system, in part or in whole is yet to be seen.

This is the first of a series of articles by Marc Krimen. Marc serves as Division Director/In-House Counsel at International Revenue Recovery Group, and specializes in international patient reimbursement issues. He welcomes any questions, and may be reached at mkrimen@pacificedi.com. In the fall issue, Marc will discuss third-party liability issues and procedures as they relate to international patients.

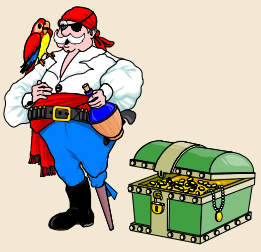
Reminder!

Study Guides Available for Certification Exams

Those who are interested can take the upcoming Certification Exams at the combined WA/OR September meeting.

To obtain Study Guides, please contact Bob Witter at Providence robert.witter@providence.org

Share the Wealth



Share your wealth of knowledge by submitting an article or experience for the Northwest Outlook newsletter ....that way, we are all enriched!

Addressing Privacy, Security & Other Pressing Healthcare Concerns

by Susan Haseley & Matthew Jackson | Protiviti

Historically, the healthcare industry has been one of the most heavily regulated and scrutinized in the United States, and all signs indicate that more pressure is rapidly approaching. President Obama has made it clear that his administration will increase federal involvement in advancing the healthcare industry's utilization of technology while strengthening the overall privacy and security of health information.

In the age of on-demand information, patients are becoming more informed and increasingly concerned about issues facing the industry. Understanding where to focus time and resources is the first step to meeting this challenge. This article discusses several relevant issues facing the industry today, including the implementation of the HITECH Act, PCI Data Security Standards, and Red Flags Rules.

The Health Information Technology for Economic and Clinical Health Act

Congress passed the American Recovery and Reinvestment Act of 2009 (ARRA) on February 13, 2009. Division A, Title XIII (Health Information Technology) is anticipated to have the most significant impact on strengthening the requirements set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the utilization of electronic medical records. Division B, Title IV (Medicare and Medicaid Health Information Technology) is anticipated to have the largest financial impact on the healthcare industry as it addresses the refunds and penalties associated with implementing components of the ARRA. The combination of Titles IV and XIII are commonly referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act.

As a result of increasing HIPAA compliance concerns, audits of covered entities were to begin in 2008, but the Department of Health and Human Services (HHS) has published little regarding audit results or proposed audit checklists. However, the October 2008 Audit Report by the Office of Inspector General (OIG) of the Centers for Medicare and Medicaid Services (CMS) found "agreed to deficiencies" in the CMS process for auditing compliance by covered entities. Among other goals, the HITECH Act aims to improve enforcement and auditing of HIPAA compliance to address these concerns. While significant guidance is still forthcoming, organizations should be assessing the impact of changes stemming from the HITECH Act (e.g., increased scrutiny on business associates, notification requirements in the event of a breach, etc.) as well as evaluating the sufficiency of their HIPAA compliance programs. In doing so, the following should be considered:

- Determine if adequate programs are in place to support compliance and promote consistency across the organization.
- Determine if the assets that hold, store, process, and transmit electronic protected health information (ePHI) have been identified accurately. This asset inventory is a core component of the risk assessment process that is foundational to successful compliance.
- The inventory should include applications, databases, servers, online storage, and any other storage media that would hold ePHI.
- Ensure that unstructured data has been considered as well. The proliferation of ePHI commonly results from the use of Access databases and Excel spreadsheets for reporting purposes. Frequently these tools are loosely controlled.

Additionally, the ARRA includes funding provisions for investments in health infrastructure, personnel training on the use of health information technology (HIT), dissemination of best practices, and miscellaneous HIT adoption grants. While the funds appropriated to healthcare are not a high percentage relative to the ARRA's total cost of $787 billion, they are still significant to healthcare organizations.

While stipend benefits are available in the near-

continued on next page...

...continued from previous page

term, long-term penalties will be instituted for noncompliance with the HITECH Act in the form of reimbursement reductions. The HITECH Act includes separate Medicare funding to provide physicians and hospitals with incentives for the adoption and maintenance of electronic health records (EHRs). Qualifying Medicare Advantage organizations are also provided incentives. Medicaid incentives are issued for physicians, other providers, and hospitals that meet the volume requirements for treating Medicaid patients. Eligible professionals include non-hospital based physicians, nurse mid-wives, nurse practitioners and certain physician assistants with at least 30 percent of patient volume ascribed to Medicaid patients, and pediatricians who are not hospital-based and have at least 20 percent Medicaid volume. As with Medicare, hospital-based physicians are not eligible for Medicaid incentives.

It is important to note that physicians and organizations are eligible to receive only one incentive regardless of whether they qualify for more than one. For example, in order to qualify for Medicaid payments, a provider must waive the right to Medicare incentives. Given these guidelines, it is critical for organizations to understand how and where they can obtain the most funding.

The Payment Card Industry Data Security Standard

Another area of increased focus for healthcare organizations is the Payment Card Industry Data Security Standard (PCI-DSS). PCI-DSS is a set of comprehensive requirements for enhancing payment account data security to help facilitate the broad adoption of consistent data security measures on a global basis. The PCI Security Standards Council was founded by American Express, Discover Financial Services, JCB International, MasterCard Worldwide, and Visa, Inc. All organizations joined together with the goal of enhancing payment account data security by driving education and awareness of security standards.

Many organizations, especially those in the healthcare industry, have been downplaying the PCIDSS requirements since the card brands enforce them instead of regulatory agencies. However, heightened attention is being paid to these requirements, especially since last October's release of version 1.2 of the PCI DSS. The changes resulting from this latest update are anticipated to shift the focus to many of the smaller merchants (which include many healthcare organizations) that, from a payment card perspective, have been operating under the radar for quite some time. However, the most significant change in the new version is related to the scoping of a PCI compliance effort. Historically, scoping was limited primarily to cardholder systems, defined as those storing, processing, and/or transmitting cardholder data. Version 1.2 makes it clear that if cardholder systems share network segments with non-cardholder systems, then all systems could be considered in scope for PCI controls.

Organizations need to make a somewhat complex determination as to merchant level and applicable validation requirements while working closely with applicable acquiring banks. Numerous factors come into play, such as the number of discrete merchant IDs being used by a particular organization, the number of transactions conducted annually for any card type, what acquiring banks are being utilized, whether areas such as cafeterias and business offices are accounted for, etc. Depending upon any combination of these factors, acquiring banks or card brands may require validation via a self-assessment questionnaire (SAQ). The SAQ is simply a summary of PCI-DSS controls. The controls for each organization will vary based on the method(s) used to conduct credit card transactions. However, it is critical that gap-assessments and remediation strategies be based on the PCI-DSS and not a validation instrument such as the SAQ.

In general, however, all merchants are required to be in compliance with the 250-plus PCI-DSS controls. Organizations should assesses the applicability of the PCI-DSS on a periodic basis and ensure appropriate mechanisms are in place to secure payment account data. Third-

continued on next page...

...continued from previous page

party companies authorized to validate an entity's adherence to PCI DSS requirements are referred to as "Qualified Security Assessors" or "QSAs." The quality, reliability, and consistency of a QSA's work provide confidence that cardholder data is adequately protected. While a QSA can help assist in these efforts, it is important to note that a QSA quality assurance program starts soon and the work of QSAs will be put under the microscope. In other words, an independent party will verify their work, and undoubtedly will be more stringent going forward to ensure compliance with the standard.

The Federal Trade Commission's Red Flags Rules

In November 2007, the Federal Trade Commission (FTC) and five federal bank regulatory agencies jointly issued the final rules and guidelines implementing sections 114 and 315 of the Fair and Accurate Credit Transactions (FACT) Act, commonly known as the "Red Flags Rules." The FACT Act requires the development, implementation, and maintenance of a written identity theft prevention program by financial institutions and "creditors" for "covered accounts." By definition, an organization is a creditor if it regularly:

- Extends, renews or continues credit;
- Arranges for someone else to extend, renew or continue credit; or
- Is the assignee of a creditor who is involved in the decision to extend, renew or continue credit.

Generally, healthcare providers are considered creditors if they bill consumers after services are completed. Setting up payment plans is a perfect example of where healthcare organizations extend such credit to patients. Healthcare providers that accept insurance are also considered creditors if the patient is ultimately responsible for the medical fees.

Additionally, a "covered account" is commonly an account used mostly for personal, family, or household purposes, and that involves multiple payments or transactions (e.g., credit card accounts, checking accounts, savings accounts, etc.). The Red Flags Rules clearly define what must be done by a creditor with covered accounts. Organizations should implement formal written policies and procedures to address the following:

- The program must be created with the goal of identifying and incorporating red flags for covered accounts.
- Red flags that are included in the program must be detected.
- Red flags must be responded to appropriately (i.e., action must be taken).
- The program must be updated periodically to reflect the risk to the patient or to the safety of the creditor from identify theft.

Guidelines have been issued by the FTC, the federal banking agencies, and the National Credit Union Administration (NCUA) to assist with the design of an appropriate program. These entities also have issued guidance listing red flags that might arise in healthcare. Examples include:

- A complaint or question from a patient who received a bill for another individual
- Records showing medical treatment that is inconsistent with the physical examination or a medical history as reported by the patient
- A dispute of a bill by a patient claiming to be the victim of any type of identity theft
- A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance

Organizations should be working aggressively to implement their programs, as the compliance date has now been set as August 1, 2009 (based on a three-month delay issued April 30, 2009). We recommend these organizations focus efforts on identifying additional red flags beyond the examples provided in guidance documentation. This guidance clearly states that it is not allinclusive and is intended solely to be a starting point.

continued on next page...

...continued from previous page

Application Implementation Practices
Meeting many of today's challenges head-on requires the increased use of technology throughout the industry. Whether an organization is implementing a full electronic health records (EHR) system or merely upgrading a legacy system, there are many barriers that stand in the way of a successful implementation. In a recent survey portending just some of the challenges related to EHR, Gartner Group determined that 30 percent of all IT projects will never be implemented successfully. Furthermore, 51 percent exceed budget by more than 180 percent while at the same time delivering just 74 percent of the originally planned functionality.

Barriers to success may vary widely based upon the culture of an organization; however, it is not uncommon for any implementation to experience one or more of the following organization issues:

- Lack of involvement/acceptance by physicians and employees
- Concerns about the inability to align workflow with a standardized EHR
- Concerns that automation of charting requires more time than paper charting
- Lack of uniform standards for documentation of clinical services
- Lack of standardized technical platforms to support EHR
- Low support for startup expenses or reimbursement for implementation costs
- Insufficient planning
- Poor communication
- Inadequate oversight and coordination of implementation efforts
- Deficiencies with vendor support
- Loose interpretation of regulatory requirements Regardless of the implementation's size, problems that typically emerge during such projects include:
- Disconnected communication between leadership and departmental personnel
- Specificity of operational workflow designs that do not have sufficient detail
- Training and communication initiatives are not adequately considered and/or planned
- Project plans and issue tracking tools are not utilized effectively to facilitate overall project management/oversight initiatives
- Formal approval checkpoints for appropriate operational representatives are not incorporated into the validation process
- The determination of security configuration requirements are made loosely or too late
- Insufficient testing is performed
- The configuration of application controls is not sufficiently considered

With the increased focus on technology across the healthcare industry, organizations should ensure implementations are managed proactively rather than repaired reactively or delivered insufficiently.

These are exciting, while understandably challenging, times for the healthcare industry. The need for a willingness to adapt and to embrace cultural change within your organization is perhaps more important now than ever before. The HITECH Act is geared towards facilitating sweeping change throughout the industry – from encouraging the implementation of EHRs to tightening the privacy and security of patient information. The PCI DSS and FTC's Red Flags Rules are also becoming increasingly important to our day-to-day lives.

Unfortunately, there is no checklist for compliance, no repository of "right" answers. Collaboration and knowledge sharing will be important to this process of change. While we are expected to begin addressing the HITECH Act immediately, HHS has reserved the right to clarify guidance, re-define requirements, or generally just change its mind in the months to come. The healthcare industry will have to respond accordingly. While compliance with the Red Flags Rules has been delayed a second time, and the guidance clearly states that it is merely intended to be a starting point, those programs must be put in place and operating effectively in the very near future. Also, we should expect to hear more and more about healthcare organizations insufficiently addressing the

continued on next page...

...continued from previous page

requirements set forth by the PCI DSS. And surely your organization does not want to be the first big headline cited for a breach. Proactively addressing each of the areas outlined in this article may be critical to your organization's continued success as we are thrust into this new era of change.

Article from Protiviti KnowledgeLeader – www.knowledgeleader.com.

KnowledgeLeader *is a subscription-based website that provides audit programs, checklists, tools, resources and best practices to help internal auditors and risk management professionals save time, manage risk, and add value. Free 30-day trials available.*

Protiviti (www.protiviti.com) is a global business consulting and internal audit firm composed of experts specializing in risk, advisory and transaction services. The firm helps solve problems in finance and transactions, operations, technology, litigation, governance, risk, and compliance. Protiviti's highly trained, results-oriented professionals provide a unique perspective on a wide range of critical business issues for clients in the Americas, Asia-Pacific, Europe and the Middle East.

Protiviti has more than 60 locations worldwide and is a wholly owned subsidiary of Robert Half International Inc. (NYSE symbol: RHI). Founded in 1948, Robert Half International is a member of the S&P 500 index.

Plan Now for the Quarterly Meeting with the Oregon Chapter

Sept. 16 -18, 2009

at the

Benson Hotel

Portland, Oregon

CORPORATE SPONSORS

The Chapter would like to thank the following companies for 2008 - 2009 sponsorships:

PLATINUM LEVEL

Audit and Adjustment Company
Bennett, Bigelow & Leedom, P.S.
Coopersmith
Dingus, Zarecor and Assoc.
Foster Pepper PLLC
Healthcare Resource Group
Merchants Credit Association
Moss Adams LLP
Outreach Services
Triage Consulting Group

GOLD

Case Mix Analysis
The Data Systems Group
Derry, Nolan & Associates, LLC
Emdeon Business Services
Garvey Shubert Barer
Healthfirst Financial, LLC
KPMG LLP
Michael R Bell & Company PLLC
Newman Dierst Hales, PLLC
PNC Healthcare
Professional Credit Services
Protiviti
R&B Solutions
RelayHealth
Siemens Healthcare
U.S. Bank

SILVER

Clark Nuber PS
FinCor Solutions
J&L Teamworks
NCO Financial Systems Inc
Ogden Murphy Wallace, PLLC
Passport Health Communications
Perot Systems Healthcare
Piper Jaffray & Co.
Red Cedar Partners, LLC
The SSI Group, Inc.
West Asset Management, Inc.

BRONZE LEVEL

AR Systems, Inc.
Cymetrix
Legend Data Systems
Mark Hugh & Associates PLLC
Parker Smith Feek

New Members

The Washington/Alaska Chapter is pleased to announce the following new members:

Scott Anders
AllianceOne Receivables Management, Inc

Trae Andersen
DaVita

Angela Barr
Audit & Adjustment

Chris Bothwell
Clark Nuber

Cathy Bussey
Providence Health System Alaska

Allen Caudle
Appleseed Healthcare Resources

Ashli Chan
Evergreen Healthcare

Lori Cook
Swedish Visiting Nurse Services

Stephen Daniel
Snoqualmie Valley Hospital

Jennifer Daugherty
Ponder & Co.

Debra Dimant

Joanne Donhoff
University Of Wa Medical Center

Patricia Dunne
Southeast Alaska Regional Health

Cathie Frizalone
Philips Healthcare

Margaret Geisheker
Northwest Hospital

Pamela Gilmore
Maniily Health System

Michael Greene
McBee Associates, Inc.

Kien Ha
PricewaterhouseCoopers

Janet Hirsch
Aon Risk Services

Graham Hunter
Ninety

Kelly Jacobs
Southcentral Foundation

Dorianne Johnson
Overlake Hospital Med Center

Gail Killion
Harborview Medical Center

Steve Krause
Navos

Seth Krevat
Virginia Mason Medical Center

Mary Krzeszowski
Evergreen Healthcare

Nancy LeClerc-Davidson
SE AK Regional Health Consortium

Nicholas Leute
Washington State University - Spokane

Katina Maier
Pacific Medical Centers

Colette Martin
Providence Health & Services

Reiien McLendon
CHC Laclinica

Annette Poppe
Deaconess Medical Center/Valley Hospital

Shelley Price
MS Services LLC

Allison Prusak
Providence Health & Services - Alaska

Adam Reese
Healthcare Payment Specialists, Inc.

Mark Sarbach
Ocs, Inc

Anne Schaefer
Group Health Cooperative

Molly Schutt
Sunnyside Community Hospital

Jie Shao

Lorraine Smith
Evergreen Healthcare

Barbie Smith
Providence

Jesse Southworth
Huron Consulting Group

Kerry Stanger
Valley Medical Center

Brooke Stegmeier
Swedish Medical Center

Melissa Strayer
Providence Health And Services

Megan Sutherland
Philips Healthcare

Les Van Horn
Yakima Valley Memorial Hospital

P. Scott Warnock
Pacific Medical Centers

Penny Weinhold
Perot Systems

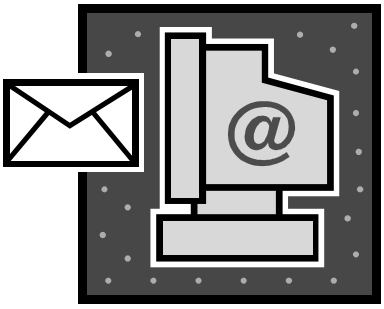
Duncan West

Doug Westhoff
Statcom

Mary Zimowski
Advanced Pain Centers of Alaska

Get Connected!

How Do I Change My HFMA Information?

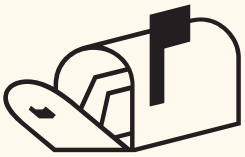


All of our chapter directory information including e-mail and addresses for the newsletter are received from the National HFMA database.

The easiest way to make changes is via the internet. Simply follow these steps to change any of your personal information.

1. **Log on to http://www.hfma.org**
2. **Go to the membership section**
3. **Log in using the username and password prompts**
4. **Follow instructions to access your Profile**
5. **Edit information.**

You could win $100 by writing an article for N.W. Outlook! Share your knowledge & experiences with other HFMA Members. You can help make a difference!



Please send information & articles for upcoming newsletters to:

Fredrik Andreasson
Outreach Services
1120 Cherry Street, Ste 300
Seattle WA 98104

Phone: 206-215-2333
FAX: 206-215-2344

E-mail:
fandreasson@outreachservices.com

hfma washington / alaska chapter
healthcare financial management association

Job Opportunities

TITLE	ORGANIZATION	LOCATION	CONTACT
Budget Analyst	Harrison Medical Centers	Bremerton, WA	Jennifer.Luedtke@harrisonmedical.org
Chargemaster Analyst	Franciscan Health Systems	Tacoma, WA	lancebabb@fhshealth.org
CFO	Mountain View Hospital	Madras, OR	Karen.Turner@expresspros.org
Controller	Whidbey General Hospital	Coupeville, WA	snowje@whidbeygen.org
Director of Accounting	Cascade Healthcare Community	Bend, OR	karen.turner@expresspros.com
Director of Performance Analytics	Cascade Healthcare Community	Bend, OR	karen.turner@expresspros.com
Finance Manager	University of Washington Medical Centers	Seattle, WA	pamurray@u.washington.edu
Healthcare Policy & Payment Methods Mgr	WA State Dept. of Labor and Industries	Tumwater, WA	OLCA235@lni.wa.gov
Supervisor, Business Office	Puget Sound Blood Center	Seattle, WA	julied@psbc.org

For more information on these listings or to include a listing, please contact
Kimie Delos Reyes at toll free 1-888-542-7290 or (360) 906-9258 ext. 3594 or email to:kimie@hawesfinancial.com

See also National HFMA's website (www.hfma.org) for additional job listings.
[Last Update: July 30, 2009]

Would you like to check your progress toward a Founders Merit Award?

Individual scoring records for the Founders Merit Award program are maintained for chapter members by LCC Council III.

To receive a copy of your record, please contact Tom Muller

Telephone: (360) 459-8994
Email: tjwashington@reachone.com

Mark Your Calendar

Oct 22-23, 2009
Alaska
Fall Meeting

Anchorage Hilton
Anchorage, Alaska

SEE YOU THERE!

Upcoming Chapter Meetings

DATE	EVENT	LOCATION
September 16-18, 2009	Quarterly Meeting with Oregon Chapter	Benson Hotel, Portland, OR
October 22-23, 2009	Alaska Fall Meeting	Anchorage Hilton, Anchorage AK
Nov/Dec 2009	One Day Workshop	Tukwila WA

NW Outlook

April - August 2009

Published bi-monthly by the Washington / Alaska Chapter of HFMA

Editor: Fredrik Andreasson
Outreach Services
1120 Cherry Street, Ste 300
Seattle WA 98104
Phone: (206) 215-2333
e-mail: fandreasson@outreachservices.com

Inside This Issue: