Northwest Outlook

hfma washington / alaska chapter
healthcare financial management association

August - October
2003

President's Message

Robert Hinman
Chapter President

50th Anniversary

It was 50 years ago that the Washington/Alaska Chapter of HFMA was born. The actual charter date for our Chapter was October 22, 1953. The organization wasn't even called Healthcare Financial Management Association at the time. The name was American Association of Hospital Accountants (AAHA). We still love the accountants in our Chapter, but HFMA has certainly expanded over the years to include many non-accountants like myself.

AAHA started operations in 1946 and the year before the Washington/Alaska Chapter was formed, the first Institute was held. The Institute was called "Better Administration through Better Accounting" and had 170 attendees. This year, HFMA's Annual National Institute (ANI) had over 3,000 individuals participating in the event. Certainly a telling sign of the growth of HFMA

50 HFMA Washington/Alaska Chapter

and its importance to the healthcare industry.

So what was going on back in 1953 when our Chapter was formed? The Korean War came to an end, Eisenhower became President, Queen Elizabeth II was crowned, and of course, the Yankees won the World Series. Certainly healthcare finance operated quite

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www.waakhfma.org

Contributing Writers

Jarod Crooks
Annette Edwards
Peggy Figy
Jim Heilsberg
Bob Hinman
Tom Muller
Corey Shank
Cindy Vidano

THANK YOU!!!

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differently in those days - no CMS regulations, no JCAHO surveys, no malpractice crisis, almost no health insurance companies, and certainly no Director of Payor Contracting (my job).

Our Chapter has had a tremendous amount of success thanks to many dedicated volunteers over the years. Much of our success in the last several years is attributed to the Chapter members who laid the foundation for us to build upon. It is that groundwork that has allowed us to enhance our educational offerings, expand our electronic presence, improve our newsletter, and to create more networking opportunities for career development.

Our Chapter's success and involvement on a regional and national basis has been extensive over the years, and none more impressive than the last several years. It was just a year ago June that our Chapter served as the host for HFMA's ANI in Seattle. This year Al Hanson was honored at ANI with HFMA's Frederick C. Morgan Individual Achievement Award. On a Regional basis, we are the lead Chapter for the upcoming Region 11 Symposium in Las Vegas this January. Now the rumor mill has it that Seattle will be chosen to host another ANI in a few years.

We have a lot to be proud of and a lot to celebrate in our first 50 years, thanks to all of you and your continued support of the Chapter. Happy 50th Anniversary Washington/Alaska! ■

ESRD:

Are you leaving money on the table?

by Jarod Crooks, Manager of Budget/Cost Reimbursement,
Sacred Heart Medical Center

End-Stage Renal Disease (ESRD), or as defined by Medicare, "chronic kidney failure," seems to be an area on the Medicare cost report that is often overlooked. This is due to a lack of understanding on how to approach the subject, or because of an over-generalization that "we probably wouldn't qualify, so do not bother with the analysis unless time permits." Usually this means that an adequate analysis on whether or not your facility qualifies for the additional "add-on" payment is not done.

The ESRD program was enacted in 1985, shortly after inpatient prospective payments became the new reimbursement format. Title 42 CFR 412.104 governs the special treatment and allocation of the ESRD additional payment. The criteria necessary to properly identify the ESRD population are vaguely stated in 42 CFR 412.104(a):

> *"…CMS provides an additional payment to a hospital for inpatient dialysis provided to ESRD beneficiaries if the hospital has established that ESRD beneficiary discharges, excluding discharges classified into DRG No. 302 (Kidney Transplant), DRG No. 316 (Renal Failure) or DRG No. 317 (Admit for Renal Dialysis), constitute ten percent or more of its total Medicare discharges."*

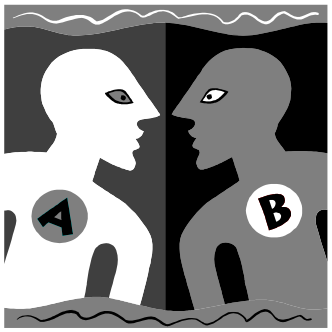
At Sacred Heart, we developed a method for determining our Medicare ESRD population, excluding the non-allowable DRG codes, and came up with qualifying years from 1998 – 2002. We are currently in the process of amending our 2000 cost report for a positive $250,000 financial impact and are finalizing our analysis for 1998 – 2002. We estimate that this ESRD project will add approximately $1.2 million in reimbursement over the qualifying years mentioned above.

In an attempt to understand what our peers are doing to report ESRD, we contacted several facilities, which have large renal inpatient and outpatient services throughout Washington, Oregon, and Montana. Many of these facilities should qualify for ESRD. Much to our surprise, only one facility was currently pursuing the issue with a consultant and none of them had reported ESRD in the recent past.

This finding has the potential to enhance your reimbursement. CMS allows hospitals to make corrections to cost reports up to three years from the NPR date. Please feel free to contact me with any questions or comments you might have. I can be reached at (509) 474-2051 or by email at crooksj@shmc.org. ■

PLAY YOUR GAME!

by Cindy Vidano, CPA
Accounting Supervisor,
Central Washington Hospital



We are deep into tennis at my house. There are lessons, matches, rackets to string, and tournaments to plan. Our family has certain game rules that we follow in tennis. Show respect to the other players, play your hardest, and most of all have fun. After all, it really is just a game. We have learned a lot about human behavior by watching junior tennis over the years. The most important life lesson I have learned, is "Play Your Game." I firmly believe that our core personality shows up in sports.

Our two boys are complete opposites, both on and off the court. Our oldest is very consistent, and he never gives up. He doesn't have an aggressive cell in his body, and he is very unemotional on the court. His line calls are-gracious. He would rather lose a match, than be accused of making a bad call. When he plays his game of patiently waiting for the right time to make the right shot, it is amazing tennis.

Our youngest, is fired up from the start. He is emotional, aggressive, goes for the lines and dearly wants to win. Life and matches are either way up or way down. He wants us to applaud and cheer him on. If he brings home a trophy, then life is good. It is so much fun to watch when he plays his hard hitting, energetic game.

Individuals are happiest and most productive when they play their game and don't try to be someone else in life. They make better decisions, take responsibility and plan for the future. If you aren't an Accountant by heart, don't try to be one by trade. You and others around you will lose. It takes unique skills, abilities and the desire to do well in any occupation. We are better family members, friends and employees when we build on our core personalities and don't try to be something we are not.

Whatever court you are on in life, it works best to "Play Your Game!"

Organizations are just a bunch of individuals who choose to hang together. Through that blending, a unique personality or culture develops. Healthcare organizations succeed when they play their game and lose when they don't. Recently I spoke (while watching a tennis tournament) with a retired nursing director. She was lamenting the wounds caused by a marriage and then later divorce of two hospitals. The merger did not go well and had left the staff, community and Doctors frustrated. She said that the merger was doomed from the start because of their different cultures.

At our hospital we have done some spectacular things for health care in our community. By coordinating with our physicians we have developed several quality programs including cardiac services. We understand that we aren't just a small community hospital, but a referral center for a large area. We don't compare ourselves only to other hospitals our size, but look to fill the needs in our community. Our administrative team believes in recruiting and retaining quality staff to provide great healthcare. They also empower and support management to lead in their areas.

Whatever court you are on in life, it works best to "Play Your Game!" ■

Welcome New Members

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

Keith Lowther
Staff Accountant
Jefferson General Hospital
Port Townsend, WA

Renee Nunamaker
Controller
Palouse Medical, P.S.
Pullman WA

MaLisa Mudgett
Director Business Services
Lake Chelan Community Hospital
Chelan, WA

David M. Keepnews
Title: Assistant Professor
Univ of Washington School of Nursing
Seattle, WA

Michael J. Flynn
Senior Analyst / DBA
Virginia Mason Medical Center
Seattle, WA

David R. Dues
Medicare Cost Report Coordinator
Harborview Medical Center
Seattle, WA

Anna Loomis
Internal Consultant
Good Samaritan Hospital
Puyallup,

Angela M. Hinnegan
Senior Accountant
Central Peninsula Gen Hospital
Soldotna, AK

Sean P. Haugen
Consultant, Business Planning & Finance
Group Health Cooperative
Seattle, WA

Andrea M. Schock
Supervisor Financial Counseling
University of Washington Medical Center
Mill Creek, WA

Dustin Taylor
Regional Manager Contract Management
PeaceHealth
Longview, WA

Leann Yurkas-Hull
Supervisor
Group Health Cooperative
Olympia, WA

Robert A. Thieling
Manager
Protiviti Consulting
Seattle, WA

Patty A. Bound
Associate Director, Bus. Operator
Group Health
Everett, WA

Annette V. Wilson
Associate Director, Bus. Operations
Group Health Cooperative
Olympia, WA

Steven M. Taylor
Director, Revenue Cycle Management
Auburn Regional Medical Center
Tacoma, WA

Angela Hamilton
Senior Consultant
Protiviti Consulting
Seattle, WA

Richard R. Baland
Chief Financial Officer
Yukon Kuskokwin Health Corp
Bethel, AK

Nina Albert
Associate
Hammes Company
Seattle, WA

Jacob Chandler
Senior Reimbursement Analyst
Overlake Hospital Medical Center
Bellevue, WA

Jacki L. Fisher
Audit Manager
Kaiser Permante / Group Health Coop.
Seattle, WA

The following members have transferred in from other Chapters

Gary L. McLaughlin
Chief Financial Officer
Overlake Hospital Medical Center
Bellevue, WA

Satchel L. Kiefer
Vice President Business Development
Healthcare Management Solutions
Milton, WA

Get Connected!

hfma washington / alaska chapter
healthcare financial management association

Job Opportunities

POSITION AVAILABLE	ORGANIZATION	LOCATION
Access Manager – Admitting/Registration	Good Samaritan	Puyallup, WA
Business Office Manager	Prosser Memorial	Prosser, WA
Charge Master Analyst	Good Samaritan	Puyallup, WA
Controller	Lower Umpqua Hospital	Reedsport, OR
Controller	Nat'l Medical Mgmt	Bellevue, WA
Controller	Washoe Medical Center	Reno, NV
Director of Finance / Controller	Providence Health System	San Fernando Valley, CA
Director of Finance - Operations	Everett Clinic	Everett, WA
Director Financial Services	Evergreen Healthcare	Kirkland, WA
Financial Analyst	Guidance Staffing	Seattle – Portland Area
Financial Analyst	PeaceHealth	Eugene, OR
Financial Analyst I	Multicare Health System	Tacoma, WA
Manager – Contracts	Evergreen Healthcare	Kirkland, WA
Manager – Physician Compensation	Virginia Mason Med Center	Seattle, WA
Patient Business Services Director	Kaiser Permanente NW	Portland, OR
Patient Financial Service Manager	Fairbanks Memorial Hospital	Fairbanks, AK
Patient Financial Services Manager	Sitka Community Hospital	Sitka, AK
Reimbursement Analyst	Washoe Medical Center	Reno, Nevada
Reimbursement Director	LeMaster & Daniels, PLLC	Spokane, WA
Reimbursement Manager	Legacy Health System	Portland, OR
Revenue Cycle Manager	Hall Kinion Health and Medical Svcs	Seattle, WA
Staffing Coordinator-Medical Division	Guidance Corporation (recruiting)	Federal Way, WA
Senior Financial Analyst	MultiCare Health System	Tacoma, WA
Tax & Treasury Manager	Washoe Medical Center	Reno, Nevada

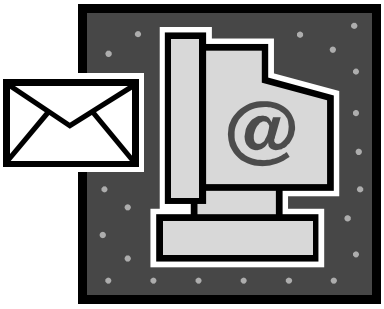
FOR MORE INFORMATION...

...on these listings or to include a listing, please contact

Peggy Figy, (509) 482-2160 or figyp@holy-family.org

See also National HFMA's website (www.hfma.org) for additional job listings.

How Do I Change My HFMA Information?



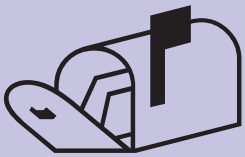
All of our chapter directory information including e-mail and addresses for the newsletter are received from the National HFMA database.

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.**

WIN $100.00

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:

Ginger Rhoades
Mount Carmel Hospital
982 E. Columbia
Colville WA 99114

Phone:
509-685-2406

E-mail
rhoadev@mtcarmelhospital.org

Don't Miss This...

December 4, 2003
HFMA Workshop

Embassy Suites
Seatac, Washington

- Guest Speakers
- LCC Meeting

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) 236-4215
Facsimile: (360) 664-8579
Email: tom.muller@doh.wa.gov

CORPORATE SPONSORS

The Chapter would like to thank the following companies for 2003 - 2004 sponsorships:

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Top Ten Reasons to Get Your HFMA Certification

by Annette Edwards, CPA, CHFP
Reimbursement Manager, Holy Family, St. Joseph, and Deer Park Hospitals

10. To learn something. The healthcare arena is constantly changing. Preparing for the exam is a great way to get up-to-speed – especially in those areas that you may not work closely in every day on the job. Continuing your active involvement in HFMA, to keep your certification current is a great way to stay up-to-speed.

9. To get your name in your organization's newsletter. Strut your stuff, brag a little, blow your own horn. Consider it an opportunity to share with your organization a little about HFMA. We aren't just a bunch of poker-playing, party animals (although we certainly do have fun).

8. To experience that great feeling of accomplishment. Remember that feeling when you complete a big project, meet a tough deadline, or maybe just survive another week. Take a deep breath and let it out quickly. You'll remember what it's like.

7. To add another accomplishment to your resume. You just never know these days, so be prepared.

6. To get more involved in HFMA. Participating in a small group is always a great way to take full advantage of any organization. Whether it's getting involved in a council, committee, or in a certification study group, HFMA is no exception.

5. To get a new certificate to hang on your wall. They are very classy.

4. To impress your boss. The leaders in most organizations are impressed and supportive of those who seek to "step-up" and go for something extra.

3. To refresh your aging memory. For many of us, college classes and textbooks were many moons ago. Preparing for the exam is a great way to revive some of those under-used brain cells. I was asked recently to put together a little analysis. The terms sounded familiar, but I hadn't actually done this in a very long time. If I hadn't just studied for (and taken) the exam, I would have had to dust off an old college textbook.

2. To get more initials after your name. Have you ever noticed nurses in your organization who have "RN, BSN, TNCC, and ACLS" after their name. Take this opportunity to catch up a little and add CHFP after your name.

1. "Because everybody else has one." Now repeat that, OUT LOUD, using the tone of voice of any teenager you know. Enough said!

The Unintended Effect on Losing the MI Program

by Corey Shank
Operations Manager
Pacific Medicaid Services, Inc.

As we all know, the Medically Indigent Program is no longer around. Looking back, I think we all did a good job at forecasting and preparing for the losses that each of us are going to have as a result of a large number of accounts, that would have had reimbursement (although it the average was less than twenty cents to the dollar) that will now most likely go unpaid.

Topographically it was pretty easy; a hospital would extract reimbursement from claims billed to MAA under the MI program and budget for those losses. Then MAA came out with more information regarding the MI Disproportionate Share program, to help mitigate these losses. The idea is that the remaining money in the budget would be earmarked to supplement hospitals that provide care for these indigent patients. Although the amount isn't a ton of money, hospitals are able to expect some restitution.

Things aren't so bad, right? Well as things come up and as the news about the elimination of the MI program spreads it is clear that the elimination of MI will have at least one critical effect: Care Management and Utilization, relating to transfers of Medicaid pending patients to Nursing Homes and Rehab Facilities.

Historically, facilities would accept patients, pending, because the MI program covered for short term placements, and would cover stays retroactively. So the risk for accepting these patients was not too high. Now, without MI, facilities are getting more and more restrictive in the pending patients they will accept, and if they haven't yet where you work, they most likely will soon.

Also, with MI, DSHS had a tendency to ignore the 30-day requirement for placement. In order for Medicaid to cover a placement, the reason or situation is supposed to necessitate services for 30 days or longer in the nursing or rehab facility. Many DSHS social workers had overlooked this requirement and approved placements more readily and MAA tended to pay these claims. With MI gone, these DSHS workers are looking more closely at this rule, and will likely not approve a placement (even if the patient is approved for Medicaid), or the facility might get claims denied

This burden will hit first in Discharge Planning, as staff in these departments try diligently to get placements for patients ready to transfer. As placements get harder and harder to come by, Utilization of beds will become an ever increasing issue. There are hospitals that reroute reimbursable admissions for lack of beds already…now this will only magnify the issue.

The bad news is that there is not a single, magic wand to make this issue disappear. The first thing to ensure is that Clinical Staff, Care Management, U/R and the business office are coordinating and identifying when placement will be an issue. This coordination will best facilitate good information to be given to the facility when a pending Medicaid or private pay patient needs a placement. I think without substantial information, rather than blanketly accepting patients, facilities will blanketly not accept them. So, if there is a patient who is 90% sure to be covered under Medicaid (CNP, MNP) and will clinically meet the requirement for placement, then being able to substantiate that to the facility will make it an easier sell for the Discharge Planner.

Second, hospitals should prepare for the scenario when a patient cannot be placed in a facility. What contingencies will be put in place? Will patients be discharged to home, or will they remain in the hospital, even though the hospital will not get payment, even if Medicaid or other funding is found or approved?

I'm not sure if this concern was ever identified in the legislative process, but it wasn't ever publicly discussed. This issue has the potential to cost hospitals a significant amount, and without proper identification of the issue, it might show its face at an inopportune moment. ■

Twenty Chapter Members Earn Founders Awards

by

Tom Muller,

Founders

Award

Chairman

Founders Awards were earned by 20 members of Washington-Alaska chapter in 2003. Nine members earned the Follmer Bronze award, five members earned the Reeves Silver award, four members earned the Muncie Gold award, and two members earned the Founders Medal of Honor.

The Founders Merit Award series gives recognition to individual chapter members for participation in chapter and national activities. The award series encourages members to make the sustained effort necessary for continued viability and growth of the chapter.

The first award in the series is the Follmer Bronze Award. To receive this award a member must accumulate a minimum of 100 points. The second award is the Reeves Silver Award and is earned by the accumulation of at least 200 points. The third award is the Muncie Gold Award. A member must earn a total of at least 300 points to reach this level.

Points are accumulated towards these awards in the following ways:

- Service as an officer or director,
- Serving as chair or co-chair of a Matrix/LCC committee or council,
- Serving as a member of a Matrix/LCC committee or council,
- Chairing or serving on other chapter committees or sub-committees
- Making presentations at chapter workshops and meetings,
- Making presentations at other healthcare related programs,
- Writing papers or articles for HFM Journal, similar publications, or the *NW Outlook* newsletter,
- Attendance at chapter meetings,
- Attendance at Annual National Institute
- Membership in National Forum(s)
- Participation in audio teleconferences
- Earning and maintaining certification,
- Proctoring certification examinations
- Maintenance of membership (Student=1/yr, Regular=2/yr, Advanced=3/yr, Life=4/yr).

By participating in a large number of activities members may earn awards in a relatively short period of time. The only limiting factor is the maximum of 40 points that may be earned in any one year and the members own time and energy limitations. Conversely, the perseverance to stay with one or two activities over a longer period of time will also earn an award. Points are transferable if a member moves to another part of the country before reaching the level of points necessary for an award.

Prior to 1994 attendance at chapter meetings was not a significant factor, since meetings were worth only one point each and there was a 4 point per year maximum on points allowed for meeting attendance. However, with the changes which became effective for the 1994-95 chapter year, chapter meetings were worth two points each with no annual maximum (except the overall maximum of 40 Founders award points per year), and the definition of chapter meetings was broadened to include workshops. For the 1998-1999 chapter year this policy was further refined to differentiate by the length of meetings. Therefore, meetings of 8 hours or less are worth 1 point, meetings of over 8 hours and less that 16 hours are worth 2 points, and meetings of over 16 hours are worth 3 points.

In 2003 nine members of Washington-Alaska chapter passed the 100 point threshold and earned their first Founders Award, the Follmer Bronze Award. These members were Charles Brown, Laura Handy, Brian McKenna, John Nutter, Craig Rixon, Ardis Schmiege, Cathy Smith, Michael Vanderlinde, and Renee Youngs.

Participation in LCC, serving as a speaker at chapter functions, ANI attendance, and chapter meeting attendance have earned the Follmer Bronze Founders Award for **Charles Brown**.

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Laura Handy has earned the Follmer Bronze Founders Award by participation in LCC, both as a chair and as a member, speaking at chapter functions, volunteer work at the Seattle ANI, ANI attendance, audio teleconferences, and attending chapter meetings.

Matrix participation has helped to earn the Follmer Bronze Founders Award for **Brian McKenna**. In addition, he has been a speaker at chapter functions, participated in audio teleconferences, and has attended chapter meetings.

Serving on the chapter board of directors, as facilities chairman, and as chairman of the chapter operations council as well as attending chapter meetings has earned the Follmer Bronze Founders Award for **John Nutter**.

John Nutter

Craig Rixon has earned the Follmer Bronze Founders Award by participation in LCC, FHFMA certification, book reviews and manuscript reviews for the National journal, ANI attendance, self study programs, and chapter meeting attendance.

Matrix participation has helped to earn the Follmer Bronze Founders Award for **Ardis Schmiege.** In addition, she has earned points for ANI attendance, audio teleconferences, forum membership and chapter meeting attendance.

Cathy Smith

FHFMA certification, ANI attendance, and chapter meeting attendance were primary factors in earning the Follmer Bronze Founders Award for **Cathy Smith**. Forum membership and writing an article for the chapter newsletter earned additional points for her.

Michael Vanderlinde has earned the Follmer Bronze Founders Award by volunteer work at the Seattle ANI, ANI attendance, audio teleconferences, and attending chapter meetings.

Forum membership and chapter meeting attendance over a long period of time have earned the Follmer Bronze Founders Award for **Renee Youngs**.

In 2003, five members of Washington-Alaska chapter passed the 200 point threshold and earned their second Founders Award, the Reeves Silver Award. These members were Barbara Belt-Lloyd, Alan Erola, Linda Firnberg, Deirdre Ridgway, and Michael Smith.

Since earning the Follmer Bronze Founders Award **Barbara Belt-Lloyd** has served on LCC committees and councils. In addition, she has earned points for forum membership, ANI attendance, volunteer work at the Seattle ANI, and chapter meeting attendance.

FHFMA certification has helped to earn the Reeves Silver Founders Award for **Alan Erola.** In addition he has also earned points for participation on LCC committees and councils, forum membership, ANI attendance, and chapter meeting attendance.

Since earning the Follmer Bronze Founders Award **Linda Firnberg** has participated in LCC councils and committees, both as a chair and as a member, spoken at chapter functions, attended ANI, and attended chapter meetings.

Deirdre Ridgway has earned the Reeves Silver Founders Award by serving on the chapter board of directors, serving on LCC, both as a chair and as a member, ANI attendance, volunteer work at the Seattle ANI, audio teleconferences, forum membership, and chapter meeting attendance.

Deirdre Ridgway

Participation in Matrix, both as a committee chair and as a committee member, ANI attendance, volunteer work at the Seattle ANI, writing articles for the chapter newsletter, audio teleconferences and chapter meeting attendance have earned the Reeves Silver Founders Award for **Michael Smith**.

Four Washington-Alaska chapter members passed the 300 point threshold in 2003 to earn their third Founders Award, the Muncie Gold Award. These members were Douglas Bishop, Lee Johnson, Eric Moro, and Claudia Sanders.

Since earning the Reeves Silver Founders Award **Douglas Bishop** has served on the chapter board of directors, served as chair of committee D, maintained

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FHFMA certification, and worked as a volunteer at the Seattle ANI. He has also earned Founders Award points for ANI attendance, forum membership, audio teleconferences, and chapter meeting attendance.

Lee Johnson has earned the Muncie Gold Founders Award by serving on the chapter board of directors, serving on LCC, both as a council chair and a council member, volunteer work at the Seattle ANI, speaking at chapter functions, maintaining FHFMA certification, certification proctoring, writing newsletter articles, ANI attendance, audio teleconferences, forum membership, and chapter meeting attendance.

Lee Johnson and Eric Moro - Muncie Gold.

Serving on the chapter board of directors, serving as chair of committee C, speaking at numerous chapter functions, writing newsletter articles, and chapter meeting attendance has earned the Muncie Gold Founders Award for **Eric Moro**.

Since earning the Reeves Silver Founders Award **Claudia Sanders** has worked as a volunteer at the Seattle ANI and has spoken at several chapter functions. In addition, she has earned points for ANI attendance, audio teleconferences, forum membership, and chapter meeting attendance.

Founders Medal of Honor

The Founders Medal of Honor award was created in 1986 by action of the National HFMA Board. Unlike other Founders Awards, this award is based on recommendations from the chapter Board of Directors, not by the accumulation of points for specific activities.

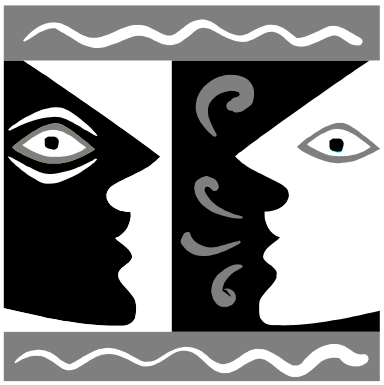
Criteria for nomination for the Founders Medal of Honor are (1) currently a member in good standing, (2) three or more years of service since earning the Muncie Gold Founders Award, and (3) significant service in at least two of the years since earning the Muncie Gold Founders Award. Significant service is defined to include active service as a committee/council member, director, or officer at either the chapter or National level. In 2003 the board of directors nominated Scott Nelson and Eric Teshima for this award.

During the three years since earning the Muncie Gold Award **Scott Nelson** has served as chapter president, chapter immediate past president, nominations committee chair, Region 11 committee chair, and on the board of directors. He has also served on LCC councils and committees, both as a chair and as a member. In addition, he has worked as a volunteer at the Seattle ANI, written newsletter articles, participated as a panel member at chapter functions, attended ANI, participated in audio teleconferences, been a forum member and attended chapter meetings. At the National level Scott has served on the Yerger Awards committee.

Eric Teshima and Scott Nelson - Founder's Medal of Honor.

Eric Teshima has served as chapter treasurer, on the board of directors, as chair of Council 1 and as registration chair during the three years since earning the Muncie gold Founders Award. In addition, he worked as a volunteer at the Seattle ANI, served as an LCC member, participated in audio teleconferences and attended chapter meetings. Although it is not directly reflected in Founders Award points, Eric has always been available to assist the chapter wherever needed.

Individual scoring records for the Founders Merit Award program are maintained for each member of the chapter by LCC Council 3. To check your Founders Award points call Tom Muller at (360) 236-4215 or send an e-mail to tom.muller@doh.wa.gov. ■



Eating Disorders

There and Back Again

Scary title huh! This is another in the ongoing series of articles from Jim about health related topics that tie in to personal thoughts and fiscal issues.

by Jim Heilsberg, CFO/COO, Whitman Hospital

Over the past 2 and 1/2 years my daughter has struggled with an Eating Disorder (ED for short). This article is not about her personal issues but rather about my perspective of the journey along the way.

I feel as if HFMA is part of my family and thus I share in a personal way about how this unspoken topic in healthcare has impacted my family's life and myself.

ED's develop as a result of many things. They are specific to the individual and can develop as a result of a specific traumatic event or as a result of a series of events that have affected the individual. The impact of the ED often include feelings of low self worth and depression. The person with the ED is often impacted by family dynamics, communication issues within the family and sometime birth orders. ED's affect hundreds of thousands of girls and women of all ages. The ED often starts very early in life.

My daughter is currently 19 has had an ED for 2 and 1/2 years and is currently experiencing recovery from the ED. I have learned that many women struggle with this issue for many years, sometimes for their entire life.

Family's are impacted greatly by the actions of the person with the ED. As you can imagine the family tries to find ways to help the person deal with their ED. ED's range from restriction to purging to a combination of both as well as the other side of the coin that is overeating with no binging. Overeating is not often thought of with ED's but the issues that drive a person to overeat can be similar and often are.

Families often do not understand ED's. They often try to treat the ED by using logic. The reality is the ED is a function of how the person feels and is often not related to logic.

Until a person can be listened to and have their feelings heard and validated and not judged, they will struggle with the ED on their own and often are unable to begin the recovery process.

There are two groups of thinkers on whether ED's can be cured or not. Some believe a cure is possible and that it is a process of recovery that involves therapy, drug treatment and potential spiritual healing. The other perspective is that there is not a cure and that you can find ways to help the person cope with the issue but that is all that can be done and people are never cured.

The Journey

Our journey led us through a process that involved physical, psychological and spiritual aspects. The spiritual aspect is provided but not as a way of saying others need to agree but rather as informational so that you can see our full perspective of the process.

Many girls go through a period where they discover their ED. In this discovery process they learn to believe that their ED helps them gain control. Their control is gained by being able to restrict or to binge and then purge or to just eat some and purge. This control is perceived but is also very real to the person and is a big part of the ED.

Many girls start with restriction and then progress to binging and purging and often after time to a combination of the two or in some cases overeating. Each person is different and may utilize one or more of the behaviors.

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When families learn of their daughters ED they try to find ways to help and motivate their daughter to eat or to just stop the behavior.

These methods seem to have success but are more often a false perception on the part of the family. The person with the ED just finds better ways to hide the behavior.

They want their daughter healed but because healing does not readily happen they regress to just wanting an escape

The deceit and discovery of the deceit is very stressful for the individual family members as well as the family as a whole.

The perceptions of improvement are often burst when the family finds out instead of being anorexic their daughter has moved to purging or binging and purging that provides weight gain but often puts the person in a different risk category.

The person that binges and purges or just purges is at risk for dehydration or electrolyte imbalance that can result in death similar to restriction. The difference is the person can be normal in appearance but is actually very ill and near death.

One unknown fact is that persons with ED's often roll into periods of substance abuse that focus on either allowing for more effective restriction or purging or in some cases to just numb the pain they feel. Diet pills are often used to aid in the restriction process. In addition significant sugared gum use or caffeine are also ways the person can gain energy without gaining calories and aid in the restriction process.

Smoking or other drug use is also an issue. The person with the ED is a person that is under stress. When the person with the ED can't deal with it any longer they are no different then others that seek drugs to dull or numb the pain they are feeling. This drug seeking can be either in the form of legal (cigarettes, caffeine pills etc) or illegal drugs.

Where our journey took us

Often families with a person that has an ED can get burnt out with dealing with the day-to-day issues of their daughter. The family can find themselves looking forward to a time when they don't have to deal with the issues of the ED. They want their daughter healed but because healing does not readily happen they regress to just wanting an escape.

Often times the ED continues through normal milestones such as high school graduation or others that result in normal expectations for separation of the family members i.e. going off to school. The thought of their daughter leaving the house for college brings relief and fear; relief at the thought of not having to deal with the issue day to day. This thought is accompanied by one of fear that you won't be able to be there to help the person with the ED when they struggle with their disorder at some point in the future.

We personally prayed daily, hourly and by the minute for solutions. Healing was our main prayer but we often did have prayers that would just result in a break. We did not find solutions until we went through a process.

The process for us involved finding a place away from us that was safe for our daughter. The separation would allow for the fog to clear. When the fog lifted we were able to determine what needed to be done next.

This separation can be good for all members because all need a break in order to gain perspective.

In our case this step happened when we sent our daughter to a relative that had been involved in a center that treated similar issues in the past. This was a big answer to our prayer because this was a safe place and one where the person receiving our daughter had some knowledge of ED's. It was only step 1 of the process.

During the time family is apart they often realize what next steps need to be. Does the situation call for full time care or can it be dealt with additional counseling? The person with the ED often gains perspective that the family is not their issue, the ED is.

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At the end of this step all family members may gain needed perspective that will allow for healthy decisions by the entire family. Step 2 ends with designing and implementing the plan for therapy. This decision needs to be done in conjunction with different caregivers involved in the care of the person with the ED.

Step 3 is often just one on one therapy over time that continues until the person with the ED (now ready to deal with their issues) obtains healing or coping.

One option that is not pursued readily is 24 hour around the clock care in a setting that would allow for healing.

This type of care is very expensive but can be critical depending on the situation. I think that 24-hour care is often not pursued because it is not covered by insurance and therefore the resources are not available.

We personally looked at options through our insurance and they were consistently just minimal therapy and not of the 24-hour care type.

We consulted a therapist outside of the HMO. The therapist had 7 years of experience dealing exclusively with ED's. That assessment resulted in the therapist saying he could help deal with this issue over a 4 year period with individual therapy but that our daughter was at great risk and if she was his daughter he would have her admitted immediately. This was a totally different standpoint from the HMO. The therapist's viewpoint was based upon dealing with ED's for a number of years and being able to recognize the signs that others may not.

We had heard of a center in Wickenburg, Arizona called Remuda Ranch. This place specialized only in ED treatment. ED's were their mission as a Christian based facility. The center proclaimed a 92% success with curing the disorder not just teaching to cope with it. Many other 24-hour centers did not promote cure or a success rate of those cured. Remuda was also JCAHO accredited which was also a positive.

Remuda required a 45 day minimum time to provide a start on the recovery process. They indicated that the time could be up to 90 days. The cost... For 45 days - over $70,000. All unfunded by insurance. It seemed that this was impossible but God took us through a process that made the funding available.

The Recovery Process

Remuda took our daughter and as part of that process we understood that we had to participate in a thing called Family Week. Family week involved another process called Truth and Love. We went to family week.

The week consisted of having 5 families coming together in a group for therapy. The only thing in common for their families was that their daughter had an ED.

We all were trained the first day on what ED's involved and what "Truth and Love " involved.

The group watched each family go through a process where the daughter with the ED told how they developed the ED, what factors triggered it, how the family was involved and how it made them feel. What each daughter needed was to be listened to, be believed that they felt the way they felt and then have their feelings validated.

The family went through a process of telling the daughter how they impacted them as a family with their ED.

Finally the family spent time making amends, apologizing and asking what each person needed to move forward.

I have never cried so much in my life as I felt the pains of others going through the process and also the pain within my own family.

It was the best week my family and I ever had. We all agree.

Our daughter went through a miraculous healing process but what was unexpected was the healing process each family member went through. I have changed in more ways then I can believe but that is another story.

I hope this article has been helpful. If you have questions or want to discuss any of this please feel free to call me or email. I am in the HFMA book.

I plan a follow up article to be titled, "How to let down the walls or take off or masks and learn not to control." ■

Snapshots

Joint Meeting w/Oregon

Sept. 17 - 19, 2003

Portland, Oregon

Rhonda Costanza from the Change Agency discussed Rapid Process Improvement.

Frank Miles, opening keynote speaker, encouraged us to laugh at fear and take risks.

hfma: it's personal

Jeanne Scott, one of the nation's leading lobbyists, briefed the attendees on some dramatic Medicare changes.

David Canfield, national HFMA President shares on the personal nature of HFMA.

Networking in the lobby of the historic Benson Hotel in Downtown Portland, Oregon.

at the Historic Benson Hotel

Congratulations on Certification

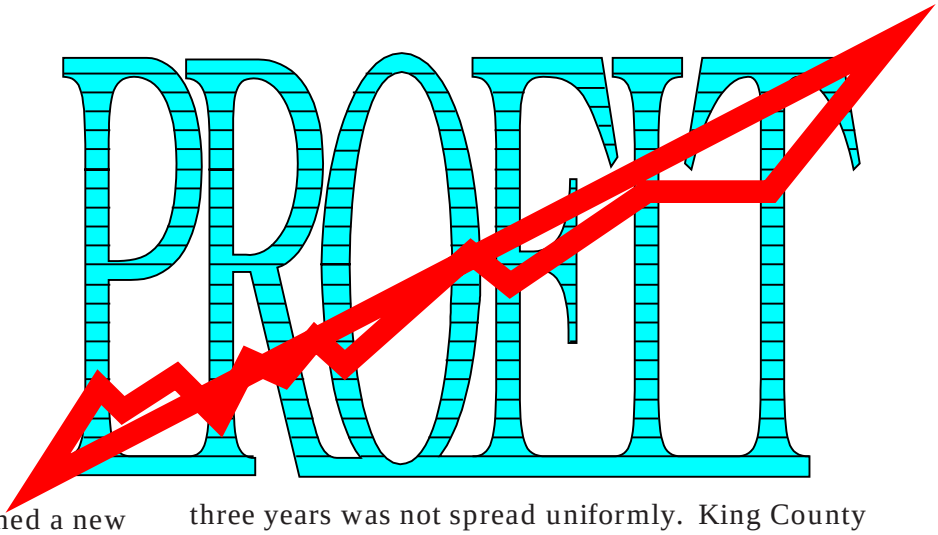
Peg Figy

Leslie Sadler

Morgan Award

Anne Stallard, Dave Canfield, Al Hanson, Tom Dingus, Bob Hinman-Al Hanson is recognized as the winner of National HFMA's prestigious Morgan Award by past and current presidents of the Washington-Alaska Chapter.

Hospital Profits Reach New High



By Tom Muller
Washington State Department of Health

During the four quarters ended June 30, 2003 net operating income of hospitals in the state of Washington advanced to $253 million, as reported by the Washington State Department of Health, Center for Health Statistics. This was 23.9% over the year ago level and established a new record high. Net operating income per adjusted discharge of $272.01 was 21.6% over the year ago level and was the highest recorded since calendar year 1997.

Net operating income is not distributed uniformly among the hospitals of Washington. A total of 40 hospitals experienced operating losses totaling $81.3 million, while 53 hospitals realized operating gains of $334.5 million. For individual hospitals operating results ranged from a loss of $12.2 million to a gain of $47.7 million. Nine hospitals had gains exceeding $10 million for a total of $212 million.

The gain in net operating income over the past three years was not spread uniformly. King County moved from $8 million to $97 million of operating income, while Eastern Washington moved from an operating income of $24 million to an operating loss of $4 million. While frontier rural hospitals experienced an operating loss of $3.4 million and remote rural hospitals sustained a loss of $12.7 million during the twelve month period ended June 30, 2003, urban hospitals recorded a gain of $250 million. By type of ownership, not-for profit hospitals experienced net operating income of $229 million, while district hospitals lost $3.9 million and proprietary hospitals realized $15.0 million of net operating income.

Net Operating Income	Twelve Months Ended		Change	Percent Change
	June 30, 2000	June 30, 2003		
Statewide Total	$118,794,234	$253,201,466	+$134,407,232	+113.1%
By Region:				
King County	8,194,903	96,785,988	+88,591,085	+1081.1%
Puget Sound	72,380,842	131,790,971	+59,410,129	+82.1%
Southwest Washington	8,714,707	16,420,871	+7,706,164	+88.4%
Central Washington	5,687,936	12,484,991	+6,797,055	+119.5%
Eastern Washington	23,815,846	-4,281,355	-28,097,201	-118.0%
By Type of Ownership				
District	3,740,172	-3,940,226	-7,680,398	-205.3%
Not-for-Profit	94,881,415	229,433,751	+134,552,336	+141.8%
Proprietary	8,773,400	15,012,389	+6,238,989	+71.1%
By Population Density:				
Frontier Rural	2,792,657	-3,435,883	-6,228,540	-223.0%
Remote Rural	-1,411,136	-12,708,954	-11,297,818	-800.6%*
Less Remote Rural	7,599,370	18,941,366	11,341,996	+149.2%
Urban	109,813,343	250,404,937	+140,591,594	+128.0%

**Mathematically, this is a positive percentage change. However, since the change is downward, a negative percentage change is less misleading.*

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During the twelve month period ended June 30, 2003...

...operating margin for hospitals in the state of Washington reached 2.91%, which was 12.2% above the year earlier level and 60.5% over the level three years ago. Operating margin levels by region ranged from 6.10% in the Puget Sound area, to -0.44% in the Eastern Washington area. Frontier rural and remote rural hospitals experienced operating losses exceeding 5.0%, while urban hospitals generated an operating margin exceeding 3.3%.

Operating Margin	Twelve Months Ended June 30, 2000	Twelve Months Ended June 30, 2003	Change	Percent Change
Statewide Total	1.81%	2.91%	+1.10%	+60.5%
By Region:				
King County	0.28%	2.52%	+2.23%	+782.7%
Puget Sound	4.74%	6.10%	+1.36%	+28.6%
Southwest Washington	1.24%	1.81%	+0.57%	+46.2%
Central Washington	0.91%	1.54%	+0.63%	+68.6%
Eastern Washington	2.89%	-0.44%	-3.33%	-115.2%
By Type of Ownership:				
District	0.37%	-0.30%	-0.68%	-180.9%
Not-For-Profit	2.03%	3.65%	+1.62%	+79.5%
Proprietary	6.63%	8.10%	+1.47%	+22.1%
By Population				
Frontier Rural	5.34%	-5.56%	-10.91%	-204.1%
Remote Rural	-0.66%	-5.08%	-4.42%	-669.3%*
Less Remote Rural	1.09%	2.14%	+1.04%	+95.4%
Urban	1.96%	3.34%	+1.37%	+69.9%

**Mathematically, this is a positive percentage change. However, since the change is downward, a negative percentage change is less misleading.*

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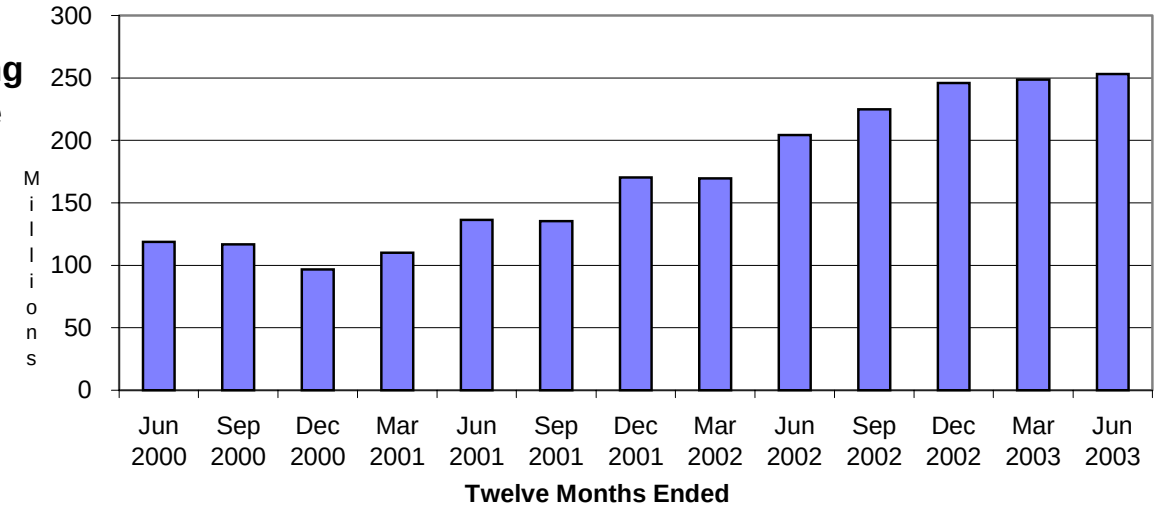
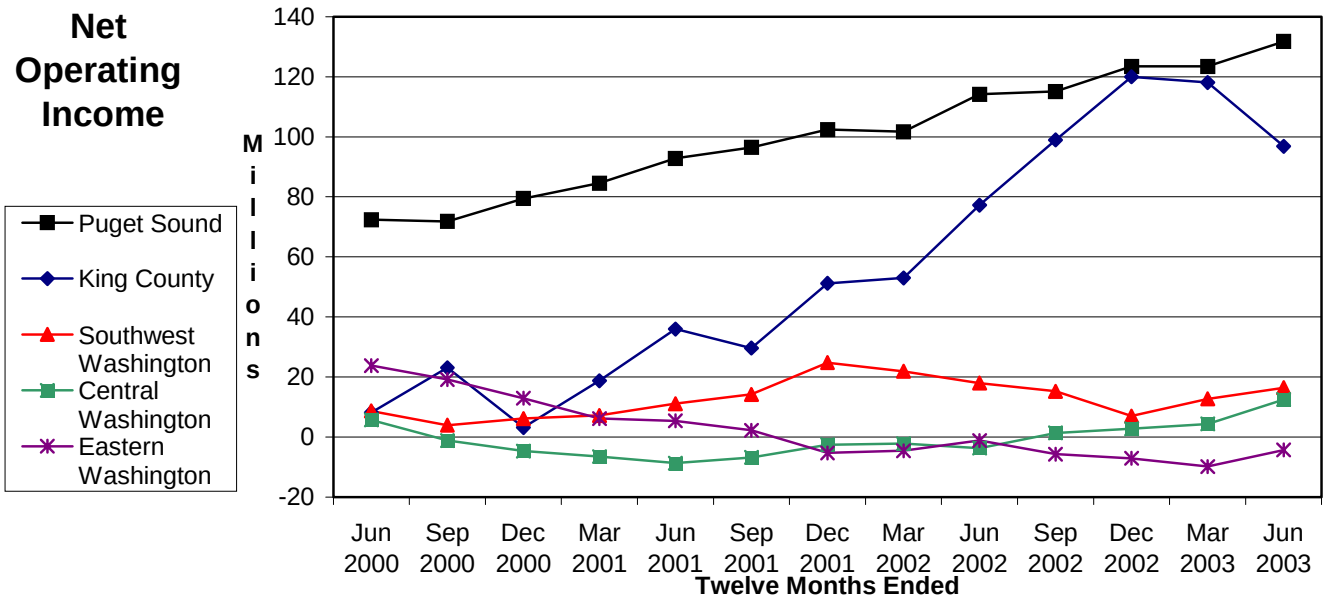
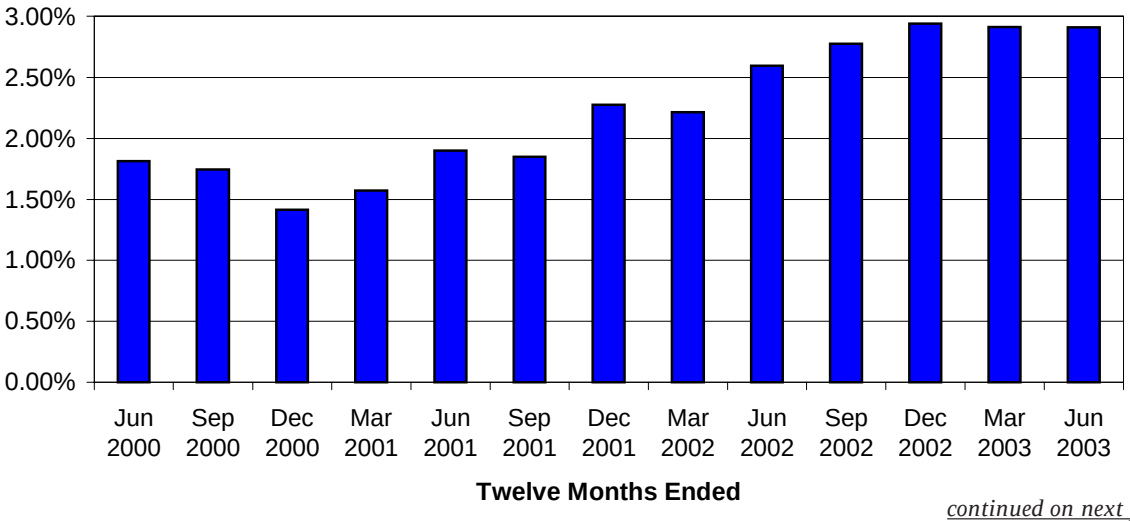
Net Operating Income



Net Operating Income



Operating Margin



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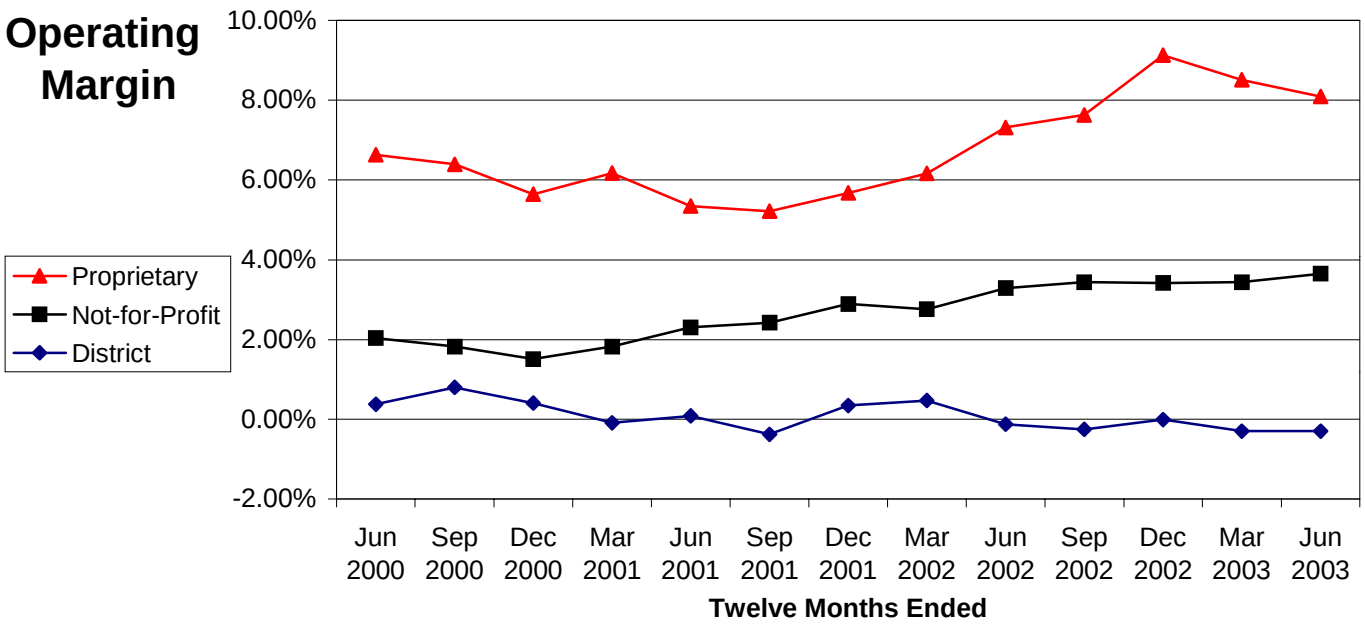

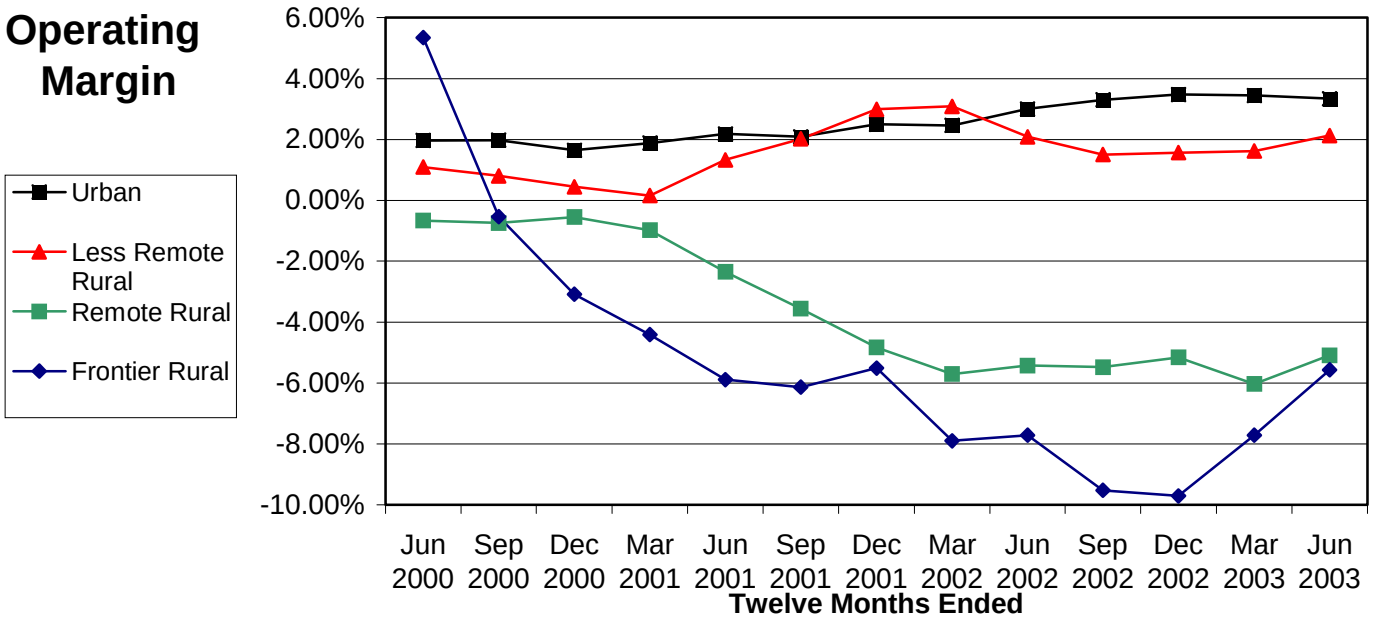

HFMA Region 11 Symposium

Las Vegas

The Chapters of Region 11 are providing a most exceptional educational and networking experience from January 25-28, 2004, at the Rio All-Suite Hotel & Casino in Las Vegas, Nevada. The keynotes alone are worth the attendance and registration.

George Will is the lead keynote – a Pulitzer Prize-winning columnist, Newsweek essayist, media icon, founding and current panelist on ABC's This Week with his hard hitting and witty commentary on issues of national importance. He was named one of America's top 100 pubic intellectuals, is a prolific author, and devoted baseball enthusiast.

Mark Russell, who turns the Washington D.C. scene in to a musical comedy tour-de-force, will leave audiences rolling in the aisles for an encore. He writes a nationally syndicated column, has recorded numerous CDs, tapes, and videos, and is best known for his live specials on PBS where his material changes right up to air time as headline stories emerge from near and far. One of his frequently asked questions is, "Do you have many writers?" "Oh, yes, I have 535 writers, 100 in the Senate and 435 in the House of Representatives and don't forget the President."

Stedman Graham will present a Nine-Step Plan to Success. He is an accomplished speaker, author, entrepreneur, and corporate and community leader. Chairman of Stedman Graham Training and Development, he is dedicated to providing quality educational seminars and products.

The Symposium will also feature the **Honorable John Kitzhaber, M.D.,** former Governor of Oregon, who will discuss Reframing the National Health Debate. Dr. Kitzhaber continues to champion healthcare reform on a national level.

Four tracks of breakout sessions (payment and regulatory, revenue cycle, CFO/strategic, and other) will also be offered including topics such as Medicare appeals and updates, Managed Care issues, customer focused pre-registration, insurance denials, improving financial metrics, the future of hospital/physician joint ventures, evaluation issues in healthcare, successes and testimonials of exceptional finance executives, and understanding personality differences in the workplace.

Check out our website www.hfmaregion11symposium.org, browse and review our program offering for which we suggest you budget for and save the date.

See you in Las Vegas!

Region 11 Symposium Planning Committee

Upcoming Chapter Meetings

EVENT	DATE	LOCATION
HFMA Workshop	December 4, 2003	Embassy Suites – SeaTac
HFMA Region 11 Symposium	January 25-27, 2004	Rio All Suites & Hotel – Las Vegas
HFMA Workshop, Meeting & Vendor Fair	February 25-27, 2004	Sheraton – Tacoma
HFMA Workshop & Meeting	May 19-21, 2004	CDA Resort – Coeur d'Alene
National HFMA ANI Conference	June 27 to July 1, 2004	Opryland Hotel - Nashville
HFMA Workshop & Meeting	September 22-24, 2004	Alderbrook Resort – Hood Canal
HFMA Workshop	December 2, 2004	Embassy Suites – SeaTac
HFMA Region 11 Symposium	January, 2005	Las Vegas
HFMA Workshop, Meeting & Vendor Fair	February 23-25, 2005	Sheraton – Tacoma
HFMA Workshop & Meeting	May, 2005	TBD – Spokane
National HFMA ANI Conference	June 26-30, 2005	Las Vegas
HFMA Workshop & Meeting	September, 2005	Joint Meeting w / Oregon – TBD

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