Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

November - December
2007

President's Message

by Greg Moga, President

2008 Gets Underway!

The first 6 months of 2008 are filled with HFMA educational opportunities for our Chapter members. Starting with Region 11 in Las Vegas (Jan. 27-29), we then have the Joint Meeting with AAHAM in Tacoma (Feb. 27-29), the Alaska meeting in Fairbanks (March 13-14), the HFMA National Spring Seminar Series in Seattle (May 5-8), our Chapter's Spring Conference in Chelan (May 21-23), and finally the ANI in Las Vegas (June 23-26). And as though that weren't enough, we will also have the first annual CFO-only dinner event with HFMA's President & CEO Dick Clarke, which will be co-hosted by Lori Mitchell, Paul Ishizuka, and Tom Risse. So, if you are looking for an opportunity to improve your knowledge and skills, and to network with your peers, please put these dates on your 2008 calendar – you'll be glad that you did!

On a personal note, one of the ways that HFMA has enriched my life is to get to know people who have more than healthcare finance in common with me. For one example, I know 2 other members of our chapter who also have 8 siblings (yes, you read that right- I have 4 brothers, and 4 sisters). For another, I know 2 other members whose families also still own the 'Family farm.' This is a picture of me at harvest time back in Bloomington, Illinois, where we still own 390 acres that we lease out for corn, soybeans and wheat production. Nothing gives me greater happiness than to drive the combine at harvest time (but seeing how hard you have to work at farming also makes me happy to know that I don't have to farm for a living!). During my time as Chapter President, I hope to learn something about each of you, and what we have in common- besides working together in the challenging field of healthcare finance. ■

Contributing Writers

Ginger Rhoades Bell
Tina Eller
Greg Moga
David Morgan
Catherine Wakefield

THANK YOU!!!

Best Practices for Self Pay Collections

by Tina Eller | Client Executive, SearchAmerica

The self pay financial class is not as simple as it once was. It contains numerous types of patients in addition to the traditional indigent or charity patients found in self pay. Unfortunately, most hospital collection processes continue to treat all self pay patients the same, and miss opportunities to collect from willing individuals or age accounts unnecessarily.

One indicator that your self pay collections need attention is if you are mailing the exact same letter to all self pay collections, regardless of their balance or ability to pay. This process may be easy, but certainly it isn't effective or in the best interest of the organization.

Fortunately, best practices for segmenting self pays are emerging.

The first step towards a smarter self pay process is to have Accounts Receivable (A/R) managers segment their self pay patient population based on two variables: Expected Collection Rate and Original Balance.

Using these variables, hospitals quickly find that their patients fit into one of the following segments:

Segment A. The patients in this segment have low original balances (often from labs, X-rays, etc.) and based on their income levels or history, they have a high likelihood of payment. These accounts are highly collectable with minimal effort, in other words they are the 'cream of the crop'. Most will respond to a simple letter reminding them of their payment obligation. This may look effective, but an even better solution is to keep these accounts from even reaching a collection stage in the first place. To do so, many hospitals are now having their registrars simply ask for payment prior care whenever possible, thus eliminating any collections or aging.

Segment B. These patients have a high original balance, and based on factors such as a high medical credit score, good historical collectability or employment status, they are highly likely to pay. Your objective with this group is to minimize account aging. While they may require more effort to collect than Segment A due to a higher balance, the financial benefit offsets most collection activities. Hospitals should be more aggressive with this segment to prevent account aging, and quickly resort to outbound call campaigns. The financial reward is well worth the investment.

Segment C. Large balances from emergency admits or underinsured individuals will be representative of those patients in this segment. Their original balance is high, but the expected collection rate is low. A/R managers should spend time evaluating the cost to collect these accounts and be smart about the resources they apply. For example, if much of the original balance has already been paid by insurance, are extensive collections efforts going to cost more than recovering the remaining 20% of the bill? Consider your efforts, especially those using costly human resources, very carefully.

Segment D. The last segment is those with low balances and low expected collection rates. First the account should be screened to see if it qualifies for your charity care program or state or federal government programs. If not, the account should be immediately sent to a third party collection agency. No internal resources should be spent on non-charity accounts in this segment, or if they are, they must be highly automated. Just as in Segment A, the better solution is for the registrar at the point-of-service (POS) to request payment before care is given, if possible.

Once segmentation has been performed, only then should hospitals develop strategies to streamline and improve self pay, starting with their communications.

The Next Step: Your Hospital's Opportunity to Excel

Improved Communications. Too often, collection letters or bills are printed in mass and include confusing language, acronyms or codes

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for medical procedures, and superfluous information. If a bill cannot be easily understood (what service is it for, has their insurance paid its portion, current balance due, etc), it will not be paid. All communications via mail, email or phone need to use clear, concise information – it sounds easy, but too often hospitals fail on this simple step.

New Payment Options. Plastic surgery centers, lasik providers and dentists have relied on payment plans or financing options for their patients for years. Most often, this option is managed by a third party who offers credit cards or payment plans that can only be used to pay for medical or dental services. Many hospitals are considering implementing these plans to alleviate many payment and collection activities.

Show Appreciation. Repeat patients are used to hearing from you when bills are not paid, but what about those patients who are responsible and pay their bills on time? Hospitals can, and should, show them some appreciation even in simple ways. For example, when a registrar checks in the patient and sees a history of on-time payments, they could simply say 'Thank you Mr. Smith for paying your hospital bills so promptly, we really appreciate it.' In today's world, it is amazing what a simple 'thank you' can do.

Tina Eller is a client executive at SearchAmerica, and has worked in healthcare for 15 years. Ms. Eller's expertise is in helping organizations drive initiatives within the Revenue Cycle focusing on the self pay population and Consumer Driven Healthcare. She is a frequent speaker at healthcare forums as well as contributor to a number of healthcare publications on the topics of Revenue Cycle best practice, challenges in the industry, etc.

Resurrecting Mom

by Catherine Wakefield | MultiCare Health Systems

This is the true story of Mom's adventures with a registration error at a hospital that resulted in her being declared dead. It is a story of human error, missed opportunities and poor process. It could happen to you.

It all started when "Gertrude" was transported to St. J's from a hospice care center. The registration clerk could not find Gertrude in the system. She asked for birth date but the birth date Gertrude gave did not correspond to any already in the system. There was a "Gertrude" in the system though (actually Mom, whom we shall call "Trudy"). The registration clerk used Trudy's Medicare ID to register Gertrude. She documented this is in the registration notes in the patient record. This is the first human error.

Gertrude was admitted twice more, each under Trudy's Medicare ID. This is more human error from not confirming the registration data on each admission. Then, Gertrude passed away at St. J's. St. J recorded the death using Trudy's Medicare ID, also known as her social security number. From this documentation, Social Security was notified that Trudy was deceased.

Trudy's first knowledge of this came via an Explanation of Benefits from her secondary insurer. She received the EOB for a date of service where she was not in the hospital. So, she took the EOB to her friend Ruth in the billing office. Trudy has been a volunteer at St. J's for 22 years. Ruth pulled up the billing records which clearly showed the error and she pulled up a face sheet which showed Gertrude's demographic information in the top section, and Trudy's SSN in the billing section. Ruth printed these out and gave them to Trudy, the wonderful long term volunteer. This was good information for the family but very poor process for the hospital. We should not have had this information provided by the billing supervisor.

In the billing records, the error was noted and the billing records indicate that staff corrected the error. The billing department did not notify Compliance or Legal of this situation. This was poor process.

Trudy's second event came when her last Social Security checks were credited out of her account. Trudy went to the Patient Representative Department at St. J's for help. The Patient Rep., Louise, started to work on the billing issues.

Then Mom called me. She told me what the situation was and I said I would follow-up with the hospital to see what actions they were taking to correct the situation. Before calling St. J's though, I contacted Legal Services at my place of work. Our attorney gave me a list of actions that St. J's should take to fix my

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Mom's new situation.

At this point, the stress of the situation was getting to my feisty 85 year old Mom. She went to her doctor to get her heart monitor off, and also to get some anti-anxiety medications. Mom had never taken tranquilizers before. She is active—still golf's—and volunteers three days a week at St. J's. She is strong, or was until her life started to fall apart.

I called the Compliance department at St. J's. The Compliance Department had not been notified. Tess said she would look in to it. I then called St. J's corporate Legal offices. I reviewed the situation with Dan, the attorney. His comment was "Well, what do you expect us to do about it?" I replied that since I was a Compliance Officer at a healthcare system in Washington, and since I had contacted our attorneys, that I had a list of things I expected their health system to do to fix my Mom's situation. He said he would get back to me. He never did. This was not only poor process but a missed opportunity to step up and do the right thing. St. J's caused the problem. Was my 85 year old mother to bear the burden of the fix all by herself?

The problem then escalated. Once Social Security is notified of a death, they notify Medicare. Trudy's claims were now rejecting as her services were being denied as "services provided after date of death." This is not good for her doctors as they could be put on alert for billing fraud. Social Security also notifies the credit bureaus. Mom's credit card was cancelled.

I called a meeting. I went to California to meet with representatives of the hospital. I asked for the CEO, CFO or COO, Legal, Compliance, and the Patient Rep. I got the Patient Rep, Compliance and the VP of Quality. It was in a small office with no offer of refreshments. They started saying they had another meeting in an hour. I had sent an agenda which we went through. They truly did not know what to do to fix my Mom's situation. We went through the agenda and my expectations. One suggestion was for the hospital to hire my mom an attorney/advocate to help her though the morass of paperwork, letters, filings, and follow-up. They said no. I followed up with a memo summarizing the agreed upon actions. This too was missed opportunity and poor process. They could have done more research into how to fix this. They could have better partnered with the family to take care of Trudy.

After meeting with hospital representatives, my sister and I took point to fix Mom. It was obvious that the hospital did not know what to do (even with a list). It took five visits to Social Security to get her back to her actual alive status. This too was human error at Social Security. Most of the fields were filled in correctly, but one field was not. With that one field not completed, then Medicare was not notified as to Trudy's actual alive status.

We requested that both Gertrude's and Trudy's medical and billing records be reviewed to ensure that the right data was on the right accounts. St. J's cited HIPAA privacy as to why we could not know this was completed. We had to request a copy of Trudy's medical records and billing records before we felt assured that the corrections were made. This continued poor customer service was appalling.

The Patient Rep was supportive. She would do whatever I asked her to do. But St. J's did not initiate any corrective actions. Louise was (and still is as all the billings are not corrected to date) very gracious and helpful to Mom.

After the meeting, action was slow. So, I wrote to the Chair of the health system Board and the CEO of St. J's, copying Joint Commission, Office of Civil Rights and the California Privacy Commission. I heard back from both the Board Chair (a form letter) and the CEO (actually a pretty good letter but he did think everything was taken care of and it still is not).

Then, Mom ended up in the Emergency Department with a spike in her blood pressure (not good for a heart patient) when she got a new notice from one of the credit bureaus saying she was still dead and that someone had filed for her death benefit. I called the Patient Rep to get this fixed ASAP. When Mom got home there was a basket of fruit from the CEO. There was no message. Another missed opportunity.

Six months later, my sister and I continue to work to

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get Mom and all the related paperwork straightened out. Joint Commission did investigate and closed the issue. I am trying still to get a copy of what the hospital sent. This has been an incredible learning experience.

I hope this never happens at my institution or yours. But if it does, be patient focused, spend some time and money to fix it, keep the patient and his or her family informed and improve your processes so this does not happen to more patients. ■

You Can Do the Thing You Think You Cannot Do

A Reprise

by Ginger Rhoades Bell

Recently, Joseph Fifer, National HFMA Chairman, spoke on doing the thing you think you cannot do at our Washington Alaska Chapter meeting. Obviously thought provoking, it motivated the writing of this article.

What have I thought I could not do?
Three years ago I wrote an article for the Northwest Outlook entitled "Beyond the Numbers: One Woman's Story". I discussed the elimination of my long-term job. At first I was not sure how to go about life without the job that meant so much to me. I opened an antique store that satisfied the artistic side of my nature but not the pocketbook. It seems I lived without the job and am also managing now with the closure of the store in May 2007.

Yet another adventure began January of 2007, in public accounting with Dingus, Zarecor & Associates in Spokane. Since I have an 80 mile commute, I now have an apartment in Spokane where I live when not otherwise traveling, going home to Colville on weekends. I guess I can live away from home, family and friends when necessary.

None of my life experiences prepared me for what I now have to do and really never thought I might have to do: continue life after notification that my son was killed in action in Iraq. The loss of my son Ryan is often unbearable, heartbreaking and sad. We persevere because death is a part of life. So it would seem that I can also do this thing that I think I cannot do. There are still times I am not certain I'll make it through the day.

To my friends and colleagues in HFMA:
I am so thankful to have had Ryan in my life. I have known many of you nearly all my professional career. We have kept track of each other's paths; we've gotten married, divorced and raised our families. Those of you to whom I am closest know that raising Ryan was not always easy. These last few years have been a blessing. Our relationship with Ryan was wonderful. We had his wedding in Colville and visited Ryan, Teri and grandsons Jason & Tyler in October at their home on Fort Bragg, NC.

My husband, Mike & I thank you all for your outpouring of love and caring and the lovely floral tributes. I want to share this brief biography written by my father.

With gratitude for my HFMA family,
Ginger Rhoades Bell

My son

RYAN MICHAEL BELL

a Biography

Ryan Michael Bell and five other members of his patrol were killed in action March 5 as the result of an exploding roadside bomb, known as an improvised explosive device, an IED. That bomb was detonated near their patrol by insurgents in Samarra, Iraq. Ryan was a rifleman with the 2nd Battalion, 505th Parachute Infantry Regiment of the 82nd Airborne Division of the United States Army.

The paratroopers were conducting a mounted combat patrol when the Humvee that Ryan was in hit the bomb killing the four soldiers inside the vehicle instantly. A second bomb killed two other paratroopers in a following Humvee.

Ryan was born April 24, 1985 to Delary Michael Bell and Sheryl Vickery, who later were separated. Ryan's father, Michael, subsequently married

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Ginger Rhoades, in April 1992, and Ryan came to live with them when he was eight years old.

Ryan attended public school in Springdale and Chewelah, Washington until he entered the eighth grade at the Riverside Military Academy in Gainesville, Georgia. At the Academy, Ryan excelled in academics and wrestling, and he completed four full years of the Army Junior Reserve Officers Training Corps Leadership and Education Training Curriculum. His academic achievements earned him a place in Who's Who in High Schools across the Nation. Ryan was graduated from Riverside on May 25, 2003, and he then worked with his father in the lawn maintenance business until he joined the army in May 2004.

After Ryan received basic training, he completed Airborne School at Fort Benning, Georgia. He had various specialty training after reporting for duty with the 82nd Airborne Division at Fort Bragg, North Carolina. Ryan was married on June 19, 2006, and he and his new wife, Teri and her two young sons, lived in a home on the base at Fort Bragg.

Ryan's personal awards included the Bronze Star Medal, the Purple Heart, the Army Achievement Medal, the National Defense Service Medal, the Iraqi Campaign Medal, the Global War on Terrorism Service Medal, the Humanitarian Service Medal, the Army Service Ribbon, the Combat Infantryman's Badge, and the Parachutist's Badge.

Captain Eugene Farris, Commander of C Company, 2nd Battalion, 505th Parachute Infantry Regiment said, "It was a tremendous honor to serve alongside Specialist Bell. On a daily basis he displayed courage, honor, and selfless service in the struggle to keep America safe and improve the nation of Iraq."

Ryan had planned to ask the Army to send him to medical school so that he could then become a physician to continue serving his country both as an Army officer and later as a civilian doctor.

Ryan is survived by his wife and step-sons, his father, his birth mother, his step-mother, his grand-parents, his aunts, his uncle, his cousins, and many hundreds of friends, especially including those in the military.

Announcing- a new HFMA resource for those who work in a Small/Rural Provider setting!

There is a community available for HFMA members who work in the small or rural provider setting called the Small/Rural Provider Community of Practice (SRCoP.) Similar to HFMA's four specialty Forums, Communities of Practice (CoP) will focus on knowledge and experience sharing on topics and challenges that are unique to different segments of the healthcare finance industry. The Small/Rural Provider CoP is focused on providing business expertise to its members through shared knowledge, resources and expertise.

"This community is important because it adds depth to your staff capabilities through resources and best practices shared by community members around the country to strengthen the organizations we serve and ensure that small/rural facilities have quality financial leadership."

The Small/Rural Provider Community of Practice Design Team

HFMA's CoPs will provide online interaction tools designed to facilitate discussion and information sharing among our members. Here, members will be able to contribute to discussions, add resources, create new learning, and build community to better the healthcare finance industry. Recent community experiences include shared resources and peer-to-peer discussions on space planning processes, demonstrating community benefit, and IRS compliance.

The Small/Rural Provider CoP was designed by individuals currently in leadership roles in the small/rural setting who started off strong by defining a mission statement: To be a vital resource of knowledge and expertise for small rural healthcare providers. The community has outlined eleven key content areas it wants to focus on:

- Leadership challenges
- Revenue cycle
- Healthcare IT
- Compliance issues for community hospitals
- Meeting community healthcare needs
- Physicians issues
- Jack-of-All Trades role
- Benchmarking
- Core Finance
- New Product Service Lines
- Quality

Upcoming members-only events include audio webcast presentations and peer sharing on Changing Demographics and the Impact on Providers in Rural Settings on November 28. A spring event on Benchmarks for Critical Access Hospitals is also in development.

To join the Small/Rural Provider Community of Practice, and to participate in these free members-only events please visit http://www.hfma.org/forums/communities/sr/default.htm or get in touch with a community member by e-mailing your question to communities@hfma.org.

Join today (https://www.hfma.org/site/forums/join_cop.cfm) and get $125 in discounts off of HFMA education.

Alaska Healthcare Watch

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

Written by David Morgan, Reimbursement Director, Southcentral Foundation

Edited by Cathy LeMay, Patient Accounts Director, Southcentral Foundation

State of Alaska Senate Finance Committee and Legislative Leadership Reports on Medicaid Reform Progress

State of Alaska Department of Health and Social Services currently serves 132,000 Medicaid enrollees at a cost of $1 billion a year in combined federal and state funds; 2025 Medicaid enrollment is projected to reach 175,000 costing approximately $4.8 billion. Medicaid is a critical component of the Alaska health care reimbursement system, responsible for providing health coverage to nearly 20% of Alaska's residents, including 34% of Alaska's children. Medicaid, the largest single payer of healthcare in Alaska, is facing major cost challenges in the near future.

Development of a comprehensive Medicaid Reform Plan was recommended by the Pacific Health Policy Group (PHPG) Study commissioned by the Senate Finance Committee last year. The PHPG study analyzed the Alaska Medicaid Program and made recommendations for enhancing program accountability and cost containment while ensuring the state continues to provide necessary services to the Alaska's most vulnerable citizens. Senate Bill 61 provided the resources and authorized the tasks and programs to implement these reforms.

The Senate Finance Committee, chaired by Senator Lyman Hoffman, has provided leadership and oversight to the Department of Health & Social Services in completing the tasks needed to implement provisions of the Medicaid reforms that were funded and authorized by Senate Bill 61. Progress to date reported by the Department of Health and Social Services (DHSS) as of November 2007:

Care Controls in Personal Care Assistant Program (PCA)
Since April 2006, DHSS has implemented the Personal Care Assessment Tool (PCAT) to determine appropriateness and scope of care for persons requesting PCA services. In the last quarter, DHSS issued an RFP to continue this cost effective management tool. Currently all PCA services must be prior authorized. These measures have substantially reduced the costs of PCA programs.

Tiered pharmacy pricing model and Pharmacy Prior Authorization
The DHSS will study a tiered pharmacy pricing model, in which different reimbursement tiers are available for rural and urban pharmacies. With this survey the Department hopes to determine the optimal reimbursement methodology for the Medicaid program and individual providers in order to maintain access and receive economies of scale for urban pharmacies. DHSS expects to have recommendations regarding a reimbursement methodology in early 2008.

DHSS had implemented additional medications that require prior authorization beginning July 18, 2007. This included all long acting and some short acting narcotics where utilization of medications is high. The Department is continuing to work with the Medicaid fiscal agent to identify other medications for prior authorization and analyze other strategies to improve cost savings.

Substance Abuse and Mental Health Waiver
Currently Medicaid eligibility categories exclude from coverage most individuals between ages 22 and 64. Substance abuse treatment for these Alaskans is funded with local funds or State general funds. This population costs Alaska hundreds of millions of dollars in lost work, increased health care, education and criminal justice costs. Federal Medicaid funds are not available under current Medicaid eligibility criteria except through a waiver or a new State Plan option for a unique benefit package. DHSS will work with a contractor to evaluate the feasibility of expanding the Medicaid program to provide behavioral health treatment services to all Alaskans.

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Federal Participation in Pioneer Homes, CAMA and Long Term Care Planning

DHSS will consolidate analysis of possible federal financial participation in Pioneer Homes, Chronic and Acute Medical Assistance (CAMA) and long term care planning. Data indicate that 60% of Pioneer Home residents have Alzheimer's disease or Related Disorders (ADRD). The Department will work with a contractor to evaluate whether it is practical to offset the cost of serving these residents through an ADRD Medicaid waiver. The cost effectiveness of other alternatives, such as using the new home and community-based services option under the DRA or increasing Pioneer Home rates, will also be considered.

DHSS will evaluate whether different service definition and service arrays to the Pioneer Homes would better meet the demand for long term care in an efficient, cost efficient, sustainable way. Technological advances that could be applied to community settings such as cameras, computers, and sensors to permit people to remain in their homes longer will be considered. Also considered will be populations which have been traditionally served by the long term care system such as elders with mental illness, individuals with traumatic brain injuries and other cognitive impairments, and aging populations leaving the correctional system.

DHSS has decided to consolidate RFP's to consider enhanced federal financing for Pioneer Homes and CAMA since both populations are significant users of long term care services. The analysis will include proposed billing infrastructure, cost development and reporting studies for rural providers.

Alternate Reimbursement Methodology and Development Disability (DD)

DHSS has contracted with Meyers and Stauffer (June 30, 2007) to conduct an analysis and review of Medicaid Program reimbursement methods. The Department will pilot proposed methodologies and select one for adoption into regulation and implementation FY 09 or as appropriate based on utilization of the contractor's transition plan and timeline. Until implementation of a standard rate methodology, DHSS will hold rates firm under the current regulatory freeze making exceptions only for health and safety concerns.

The Legislature has appropriated $3 million dollars to remove people from the SDS Registry (previously known as the "DD Waitlist") by placing them into services approved during the previous legislative session. As a result, the Department has increased the number of people it draws from the registry from 25 to 50 people per quarter. There has been substantial improvement in policy and practice for screening and placing people on the registry into service over the past 18 months including a pilot project to use State care coordinators.

Increase Rural Providers Federal Funds Participation

Significant issues must be addressed for rural tribal health provider organizations to successfully manage the care for all Medicaid-eligible tribal members. The Reform Plan categorizes these issues as strategic planning, service planning and service definitions and cost development, reporting and billing infrastructures. The primary vehicles for addressing these issues are grants awarded by DHSS to Alaska Native Tribal Health Consortium and Yukon Kuskokwim Health Corporation.

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Alaska Meeting Photos

Representatives from the Alaska Department on Health & Social Services provided updates on the Medicaid program and the PERM project.

Linda Corley, Compliance Officer for Perot Systems, discussed aligning employee and organizational goals during one of her presentations and attaining compliance in billing and coding processes in her second session.

Day Egusquiza, President of AR Systems, Inc., discussed privacy in the revenue cycle in one session and customer driven charge masters in her second session.

Jeanne Scott, talking head for health-policies.com, provided a view of healthcare issues and topics being discussed, debated and considered at the national level from the presidential campaign perspective.

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Implement Disease Management Program (DM)
Disease Management (DM) is a system of coordinated health care interventions and communication for certain populations with chronic diseases. The initial DM program will target blind and disabled adults who end up receiving care in Emergency Departments and/or become hospitalized. DHSS will work with a contractor who will assist in the development of an RFP, in reviewing proposals, and in negotiating with bidders.

The 12 tasks, studies and RFPs currently under development or in process will have a budget over $12 million dollars and are planed for completion by FY 09. DHSS is in the process of hiring additional staff to work on reimbursement methodologies, to coordinate between multiple contractors, grantees and DHSS staff and add to the Departments structure necessary to sustain this major Medicaid reform initiative. ■

Links for Medicaid and State of Alaska Regulations Updates and Information:

First Health Services Corp (Medicaid Updates): http://alaska.fhsc.com

State of Alaska Regulations: http://www.hss.state.ak.us/publicnotice/regulations.cfm

4th Annual HFMA Anchorage Educational Event

The 4th Annual HFMA October meeting in Anchorage was a great success. Thank you all for making our educational conferences better than ever. Approximately 70 individuals attended this year. Here are a few of the program highlights.

- Jeanne Scott, one of the nation's leading health care lobbyists, discussed the "State of Healthcare" in the US, with a run down on the 2008 presidential and congressional elections. Her "tongue-in-cheek" perspective made for a great session.
- Alaska's Medicaid Director provided an update on current agency developments, priorities and initiative and detailed the anticipated changes for 2008.
- Representatives from the Department of Health & Social Services updated us all on the PERM Project.
- Day Egusquiza delivered a great program on the common sense approaches to privacy in the revenue cycle and how to develop and implement a consumer driven charge master.
- Tom Dingus' session focused on the importance of statistics in the cost report and how to be prepared for an audit by Medicare intermediary. His take-a-ways were the importance of patient day allocation and record keeping.
- Linda Corley's second day keynote focused on how to align individual employee goals with overall corporate objectives.
- Donna Small presented an update on Medicare compliance requirements including priorities, initiatives and anticipated changes for 2008.
- Phil Hass detailed the tools and information that providers need to bridge the information gap between the payers and providers.
- Telehealth initiatives in Alaska: Representatives from the Alaska Federal Health Care Access Network (AFHCAN), Alaska VA Healthcare System and Regional Office and the Alaska Native Tribal Healthcare Consortium highlighted the potential positive impact of Telehealth on the cost and quality of healthcare delivery in our State.

Merry Christmas and Happy Holidays from Alaska!

hfma washington / alaska chapter
healthcare financial management association

Job Opportunities

TITLE	ORGANIZATION	LOCATION	CONTACT
Accountant	Swedish Physician Division	Seattle, WA	valerie.paul@swedish.org
Accountant III	Salem Hospital	Salem, OR	amyl.schmidt@salemhospital.org
Accountant, Staff	Michael R Bell & Company	Spokane, WA	bellcpa@bellcpa.org
Business Manager - Specialty Clinics	Alaska Native Tribal Health Consortium	Achorage, AK	yaknecht@anthc.org
Chief Financial Officer	Large Hospital	Arizona	bwhren@hwhealthfinders.com
Chief Financial Officer	Renown Health	Reno, NV	chris.corwin@kornferry.com
Compliance Auditor	Coopersmith Health Law Group	Seattle, WA	susan@coopersmithlaw.com
Controller	A Health Plan Company	Bend, OR	crichards@hewittpartners.com
Decision Support Analyst	Catholic Health Initiatives	Tacoma, WA	StaceyLucas@catholichealth.net
Decision Support Analyst	Providence Everett Medical Ctr	Everett, WA	heidi.miller@providence.org
Decision Support Analyst	Southwest Washington Medical Center	Vancouver, WA	ddomila@swmedicalcenter.com
Director Fiscal Services and Decision Support	Central Washington Hospital	Wenatchee, WA	jpowers@cwhs.com
Dir. of Reimb. & Revenue Cycle Management	Central Washington Hospital	Wenatchee, WA	jpowers@cwhs.com
Executive Director - Health Information Prog.	Washington State Hospital Association	Seattle, WA	connier@wsha.org
Finance Director	Edmonds Family Medicine Clinic	Seattle, WA	cdewberry@gsblaw.com
Finance Manager	Highline Medical Center	Seattle, WA	gterreson@highlinemedical.org
Financial Analyst	Providence Everett Medical Ctr	Everett, WA	heidi.miller@providence.org
Financial Analyst	Providence Health Care	Eastern Washington	CrooksJB@Holy-Family.org
Financial Systems Analyst	Overlake Hospital Medical Center	Bellevue, WA	Jennifer.Garrepy@overlakehospital.org
Patient Accounts	United General Hospital	Sedro-Woolley, WA	deeann.valdivia@unitedgeneral.org
Revenue Cycle Mngt Auditor/Analyst	Providence Washington Regional Svcs	Renton, WA	pwrsrecruit@providence.org
Senior Accountant	Multicare Health System	Tacoma, WA	julie.richards@multicare.org
Senior Financial Analyst	Providence Everett Medical Ctr	Everett, WA	heidi.miller@providence.org
Senior Financial Analyst	Multicare Health System	Tacoma, WA	julie.richards@multicare.org
Staff Account	Highline Medical Center	Seattle, WA	gterreson@highlinemedical.org
Tax Accountant - Healthcare	Newman Dierst Hales, PLLC	Seattle, WA	nnewman@ndhaccountants.com
VP - Revenue Cycle	MultiCAre Health System (MHS)	Tacoma, WA	meekj@kadlecmed.org

For more information on these listings or to include a listing, please contact Kimie Delos Reyes at (888) 542-7290 / (360) 906-9258, ext 2711 or mailto:kdelosreyes@professionalcredit.com

See also National HFMA's website (www.hfma.org) for additional job listings.
[Last Update: October 17, 2007]

Mark Your Calendar

Feb 27-29, 2008
HFMA / AAHAM
Vendor
Fair

Sheraton
Tacoma, Washington

SEE YOU THERE!

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

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10th Annual

HFMA Region 11 Symposium Speakers Confirmed

HFMA's Region 11 Symposium Committee has confirmed the featured speakers for the upcoming Symposium to be held January 27th – January 30th, 2008 at Caesars Palace Resort in Las Vegas.

This year's opening keynote speaker will be former Secretary of Education under President Reagan and the "drug czar" under President Bush, Dr. William Bennett. Dr. Bennett's presentation will focus on his recently completed two-volume history of the United States, America: The Last, Best Hope. Named by leading analysts as the "Best Communicator of 2002," Dr. Bennett has authored 16 books, two of which rank among the most successful of the past decade. Dr. Bennett is sure to be a speaker worth hearing.

The second keynote speaker of Monday morning will be Dr. Ian Morrison. Dr. Morrison is an internationally known author, consultant and futurist specializing in long-term forecasting and planning. He will speak on "The future of the Healthcare Marketplace," focusing on the political, economic and strategic context of change in healthcare. He has worked with more than 100 Fortune 500 Companies, including Kaiser Permanente and Pfizer. Dr. Morrison is sure to bring his knowledge and experience to the Symposium.

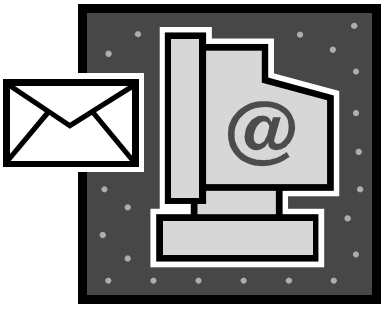
Former Assistant Secretary of Defense for Health Affairs, Dr. William Winkenwerder, Jr. will speak on "Reforming the American Health Care System." Dr. Winkenwerder's has experience of 13 years of executive leadership positions in the healthcare industry including Blue Cross Blue Shield of Massachusetts and Prudential Health Care before going to the Pentagon. He also held senior positions at Emory University and Prudential Health Care, and practiced primary care medicine. He will bring a wealth of knowledge and experience to his session.

Connie Podesta will close the Symposium on Wednesday. The topic of her session is titled, "Life Would Be Easy If It Weren't For Other People." Ms. Podesta will highlight serious issues that affect productivity and morale in the workforce and will remind us that the quality of one's personal life and values directly affect professional success. Connie Podesta is internationally known for her high-energy interactive and entertaining sessions.

The Symposium will also present an array of other educational sessions, including a State Association Panel, a presentation of portions of the film "Sicko" by Michael Moore narrated by Richard L. Clarke, and an International Executive Panel regarding the Pros and Cons of Universal Healthcare. The conference also has 12 educational programs on a wide variety of subjects impacting all healthcare executives, including presentations on Medicare FY2008 IPPS DRG Change Impact, RAC Attack, Medicare Specialty Reimbursement Issues, and the CFO Technical update to name just a few.

Be sure to mark your calendar now to attend starting Sunday, January 27th, 2008, or go to www.HFMARegion11Symposium.org for more details.

How Do I Change My HFMA Information?

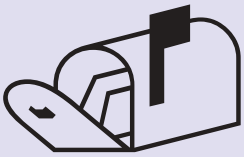


All of our chapter directory information including e-mail and addresses for the newsletter are received from the National HFMA database.

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:

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New Members

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

Bita Alu ..... Red Cedar Partners
Shauna Briggs ..... Anderson And Lohr Healthcare Consulting Services Llc
Roberta Bromlow ..... Providence Anesthesia
Sherry Catlett-Jones ..... Group Health Cooperative
Pamela Gallagher Felt ..... Swedish Health Services
Trina Gleese ..... Newport Community Hospital
Gary Golliher ..... Group Health Cooperative
Donovan Joseph ..... Evergreen Healthcare
Mary Kelley ..... Group Health Cooperative
Catalina Marquez ..... Providence Health System Alaska
Jeanne Nindel-Edwards ..... Evergreen Healthcare
Kathryn Reed ..... ECG Management Consultants
Betty Sable ..... Multicare Health Systems
Nichole Salyer ..... Providence Health System Alaska
Jay Smith ..... Harborview Medical Center
Eva Szyszka ..... Group Health Cooperative
Brandon Wong ..... Moss Adams Llp
Ysidero Ybarra ..... Providence Health System Alaska

Get Connected!

Upcoming Chapter Meetings

DATE	EVENT	LOCATION
February 27-29, 2008	HFMA-AAHAM Vendor Fair	Sheraton, Tacoma, WA
March 13-14, 2008	Second Annual Fairbanks HFMA Meeting	Westmark, Fairbanks, AK
May 21-23, 2008	Spring Conference	Campbell's Resort, Chelan, WA
September 24-26, 2008	Fall Conference	Suncadia Resort, Cle Elum, WA

Members of the Washington/Alaska Chapter of HFMA,

It is with great sadness that we share with you the passing of David Berk on December 18, 2007 in Anacortes, Washington. Dave was hired in 1979 as the Chief Financial officer of Island Hospital. In 1987 Dave started his own business, Rural Health Financial Services, which served over 100 rural hospitals in the Pacific Northwest and throughout the country. His company was unique in the industry. He started his consulting career by developing a computer modeling program for the Washington State Hospital Rate Setting Budget. The program saved all of us our sanity in those years! Dave had a passion for rural health and knew the value and importance in our country's healthcare system. His ease, creative abilities and ultimate success with his clients was a gift. He served the HFMA membership in a variety of ways over the years. He spent four years on the National Advisory Committee on Rural Health. He will be truly missed.

www.waakhfma.org

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