Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

November - December
2008

President's Message

by Greg Moga, President

Stay close to HFMA! That is my advice for everyone as we begin a new year and a new administration in Washington.

2009's educational events begin for the Washington/Alaska Chapter on Tuesday, February 24th, with the 2nd Annual CFO-only Dinner at the Rainier Club in downtown Seattle. This special event is by invitation-only for hospital CFO members.

Next on the calendar is the HFMA/AAHAM Joint Meeting and Trade Fair, February 25th-27th at the Murano Hotel, Tacoma. This is our biggest conference of the year, and you won't want to miss it. Our Chapter planning meeting (LCC) is that Wednesday evening and I hope that all members will try to attend. Please remember that in the interest of saving printing fees and postage, your notification for Chapter events is only being sent via e-mail. You can go to our Chapter website: www.waakhfma.org <http://www.waakhfma.org> for the agenda and sign-up.

I have always been extremely careful in my HFMA leadership roles and especially as President of your Chapter to keep my business interests separate from the business of leading the Chapter. However, I feel that I have to comment upon my vantage point of leading a company, Outreach Services, which is seeing the economic pressures hitting the bottom lines of hospitals from Florida to Hawaii.

We have always had hospital clients who were on the razor's edge of financial disaster, particularly the older inner-city hospitals which primarily served an immigrant and indigent population. But now virtually all our hospital clients are seeing the impacts of declining coverage, higher deductibles, reduced coverage, higher unemployment, and lengthening payment cycles for Medicaid reimbursement. It is a perfect storm!

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Contributing Writers

Jim Heilsberg
Greg Moga
David Morgan
Renae Price
Judy Veazie
Catherine Wakefield

THANK YOU!!!

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When I began this company in 1987, Outreach Services' niche- Medicaid and SSI advocacy- was almost an afterthought for many of our hospitals. Our results were noticed by few, and our financial impact, while appreciated, was slight. This has undergone an amazing change. Our liquidations have become the bottom-line margin for many of our hospitals. What was of interest only to the business office, has become a critical financial number for the entire management team. I should be pleased by all of this attention- who doesn't want their work to be noticed and appreciated? But frankly, these trends are scary, and where they are leading us, is hard to imagine.

I want to end my President's Message on a happier note by welcoming two new family members of our Chapter. On December 20th, Fredrik and Suzanne Andreasson welcomed son Alex Thomas; and on January 2nd, Brandon and Vivian Tokar welcomed son Brady Nicholas. As someone who is grandpa-aged but does not have any grandchildren (yet), I envy the new grandparents. Congratulations and best wises to both families!

Best Christmas Present Ever!

HFMA Editor-to-Be?

Alex Andreasson

OBJECTIVE COMPASSION Balancing Self Pay Collections in The New Economy

by Judy I. Veazie | CPAM

One of those quick lists on the daily Yahoo newsflashes listed the top five cities to ride out the recession. Bellevue was in the list. Interestingly in the top of five "richest little towns" in the US was Clyde Hill. In contrast, that same week the Sunday Seattle Times employment ads barely covered one page of newsprint.

When a population feels they are facing "financial hardship" the definition is applied regardless of income level. As my son who lives in New York pointed out, when foreclosures are being filed in the Hamptons, economic hardship translates to everyone at every economic level.

Without understating the seriousness of the economic trends, these conditions create social trends that will create operational consequences for hospitals. Hospitals operating under Washington State charity rules have an additional level of financial and administrative challenge.

Even during peak economic times, I noticed that the majority of patients felt they could not "afford to pay" their medical bill. Without the proper tools and training, most of hospital staff agree. I notice that the majority of self pay balances are escalated to management for "consideration" of charity. Often the staff recommendation is a well intended action to "help" the patient. When I query staff about the basis of their "hardship determination" they had often based their conclusion on the emotional factors rather than the facts. When I survey about the components they considered, they usually list all the factors that influenced their decision from the patient's "story" (the patient was nice, they had children, they had been very ill, etc). I pointed out that if I applied all those factors, we would never collect payment from any of our patients because all of them shared at least one of those characteristics. Regardless, most of these patients were not categorically eligible

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based on prior income, but they do feel that the unexpected medical debt created a budget crisis and they cannot pay.

So, an economic downturn plus gaps in employment/income combined with universal access to charity care: a formula for financial disaster for hospitals.

It is difficult to discuss this challenge without sounding uncaring and uncompassionate. But unless we mix our compassion with a clear objective process, we will be essentially removing self-pay payments from our cash projections. I am calling for a more objective compassion.

If patients think they will not have to pay their medical bills what are the incentives for them to "cover" that risk? They make different choices, with their COBRA election, with that insurance check from their auto accident, etc.

Hospitals must be prepared for this new environment. Here are five objective steps to balance compassion:

1. Exhaust all payer sources before allowing charity consideration. Invest in covering the COBRA for patients and have a dedicated process to seeking COBRA if the balance warrants the investment. Protect the hospital interests by conducting a lien program on TPL cases rather than allowing the money to be split between the attorney and the patient. Lock in all government funds by using a patient advocacy vendor that provides full regional coverage including field workers and legal resources.
2. Be proactive about "preventable losses" with insurance process gaps (eligibility periods, benefit limits, elective and non-covered services, pre-existing, etc);
3. Increase the objective process for uncompensated care review. Integrate Credit Bureau Reports into the charity process to properly map the patient ability to pay. Institute a review group to adjudicate more complex cases. When a patient thinks decisions rest in one person's hands, they feel compelled to influence that person with their story, an appeal to emotion. These decisions must be fact based. A review process rather than a person lends objectivity to the process.
4. Keep the role of hospital staff to maintain objectivity about their financial role. Their compassion and desire to help the patient is an asset, but not the role they have been hired to perform. They are not social workers, or therapists. But above all, they are not professional budget counselors. That role is for a professional and indeed there are excellent resources in the new Federally qualified Budget Counseling Services. (Note: since the change in the bankruptcy laws, patients must go to a federally qualified budget counselor to file for protection.)Provide patients with a connection to budget counseling.
5. Create a strategic pathway to enable patients to pay their balance. Expand payment options. Develop prompt payment discount programs to encourage payment resolution.
If patients think they will not have to pay their medical bills what are the incentives for them to "cover" that risk? They make different choices, with their COBRA election, with that insurance check from their auto accident, etc.

As more states adopt restrictions on the hospitals ability to collect from patients, the pool of potential self pay dollars continues to shrink (even though the uninsured population increases). Recently a Blue Cross executive alluded to the dilemma for hospitals, pointing out that our collection options for hospitals had reduced the collection clout with patients.

Taking his point (and proving there is a silver lining in every cloud) I pointed out that indeed Blue Cross should be more concerned about the trend on their company. While they always need healthcare, Blue Cross will have to make their case? My point: if the rules do prohibit the hospitals from collecting from patients, then why will they need insurance?

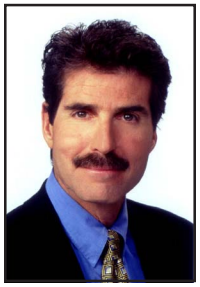
■

11th Annual

HFMA Region 11 Healthcare Symposium

Caesars Palace Las Vegas, Nevada January 25-28, 2009

The seven HFMA chapters that make up Region 11 are proud to present the 11th Annual Region 11 Healthcare Symposium. This event will take place at Caesars Palace, Las Vegas from January 25 – 28, 2009. We have put together a program that will provide attendees with an outstanding educational experience of policies and trends affecting major segments of the healthcare industry.



John Stossel

This year's opening keynote speaker will be **John Stossel,** ABC News Correspondent and co-anchor of the 20/20 news magazine show. As an award-winning journalist and correspondent (19 Emmys and five National Press Club Awards), John has been on the forefront of many in-depth reports, including those involving the healthcare industry. "American Healthcare—In Critical Condition" will lead this year's assessment and prognosis of our current situation.

Monday morning will continue with **Chuck Lauer,** former publisher of Modern Healthcare, moderating a panel discussing the topic "Healthcare in the Hot Seat" as HFMA's own President, Richard C. Clarke, and MGMA President and CEO, William Jessee, MD, join Chuck for their assessments of healthcare's future under a new Presidential administration.

On Tuesday morning a panel of three Modern Healthcare Top 100 Hospital CEOs will discuss their facility status and the traits and qualities which allowed them to achieve their distinguished status. This panel will be moderated by **Catherine A. Jacobson,** CPA, HFMA National Chairman-Elect.

Our Tuesday morning speaker will be **Cam Marston,** founder and President of Generational Insight. Cam's presentation will focus on the four generations of employees that work side by side in our organizations and the conflicts inherent in the differing value systems of the different generations.

Wednesday morning's panel will revive our popular format of "What Keeps a CFO Up at Night?", featuring three of our Region's prominent CFOs and their nighttime visions of the most pressing problems and dilemmas. This panel will be moderated by **Mike Seeley,** President, Seeley Healthcare Consulting LLC.

In Wednesday morning's closing session we will hear from **Dr. Bertice Berry,** noted sociologist, author, lecturer, and educator. Dr. Berry's presentation, "From the Patient's Perspective," will provide us with a moving analysis of the often overlooked caring side of our professions and their importance in the healthcare business.

Monday and Tuesday afternoons will be devoted to your choice of sixteen breakout sessions focusing on intermediate and advanced topics designed to provide every attendee with valuable proven techniques on current issues and developments from healthcare professionals around the country.

For more information please visit our website at www.hfmaRegion11Symposium.org or e-mail any questions to lori@hfmaregion11symposium.org or call (714) 279-8675. We hope to see you there!

HFMA Click to Connect >>>>>>>

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

On December 4, Governor Sarah Palin announced her health priorities which included the creation of a health care Commission. Governor Plain signed Administrative Order No. 246 creating the Alaska Health Care Commission in the Department of Health and Social Services. The purpose of the commission is "to provide recommendations for and to foster the development of a state wide plan to address the quality, accessibility, and availability of health care for all citizens of the state. "The administrative order outlines the duties of the Commission. These duties are as follows:

1. serve as the state health planning and coordinating body;
2. consistent with state and federal laws, provide recommendations for and foster the development of a:
   a. comprehensive statewide health care policy;
   b. strategy for improving the health of Alaskans that includes
      i. encouraging personal responsibility in prevention and healthy living for all residents of the state;
      ii. a reduction in health care costs for all residents of the state to be below the national average;
      iii. access in communities of the state to safe water and wastewater systems;
      iv. The development of a sustainable health care workforce in the state;
      v. Quality health care being accessible for all residents of the state; and
      vi. Increasing the number of residents of the state who are covered by health care insurance; and

3. Submit a report to the Governor Legislature on or before January 15, 2010 regarding the commission's recommendations. The commission will be comprised of "seven voting members appointed by the Governor." The voting members are as follows:
   a. the Chief Medical Officer of the Department of Health and Social services, who shall serve as the chair of the commission;
   b. a representative from the tribal health community in this state;

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c. a representative from the Alaska State Chamber of Commerce;
d. a representative from the Alaska State Hospital and Nursing Home Association;
e. a health care provider, who is
   i. actively practicing the provider's profession in this state;
   ii. licensed in this state; and
   iii. not affiliated with Alaska State Hospital and Nursing Home Association;
f. a representative of the health insurance industry in this state, and
g. a health care consumer who is a resident of this state.

The commission also includes three non-voting members. These members are as follows:

1. and ex officio, non-voting member from the executive branch, appointed by the Governor;
2. and ex officio, non-voting member from the Alaska House of Representatives, appointed by the speaker of the house; and
3. an ex officio, non-voting member from the Alaska Senate, appointed by the president of the senate.

We all applaud Governor Sarah Palin for establishing the Alaska Health Care Commission and recognize the importance of the Commission in pursuing health reform in the State of Alaska.

Governor Palin Releases Fiscal Year 2010 Budget: The operating and capital budgets total $4.9 billion in general funds and $11.2 billion in total funds. The proposed FY 2010 general fund and total fund spending represents a 7 percent decrease from the FY 2009.

The FY 2009 Governor's budget requests for health and safety total $2.1 Billion. The budget projects are based on an oil price average forecast of $74.41 per barrel with a production of 665,000 barrel per day. The price has fallen below $50 per barrel for December 2008. State lawmakers set aside $5 billion in anticipation of a potential rainy day in FY 2008. The next session of the legislature budget short falls will the number one issue, we see thunderclouds on the horizon. The Alaska State Legislative Session begins January 20, 2009. We will keep updating the Alaska membership the Legislative Session with "email updates during the session."

Detailed FY 2009 Budget information can be found at the Alaska's Budget – FY 2009 Budget at http://gov.stat.ak.us/omb/09_omb/budget/index.htm. This Legislative Session will address health care reform, Myers Stauffer Home and Community Based Services cost survey and rate setting recommendations and major budget issues.

Other Updates:

- Free UAF Online Health Care Courses – for application fee waivers, funding support for textbooks and courses are live online and students can participate from anywhere. Funding is limited, apply soon! Contact: ALLIED HEALTH PROGRAMS @ THE UNIVERSITY OF ALASKA FAIRBANKS (http://www.alaskapca.org).
- Joint Commission Hospital Updates – Joint Commission Hospital Updates Tuesday, January 27, 2009 8:00AM to 4:00PM at the ANTHC, COB Building 4000 Ambassador Drive, Anchorage, Ak 99508. Want more information; contact Brenda King at (907) 7229-4045.
- University of Alaska Anchorage launches needs assessment of breast cancer survivors – Behavioral Health Research and Services seeks 600-1,000 breast cancer survivors to complete survey. Through this research, BHRS hopes to identify the needs of Alaska women facing breast cancer, increase the body of knowledge about breast cancer in Alaska, and provide baseline data about necessary service development to meet the needs of women diagnosed with breast cancer in the State of Alaska. The study is funded by Providence Alaska Medical Center, the Alaska Comprehensive Cancer Partnership and Breast Cancer Focus, Inc. Call (907) 561-2880 to request a copy of the survey and pre-paid return envelope.

A Personnel Note: I want to thank everybody that inquire and wished me good health during my illness this summer. I had to take a holiday from the Alaska Healthcare Watch, but I'm healthy now and we will update the Alaskan membership in the future.

New Members

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

Aaron Allensworth
Providence Health Services Alaska

Pat Cain
Virginia Mason Medical Center

Ruth Dearborn
Searhc Hospital

Jamie Ducas
Providence Health & Services

Janet Elloitt
Swedish Health Services

Julie Erickson

Paul Fisk
Stevens Hospital

H Marty Grasmeder
SEARHC Mount Edgecumbe Hospital

Atalaya Jimenez
Yukon Kuskokwim Health Corporation

William Lam
Overlake Hospital Med Center

Charles Lundquist
AllianceOne

James Maguire
Quality Reimbursement Services

Natalia Meyers
Providence Hospital Alaska

Molly Miller
Regence Blueshield Of Washington

Marti Morehouse
Providence Health System

Harry Odden
Providence Health and Services Alaska

Sonia Paul
Overlake Hospital Med Center

Daniel Perrow

Matthew Rosenberry
Evergreen Healthcare

Carol Schroeder

Monica Severtsen
Evergreen Professional Recoveries, Inc.

Stefan Shipman

Jennifer Weldon
Capital Medical Center

Get Connected!

RAC Attack

by Catherine Wakefield | Multicare Health System

At the November 20th HFMA meeting at Cedarbrook, the ever excellent Day Egusquiza presented on RACs – The CMS Recovery Audit Contractor System. RACs will be coming to WA and AK around August 2009 (depending on the outcome of the contractor selection process protest.)

Recovery Audit Contractors

Day presented in the morning on the RAC audit process and in the afternoon on the appeal process. Summarizing her 6 hour presentation into takeaways is a challenge but here are the key points.

Build your team now - The RAC audit and appeal process affects numerous departments including HIM, Patient Financial Services, Compliance, UR, Case Management and clinical operations. Clinical operations representation is critical to address documentation. Findings from the demonstration projects included lack of documented start and stop times, inaccurate admit statuses, and poor documentation of medical necessity for one-day stays.
Hold periodic meetings, keep updated on how others are faring, monitor RAC websites for risk areas, and establish your own internal best practices.

Be Proactive – Start your data analysis now to see where your risks are. There are three very good reasons to do this:

1) Completing an analysis of the risk areas now will give you the information to address and correct the underlying causes of the errors. High risk areas include: DRG's coded to a higher DRG, transfer dispositions, missed charges (when charges are already present—RAC does not do "lost" charges), Incorrect coding, Medically unnecessary setting and/or service, modifiers, drug administration start and stop times, outlier payments, units billed, and self-administered drug coding—to name but a few.
2) Since RACs can go back to October 2007 for their audit surplus, you can minimize future risk.
3) You can also identify "at risk" amounts for financial planning purposes. The take-backs can affect your bottom line. New York hospitals averaged a 2.5% margin loss due to RACs per demonstration project data. Depending on your year end, you may want to accrue a liability for the take-backs.

Establish your processes now - RACs can request up to 200 records every 45 days for every NPI. These volumes can be overwhelming. To meet the time line requirements for initial responses and appeals you have to have all the team members performing their functions flawlessly.

This will take practice. You can practice on CERTs and other Noridian audits.

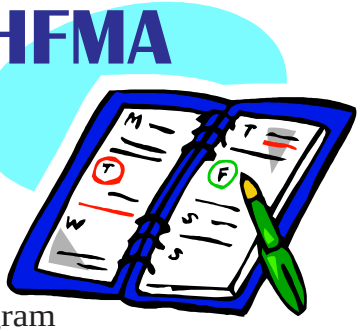
Day provided some suggestions based on her consulting experiences.

- Consider having all RAC requests and correspondence sent to a separate dedicated lock-box. This will help ensure timely receipt of all RAC information.
- Consider carefully what to appeal and what to pay. The statistics on successful appeals to RAC findings are not encouraging and they are costly in terms of time and effort.
- Consider carefully if you want to pay versus get interest. If you appeal and fail and have not already had the funds recouped, you can pay the current interest rate of 11.75%. If the amounts have been recouped and you win, you will be paid interest at 11.75%.
- A question was asked about tools. Day provided an Excel spreadsheet template for tracking audits and appeals but also referenced that there are other vendors who have tools. Consider your needs before spending a lot of money on a software tool.

You still need to have good processes. A software tool will not help if you don't have someone managing all the steps

Day's presentation was both scary and useful. My personal advice on RACs is: Assign it to someone else! ■

Plan Now for Great 2009 HFMA Educational Opportunities



2009 promises to be a special year with a number of great educational and training opportunities for the HFMA Washington-Alaska Chapter. Start to plan now for these events:

The year begins with the ever-popular Region 11 Healthcare Symposium in Las Vegas. This year's event will be January 25th – 28th at Caesar's Palace. One of the keynote presentations will be by John Stossel.

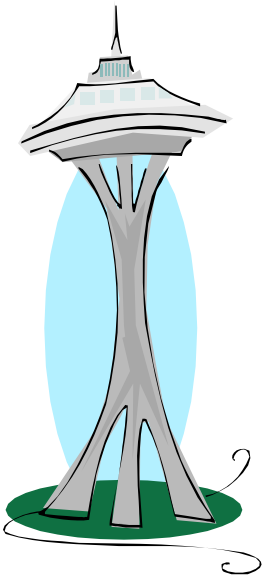
February 24th – 26th is the chapter's biggest annual event; the Joint AAHAM meeting and Trade Show at the Hotel Murano in Tacoma, WA. Our three-day meeting is expanding in 2009, with a special event on Friday, February 26th.

Fred Lee

Nationally renowned author and speaker, Fred Lee will be here, presenting: *If Disney Ran Your Hospital, 9 1/2 Things You Would Do Differently.* Fred's book on this subject was awarded the 2005 Book of the Year Award from the American College of Healthcare Executives. Don't miss this opportunity to come and hear this important message from the perspective of a world-leading, customer-service organization.

In March, the chapter will again offer a spring program in Fairbanks, Alaska. Dates for this event are being finalized.

The annual May quarterly meeting will be shorted next year to one-day, held on May 14th at the Cedarbrook Conference Center in SeaTac. We are only having a one-day meeting in May because:



HFMA's Annual National Institute (ANI) is returning to Seattle! Join thousands of other healthcare finance professionals from around the nation June 14th – 18th. The 2009 ANI will be held at the Seattle Trade and Convention Center.

The annual September 2009 quarterly meeting will also be a big event, as we join the Oregon HFMA Chapter for our next joint meeting. The joint meeting is at the Benson Hotel in Portland from September 16th – 18th.

2009 wraps up with our annual Anchorage, Alaska fall meeting in October and the Washington November one-day event.

Who Can You Trust with Your Electronic Claims?

by Renae D. Price | CPA, CHBME, CMPE

Sixteen years of medical records covering 2.2 million patients — with 1.3 million social security numbers — stolen from a Salt Lake City hospital due to vendor neglect.

It's *the kind of story* that makes compliance officers nervous.

Nearly every vendor will claim something like "protecting your data is our highest priority." But public relations crises like these raise the question: "How can we be certain that a vendor's security and HIPAA-compliance assurances are real?" For hospitals, health systems, medical groups, and other healthcare organizations, that's an increasingly difficult question to answer with confidence.

As a provider, you should be aware that there is an independent, non-profit accreditation organization that represents you. It's called EHNAC (Electronic Healthcare Network Accreditation Commission), and part of its core mission is to ensure that clearinghouses, electronic health networks (EHNs), and other vendors adhere to a range of standards regarding management of claims data. If you're dealing with a clearinghouse that is not EHNAC accredited, you may want to reconsider your risk exposure.

For 15 years, EHNAC has promulgated standards for secure and efficient processing of healthcare transactions. These standards are the product of transparent, voluntary collaboration among EHNs, payers, security organizations, hospitals and health systems, physicians, consumer groups, financial services firms and vendors.

As technologies and best practices have changed, EHNAC standards have evolved as well. Version 9.4 of the EHN standards is freely available online, and EHNAC uses these guidelines for its accreditation activities. Somewhat comparable to Joint Commission accreditation, the first step in the process is a self-assessment. EHNAC's independent reviewers then perform site visits to ensure that physical and organizational safeguards are in place and operational — not just filed away in a three-ring binder.

EHNAC has accredited more than 40 EHNs, and that number is growing precisely because it's a practical way to gain confidence in business partners' security and quality practices. Payers like Aetna, United Health Group, and Kaiser Permanente, for example, require accreditation. And as a proactive measure, New Jersey and Maryland require that payers in those states use EHNAC-accredited clearinghouses.

"We have to ensure that our member's data is secure and privacy is protected," says Tony Rizzi, an EHNAC commissioner and Compliance Director, National EDI Business Operations at Kaiser Permanente. "The EHNAC process allows for a low-cost, private-sector solution that allows us to have greater trust in our EHN vendors. In addition, the EHNAC structure allows security requirements to evolve as we learn more about the implications of conducting business electronically. Input from the EHNAC commissioners and the public allows us to steadily refine data protection standards that are only generally described in the HIPAA legislation."

EHNAC commissioner Dave Schinderle, VP of finance at Children's Hospital of Orange County (CHOC) sees EHNAC as an efficient mechanism for better business: "EHNAC is the industry's answer to develop and promote best practices within the private sector in a cost-effective fashion. Commissioners are unpaid, and fees paid by accredited entities are kept low by our

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non-profit approach. At CHOC, we insist that our clearinghouses are EHNAC accredited. We feel that this eliminates substantial risk because we have taken the extra step of having our vendor prove to an external body that security procedures are in place and effective."

The EHNAC seal of approval is spreading to other industries. EHNAC also accredits EHNs that provide e-prescribing services. Draft criteria are also under development for third-party medical billers.

As healthcare information exchange grows, the importance of building trust among trading partners increases. At no cost to providers, EHNAC offers a proven, private-sector solution for establishing business relationships with confidence and avoiding the kind of episodes that make compliance officers nervous.

Renae D Price, CPA, CHBME, CMPE is a member of the HFMA Kentucky Chapter and has been actively involved in the development of EHNAC criteria for third party medical billers.

Mark Your Calendar

Feb. 24-26, 2009

HFMA / AAHAM Joint Workshop & Meeting

Hotel Murano
Tacoma, Washington

SEE YOU THERE!

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

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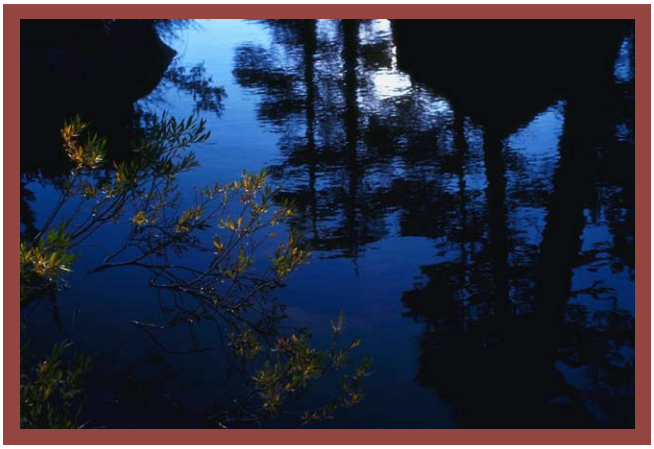
My Father-in-Law Died Today

by Jim Heilsberg | INHS



About 5 years ago, my dad died. It profoundly impacted my life and changed my view on the world. This fall, my father-in-law died. It has given me another opportunity to view death and the healthcare system through another lens.

My father was 75 at his death and my father-in-law was 85. My father was mobile up until his death. My father in law suffered a stroke 2 years prior to his death. That stroke caused him to take a much different path then my father to the final days of his life. His steps are what this story is about.

My father-in-law's name was Harlan. Harlan lived a very simple life and was a truck driver for a cement company for much of his adult life. Harlan and his wife Olive spent many hours working on a lake place that they would eventually retire to. It was built on a hillside and not the easiest to maneuver up and down in their aging years. When they retired they moved to their dream location but as they aged, it became more and more difficult to live there. Life changed when a stroke came in 2006, it threw the balance in their living situation for a loop. Harlan lost mobility for most of his right side of his body. The realization of mobility challenges forced a quick sale of the place they built with their own hands and had invested so much into.

Health challenges are not convenient. They are often unplanned and force changes on people instead of allowing for a calm environment to process the change. In reality they are quickly forced upon us, which does not allow for a smooth transition from the event to deciding what to do. The end result is chaos for those involved. In Harlan's case, that meant he was now going to be cared for by others and not by himself. It meant for Olive that she was now the caregiver and would choose to put her life on hold. It meant they sold their lake place and had to move to a place that while was their choice, may have been different with more time. It meant that the family members and spouses had to try and choose how to support their parents, from far away and next door. It meant that spouses, i.e. me, had the privilege and responsibility of building a new home for them. I'm lying and telling the truth, it was a privilege but also a great burden, that I did not always bare with grace, i.e. I complained a few times….Ok quite a few times. It was part of the journey however and the learning experience was of great value.

There are so many impacts in a family when a parent has a health event that significantly impacts the mobility of their life. We all ponder how we would handle the illness of a loved one but are often ill prepared to greet the reality when it happens.

Soon after Harlan's stroke, reality began to set in. He was going to need assistance with walking if he did walk. Best outcomes hoped for, proved not to be reality. The grim news was greeted by some as reality and by some with denial. Denial is an odd feeling that is more necessary then we believe in times of great trauma. Denial helps us put off pain till we can try and deal with it. In my in-laws situation, denial allowed for plans to be made but to avoid certain decisions until a later date. The denial for some is very unsettling. Some like to greet things head on. However, these individuals often are not right in the middle of the situation, nor do they understand all the impacts to the spouse.

One example of inappropriate handling a

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situation head on, is a sibling talking to the parents on the phone and surmising from the parent conversation, what the answer to a particular problem could be and then telling the parents or others what to do. In reality they are not in the situation, have part of the information and have less of a clue then believed to make a conclusion and recommendation.

The issue impacts everyone,

The health condition of a loved one can often be devastating. There are emotional, financial and physical impacts that are only known to the spouse. The health event can result in extra costs, not planned for, emotional loss as well as increased physical demands on the spouse as they try to care for the loved one they have spent their entire life with. Many caregivers are unable to handle the issues that come their way. My mother in law while one of the most stubborn women I have met, is also one of the most gracious and committed spouses I have ever encountered. She and Harlan are truly examples of great commitment to each other.

Olive ended up becoming the main caregiver for Harlan, and spent her days feeding, bathing and cleaning him. Due to the fact that Harlan and Olive moved next to us on our property in Colfax, My wife and I ended up providing care that we never envisioned.

This process has made me ponder how we as a nation could take care of our loved ones at home. We see advancements in technology occurring all around us and to help us age at home. We also see similar advancements in hospitals, nursing homes or assisted living facilities.

However…..I have to wonder whether we are not just in denial as a nation. We believe technology will solve everything in time.

As I have observed, the only way to keep someone out of one setting and in another is to have someone to care for them at a very basic level and to have technology that will help them monitor various basic health conditions. We as a country have become more mobile and busier. Technology can help with some issues but you can't take care of a loved one without much time and availability. I am unclear if we have the patience and stomach for the work that will be needed to be a basic care giver. In essence you put much of your life on hold for extended periods of time. You have to spend time doing tasks that are not that fun and get burdensome over time. Many wear out and end up placing their loved one in another setting. Many literally don't have the ability to quit a job and care for a loved one.

Things have change or have they?

Another view……I recently sat in a meeting that discussed technology for home, and it hit me that we are coming full circle. In early stages of medicine we saw caregivers go to the patient's home and provide basic healthcare. This model gave way to the patients coming to the doctor. Now with resources being stretched, we are looking to decentralize intelligently and move back to where the patient stays at home and does not incur large dollars associated with institutional provided medicine.

In addition to the doctor, early medicine social setups relied on providing support for aging members of the family at home. As our social structure has changed so that family members work outside of the home, there is little network left to provide for care of aging parents or those caught in a medical condition/trauma such as cancer etc. that requires someone to care for the patient.

If we are going to transition to a scenario where patients stay at home, we will have to solve this caregiver problem. Technology alone, will probably not solve how to help someone get to the bathroom and to help clean themselves. It may but at this point, many human cleaning tasks are provided in a manual fashion. Sorry if this was more information then you wanted to know but in my observation, the simplest things are some of the most difficult to automate.

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So back to Harlan and Olive...

The care needed for a stroke patient is laborious and often results in long, drawn out battles prior to death. The initial loss of some cognitive and motor function is a reality and a deteriorating motor and cognitive function happens as time goes on. This dynamic played itself out with Harlan.

A compounding factor for aged stroke patients is the muscle deterioration that happens when a person goes in a hospital for an unrelated illness. As the patient prepares to go home, the spouse is once again faced with how to deal with a spouse worse off, due to less muscle remaining after the hospital stay compared to when they left the home. It is a difficult road because hospital visits can be more and more frequent in later stages so that there is a constant rebuilding of muscle and a continual downward spiral of muscle mass and health.

As we all know healthcare is expensive. That is only part of the financial puzzle however. The spouse can be forced to make choices about trying to find solutions to bring their spouse back to a normal state. This can mean trying to find the right solution, let alone pay for it. Stroke patients and caregivers are confronted with decisions about using restorative therapies, DME or other solutions that are not all medically proven but are touted by well intentioned and deceitful individuals as the way to make their loved ones healthy again. These are all sought out with the intent of keeping their loved one out of more expensive and permanent choices such as nursing homes and home care.

Finances often get depleted and the choice of nursing home care is probably not a quickly chosen choice, due to the fact that to qualify for Medicaid, you need to be very financially destitute. In my in-laws situation, my mother in law would live longer then my father-in-law. To go on Medicaid, often meant the house and other resources would ultimately become the states'. This fact does not sit well with many of our aged population. They see their assets as something they have worked for their entire life. To turn them over can be traumatic. In my in-laws situation this was a last step that they did not have to take but had pondered many times.

All in all, healthcare is difficult as you age. It is difficult on the caregiver as well as the family. Decisions are difficult and often result in a different type of trauma then the illness the patient brings.

As with much of life, we understand only what we have gone through. We intellectually understand what we have not gone through but cannot appreciate all the dynamics of a particular situation without having gone through it. We learn as we go and learn to appreciate other things. I definitely have another notch in the belt in experience and see aging in a whole new perspective.

hfma washington / alaska chapter
healthcare financial management association

Job Opportunities

TITLE	ORGANIZATION	LOCATION	CONTACT
Director of Divisional Finance	Group Health Cooperative	Seattle, WA	spence.c@ghc.org
Financial Analyst	Overlake Hospital Medical Center	Bellevue, WA	jennifer.garrepy@overlakehospital.org
Manager, Government Reimbursement	Legacy Health System	Portland, OR	njain@lhs.org
Manager Patient Business Service	Legacy Health System	Portland, OR	njain@lhs.org
Patient Financial Services Manager	Tri-State Memorial Hospital	Clarkston, WA	cfo@tristatehospital.org
Patient Financial Services Manager	North Valley Hospital	Tonasket, WA	hrasst@nvhospital.org

For more information on these listings or to include a listing, please contact Kimie Delos Reyes at (503) 567-3594 or mailto:kimie@hawesfinancial.com

See also National HFMA's website (www.hfma.org) for additional job listings.
[Last Update: January 2, 2009]

from your Washington-Alaska Board Members

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.

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$100

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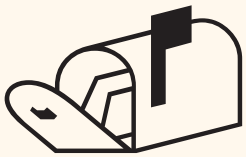

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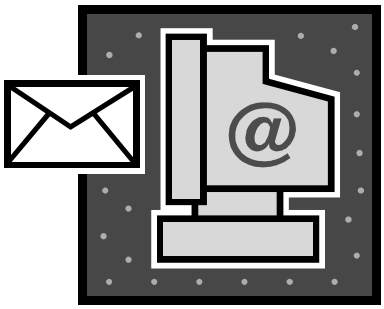

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2. **Go to the membership section**
3. **Log in using the username and password prompts**
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Upcoming Chapter Meetings

DATE	EVENT	LOCATION
January 25-28, 2009	Region 11 Healthcare Symposium	Caesar's Palace, Las Vegas, NV
February 24-26, 2009	Joint HFMA/AAHAM Meeting & Trade Show	Hotel Murano, Tacoma, WA
March 2009 (TBA)	Spring Alaska Meeting	Fairbanks, AK
May 14, 2009	Quarterly Meeting	Cedarbrook Conference Center, SeaTac, WA
June 14-18, 2009	Annual National Institute (ANI)	Seattle Trade & Convention Center
September 16-18, 2009	Quarterly Meeting with Oregon Chapter	Benson Hotel, Portland, OR

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