Fall 2009
Volume XXXXX - No. 2

Fall Institute

November 11-13, 2009

The Wynfrey Hotel, Birmingham

It is time again for the annual Alabama HFMA Fall Institute Conference which we are holding this year at the Wynfrey Hotel in Birmingham November 11-13. The theme for this year's conference is "Failure is not an Option" and will be highlighted by our keynote speaker Fred Haise, one of the astronauts on the Apollo 13 space mission. Mr. Haise will speak from personal experience about the importance of strong leadership, motivation, communication, and perseverance in achieving success in any workplace situation. Mark it on your calendars- this is your chance to meet and learn from a true American hero!

Over the course of three days the conference will feature 15 sessions on a variety of topics relevant to healthcare reform from insurance updates and computer-assisted coding to compliance and the RACs. We have a fantastic lineup of extremely knowledgeable presenters, so these should be very interesting and informative. Everyone should be prepared to learn a lot and have a great time as well! The event will also include a 50th Anniversary celebration of the Alabama chapter and we are bringing back Casino Night. Log onto the website at alabamahfma.org to review the agenda in its entirety.

For the past several years, our theme has been geared towards football (Southeast football that is), well this year, since the conference begins on November 11, Veteran's Day, and since we have Fred Haise as our keynote speaker, we thought it would be an ideal time to honor our Veteran's who have served and continue to serve our country. Be sure to wear your red, white and blue, take part in the "Coats for Vets" coat drive (see Johnathan's article on page 10) and let our Vets know that what they do for us is appreciated.

We look forward to seeing all of you there!

- Jerry Smith
Vice President - Fall Institute

SAVE THE DATE

The Wynfrey Hotel
Birmingham

NOVEMBER 11 - 13, 2009

APOLLO XIII
EX LUNA, SCIENTIA

hfma alabama chapter
healthcare financial management association

www.alabamahfma.org

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Linda J. Maddox
President

As I begin to write to you, our members, there is clearly a change of weather before us. I hope you are enjoying Fall as much as I am! Football season, festive events, leaves changing colors, and that first cool snap is in the air. I cannot believe we are now over 4 months into this year for Alabama HFMA.

At the beginning of the year it seemed like a forever event. As I look at it today, I remember what my parents would always say to me," WE have a LONG way to go and a SHORT time to get there"! This certainly applies to our chapter. I ask, "What are you doing to help MAKE IT COUNT for our chapter this year?" I would love to hear your ideas and suggestions about how to make us a stronger chapter and most beneficial to our healthcare professionals. After all, this is the mission of HFMA .

November is just around the corner and I want to personally invite you to attend the Fall Institute, November 11th - 13th at the Wynfrey in Birmingham. This one is going to be GREAT. The theme will be patriotic, so make sure you wear your RED, WHITE and BLUE to the meeting. If you've not registered, please look at the home page and do it NOW - while it's on your mind, and if you're reading this on the web (good member, you've truly gone green) you have it at hand.

I want to update everyone on where we are with specific categories that affect us as a chapter and how our score card will reflect our strengths.

- **Volunteer Projects** for the year: Johnathan Bedell heads this committee for us. He is coordinating the *COAT for VETS event* -

WE are in need of the following:
- Distribution points throughout the state for coats to be dropped off for distribution. (We aren't asking you to distribute, just simply let people drop them off and we'll coordinate getting them and distributing them.)
- Contributions of coats and jackets
- We will have someone from the Veterans Administration receive the donations at our November meeting. Let's ensure we do all we can as an Alabama organization to support this event. Coats for the Vets and their families will also be collected during the Fall Institute. Look for Johnathan's article in this edition of the CHATTER.

CAN YOU HELP OR WILL YOU CONTRIBUTE? (in doing this you will help in MAKING IT COUNT)

- **February-Volunteer Month for our VETS.** WE need names of family members that are currently deployed overseas at war. IF you have a family member, please consider submitting the information via email to Johnathan so we can coordinate care boxes to be mailed out in February. All the chapters in Region 5 have all jointly agreed to do this. Can you imagine how many military members can be receiving a package?

Submit the name and address of the deployed person to:
Johnathan.Bedell@na.firstsource.com
Include in the email your name and phone number so we can obtain specific information needed for proper delivery. There are a lot of us who want to

2009-2010 Leadership

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MAKING IT Count

participate and know what a blessing this will be to those away from home. All of us can contribute one item to a care box and it will amaze you how many boxes our chapter will be able to send as a THANK you for the contributions and sacrifices they make.

• **Certification** - Vicki Parks is currently offering training at our November meeting as well as a test site that same week. We have 3 registered to date and of course we want to improve over last year and to meet our goal.

• **Road Shows** - we have the 3 Forum Groups that continue to pull together educational sessions throughout the state. Is your organization supporting the events as they come to your area? We have PFS, CFO, and Compliance forums making it possible for you to attend and receive quality education either in one day sessions, or perhaps maybe in a couple of hours.
Are you on one of the forum committees? If not, I encourage you to help in some way. Perhaps you may offer to host a show at your facility, or volunteer the day of the event in some small way. It will make a difference.

• **Chapter Survey** - the Alabama Chapter will mail a survey toward the end of October to a random sampling of our members. If you are selected to receive the 2009 HFMA Chapter Survey, please take a few minutes to complete it. This only comes out every other year and it is a very important planning tool for the Chapter. The information you share with us helps us to move forward with planning for the Chapter in the current year as well as the years ahead.

I look forward to seeing you at the Fall Institute. Don't forget to wear the colors, bring a coat, a family name of a loved one serving at war and volunteer to help in some way so that when it is all said and done you too can proudly say I helped "MAKE IT COUNT" in 2009!
I promise you will never regret it!

Lastly I want to say THANK YOU to all of the dedicated sponsors who continue to support the chapter and to the members who volunteer their time, energy and expertise in making the Alabama Chapter one of the best regionally and nationally. Also to all of the new volunteers that have stepped up to the plate to help this year, a BIG thanks to you as well. Without, you the members, all of this could not happen!

May you be blessed in all that you do!

- Linda Maddox
2009-10 President

Discover Charleston

DIXIE INSTITUTE 2010
Charleston, South Carolina
Charleston Place Hotel
February 16-19

For registration, exhibit, or sponsorship information, contact
Tommy Cockrell 803-744-3510, tcockrell@scha.org
Camie Patterson 864-725-4255, cpatterson2@selfregional.org
Jay Rickman 803-217-3831, jay.rickman@amcolsystems.com

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hfma Alabama Chapter healthcare financial management association

RESERVE THE DATE
RESERVE YOUR SPOT - Only 200 Spots, and they go fast

3rd ANNUAL AAHIM & HFMA SYMPOSIUM

Changes continue – be proactive, don't get caught

Behind The 8 Ball

WHO SHOULD ATTEND:

CFO's, Controllers, Finance Directors
Coders
Compliance Officers
Directors of the Revenue Cycle
HIM Directors
Patient Billing
Utilization Review Coordinators
Anyone related to the Revenue Cycle

BACK BY POPULAR DEMAND:

Joy King, Joy King Consulting

Dr. Greg McKinney, Cahaba GBA

Other speakers:

Joan Hicks, CIO, UAB Health System

Tessa Strickland, Health Management Unit Manager, Blue Cross/Blue Shield

Gregg Everett, Vice President and General Counsel, ALAHA

WHERE:

Vestavia Country Club
400 Beaumont Drive,
Vestavia Hills (Birmingham), Alabama

DIRECTIONS:

Refer to www.vestaviacc.com

WHEN:

Thursday, December 10, 2009
Registration: 7:45 - 8:40
Meeting: 8:45 - 4:00

WHAT:

ICD 10s, ARRA, CURP, MACs, RACs, MICs,
Reimbursement Audits In Alabama
Healthcare reform - National and State Level

Costs: $45 Per Person, Includes Breakfast, Lunch and Afternoon Snack

Register today at: www.Alabamahfma.org

CPE's will be awarded

CAHABA GBA - Transition Complete and How Does It All Effect You, The Provider?

Cahaba Government Benefit Administrators®, LLC (Cahaba) is pleased to announce that our transition of the Jurisdiction 10 (J10) work is now completed.

Under the Medicare Modernization Act (MMA), Medicare began realigning states into Jurisdictions through a process known as Medicare Contracting Reform (MCR). Under MCR these aligned jurisdictions were then placed into a federal contracting process to be awarded to prospective contractors. These prospective contractors are known as A/B Medicare Administrative Contractors (MACs) and Specialty MACs. There are currently 15 A/B MACS that are charged with doing the traditional Part A and Part B work. Regarding the Specialty MACs , there are both 4 Durable Medical Equipment MACs (DMERCs) and Home Health and Hospice (HHI) MACs. A complete overview of MCR as well as jurisdictional maps can be found at http://www.cms.hhs.gov/MedicareContractingReform/

J10 includes the states of Alabama, Georgia, and Tennessee. The following are statistics for J10:

*Fee-For-Service Beneficiaries	2,966,296	(as of July 1, 2008)
*Number of Practitioners	73,824	(as of July 31, 2007)
*Total number of Medicare Hospitals	459	(as of December 31, 2008)
*Total Annual Claims Volume	7.3% of nat'l workload	(as of September 30, 2008)

After Cahaba was awarded J10 on January 7, 2009 the process of transitioning each segment of the workload (GA-A, GA-B, TN-A, etc.) began with the last segment (Tennessee Part B) transitioning on August 29, 2009.

Cahaba has been a Medicare contractor since the inception of the program in 1966. Prior to MCR, Cahaba served as the Part A (Fiscal Intermediary) Contractor for Alabama, Iowa, and South Dakota; the Part B (Carrier) Contractor for Alabama, Georgia, and Mississippi. Currently, Cahaba still serves as the Part B (Carrier) Contractor for Mississippi as well as the Regional Home Health and Hospice Contractor for the Midwest (15 states) until these geographic areas are transitioned to their new contractor.

Website

Cahaba's website (www.cahabagba.com) should be each provider's main source of information. Located on the website is useful information regarding such topics as Provider Enrollment, Appeals, Financials, and Coverage. Other aspects of the website include online registration for seminars, online forms, and consolidated list of contact information. "What's New" is a section of our website that allows information to be posted in an expedited manner; whereas routinely, most information is published in our monthly News Bulletin. Finally, our 'list serve' is an invaluable tool to receive information on topics from a self driven pre-selected menu of topics. Cahaba encourages all providers and their staffs to join our list serve.

Coverage

Policies and guidance from a contractor typically fall into one of the following categories: National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and articles.

NCDs are policies set forth at the CMS national level. All contractors are obligated to comply with these coverage guidelines. NCDs can be located on the CMS website at http://www.cms.hhs.gov/mcd/index_list.asp?list_type=ncd LCDs are policies developed by each contractor allowing some local input into coverage guidelines. LCDs are created as a result of contractor data analysis, CMS referrals, OIG referrals, etc. The process of developing and implementing LCDs is outlined in the Internet Online manuals under the Program Integrity Manual , Chapter 13 at www.cms.hhs.gov/manuals . As part of the LCD development process, Cahaba will, via web announcements, solicit comments and request attendance either in person or telephonically. These web announcements can be found

on the "Calendar of Events" section of our website. Cahaba's LCDs can be found on Cahaba's website at www.cahabagba.com under the Coverage and Medical Review section. Currently LCDs will be delineated as MAC A and MAC B LCDs.

Articles are documents that allow contractors to provide billing instructions, educational information, self-administered drugs, and extended guidance for NCDs. Articles can be found on Cahaba's website at www.cahabagba.com under the Coverage and Medical Review section.

Medical Review (MR)

MR is the clinical department of Cahaba that is responsible for reviewing claims for medical necessity. Through data analysis, CMS and OIG referrals, MR reviews topics as well as specific providers to determine if a "probe" (audit of claims) should be performed. The fact that a provider has been selected for a probe does not imply any abuse, but merely that the provider has appeared statistically aberrant through data analysis.

Provider Outreach and Education (POE)

POE is a department within Cahaba that is charged with educating providers on broad coverage and billing topics. They host numerous 'in person' and telephonic educational events throughout the year. Examples of educational events include Provider Enrollment; Top Claims Processing Denials; Medicare 101. A list of these educational events along with registration instructions can be found on our website under the 'Calendar of Events' section. Also POE is involved with educating providers who have been placed on 'review' (i.e. probe) by Medical Review.

Customer Service

Our Provider Contact Center (PCC) is the first contact for information that we ask all providers to utilize. The PCC will be able to give you information on claim status, denial reasons, provider enrollment and many other essential aspects of day to day claims issues. CMS has charged all contractors with focusing providers on accessing the PCC first. If you should access PCC with an issue, always remember to please obtain a reference number which will be your confirmation regarding your PCC call. Areas such as Medical Review, Contractor Medical Director, POE, and Appeals are not able to assist with individual claim issues and, per CMS will redirect those inquiries to our PCC.

As most are aware, Recovery Audit Contractors (RACs) have begun their contractual work for Medicare. Connolly Healthcare (CH) is the RAC for Alabama and has begun adjusting claims and will roll out claim review in early 2010. This past summer, CH held two seminars in Alabama as a means of introducing themselves. In a partnering role, Cahaba will perform the adjustments and review the appeals for 'denied' claims. More information on Connolly can be found at their website at www.conollyhealthcare.com.

Finally, corporately Cahaba's home office is located in Birmingham, AL with satellite offices in Savannah, GA and recently Chattanooga.

-By Greg McKinney, MD, MBA
Senior Contractor Medical Director
Cahaba GBA

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Health IT: Invest Now or Pay Later

The American Recovery and Reinvestment Act (ARRA) is a key component of realizing the federal government's goal of leveraging healthcare information technologies to enhance the quality of healthcare in America in a cost effective manner. ARRA designated more than $17 billion in Medicare and Medicaid funding to incentivize physicians and hospitals to demonstrate 'meaningful use' of certified healthcare information technology with incentive payments starting as early as 2011. For those whom the incentives do not provide enough of an impetus to consider investing in health IT, there are the significant Medicare penalties starting in 2015 to look forward to.

ARRA prescribes that physicians who are not meaningful users of health IT by 2015 can expect a reduction in their Medicare payments starting in 2015, with the reduction in Medicare payments increasing by 1% for each subsequent year physicians cannot demonstrate meaningful use up to a maximum reduction of 5%. Likewise hospitals who are not meaningful users by 2015 can expect a reduction in their market basket adjustment starting at a 25% reduction in 2015 up to a maximum reduction of 75% in their market basket adjustment for each subsequent year after 2017 that hospitals are not meaningful users.

The overarching goals of the ARRA incentives are to accelerate the adoption and 'meaningful use' of health IT by providers. The exact definition of 'meaningful use' and the measures that determine compliance therewith are anticipated to be released by the Health and Human Services (HHS) Secretary by the end of 2009. ARRA has charged the federal HIT Policy Committee with developing recommendations regarding 'meaningful use'. The HIT Policy Committee recently released their recommendations of which some of the key elements include the use of a certified electronic health record (EHR) capable of electronic prescribing, decision support tools, closed loop medication management, computerized physician order entry, increased engagement of the patient in the care they receive, all of which have increased reporting requirements associated to ensure meaningful use compliance. These recommendations cannot be achieved without increased exchange of patient information across multiple providers and organizations to achieve greater coordination of care.

To protect against the potential risk associated with increased sharing of patient information, ARRA has significantly expanded upon the privacy and security provisions of the HIPAA regulations. These include providing more stringent guidelines for defining a breach of an individual's protected health information (PHI) as well as prescribing specific corrective and notification activities in the event of a breach. ARRA also extends HIPAA compliance responsibilities to include those with whom the covered entities have business associate agreements. Business associates are now held to the same expectations as covered entities for maintaining the security and privacy of PHI. In the event of a breach, the law mandates that the covered entity send written notification to all affected individuals explaining what information might have been revealed and to maintain a log of these breaches to be submitted annually to HHS. In the event that a breach involves 500 individuals or more, the law requires the local media and HHS are notified; at which point HHS will post the information about the breach and the affected organization on their web site. In addition to the already significant penalties associated with HIPAA violations, ARRA reinforces these penalties by making organizations' meaningful use incentive payments contingent on resolution of any and all unresolved HIPAA privacy or security incidents.

HHS is in the process of incorporating meaningful use recommendations from the HIT policy committee and the HIT standards committee to develop its interim final rule by December 2009 which may then be followed by a 60 day comment period before the final rules and regulations are issued. With a relatively short period of time available for organizations to meet the 2011 meaningful use objectives, organizations need to decide upon their course of action as soon as possible.

The HIT policy committee recently published their final meaningful use recommendation . This would be a good starting point for an assessment to determine organizational readiness in meeting the meaningful use recommendations and to begin developing an organizational response strategy. Organizations should evaluate their current systems for existing functionality, utilization rate of existing functionality, and any additional functionality that may be needed to meet the meaningful use recommendations. This readiness assessment when mapped back to the organization's

current health IT strategic plan and projected timelines would provide a clear understanding of any gaps in functionality as compared to the meaningful use recommendations. This in turn would provide the framework for discussion needed to engage organizational senior leadership to develop an action plan on how to best address functionality gaps to meet the ARRA requirements while aligning with the overall organizational strategic goals as well.

After defining the new health IT strategic direction, the new organizational direction should be communicated throughout the organization as soon as possible so as to be able to address any concern and minimize resistance prior to implementing any changes; ensuring a more successful adoption, especially if the new strategy implies a shift in clinical practice workflow. It goes without saying that importance of stakeholder engagement in the success of any project, equally important is the identification of the project champion and their ability to affect change. The champion would be responsible not only for the timely identification and addressing of issues, but also for maintaining the project momentum. This helps to create interest and buy-in among their colleagues into the process change and ultimately ensuring a successful adoption.

Implementing a process change also affords an excellent chance for identifying opportunities for improving the current workflow through standardization of processes across the delivery of care environment and elimination of non-value adding steps. Organizations that are further along in their EHR implementation may have fewer opportunities for process redesign than those who plan on implementing a new EHR system or significantly changing their existing EHR system. It would be prudent for organizations planning on a significant EHR investment to not just replace their current paper processes with electronic ones rather they take a systematic approach to understanding the workflow and to design the new workflow to reduce duplicative efforts and streamline the delivery of care process.

The tremendous focus on EHRs and the functionality required to ensure meaningful use demonstration, has also placed an acute strain on EHR vendor resources. A challenging feat in and of itself given that the goal would be to have these systems in place by 2011 when the incentives begin, but add to that all the organizations who will now almost synchronously be expecting vendors to help with their individual EHR implementations without the trained staff to implement these changes and it becomes an insurmountable task. If your organization decides to invest in a commercially available product it is important to begin discussions with the vendor as soon as possible so as to be able to set realistic expectations.

With all the focus on investing in health IT, it is important not to lose sight of the expanded privacy and security provisions. They have the potential to negatively impact an organization's reputation not to mention the financial cost associated with resolving a privacy or security incident. One of the first steps to take towards addressing the privacy and security provisions is to conduct an assessment of your organization in relation to the new provisions. You should then review and update your PHI handling practices, policies, and forms to ensure that they align with the new provisions. In addition to ensuring process compliance, it is also important to ensure personnel compliance, which is often more challenging, as it requires constant communication with and reeducation of everyone throughout the organization about the new breach guidelines and their organizational impact. It is equally important to engage business associates in HIPAA compliance discussions and to evaluate business associate agreements to ensure they address the role HIPAA will now play in this relationship.

With the significant resources needed to successfully implement health IT solutions and the relatively short time period available to meet the ARRA guidelines, it is especially crucial to engage organizational senior leadership early on in the strategy development and planning process to ensure timely access to capital and other resources. The decisions they make have the potential to either help subsidize your organization's health IT investments through incentive payments or cost the organization penalties for not being able to demonstrate meaningful use of health IT.

- Joan Hicks
Chief Information Officer
UAB Health System

Ms. Hicks may be reached at jhicks@uabmc.edu

Hospitals Reaching Out to Communities to Provide More Charity Care

It may come as a surprise to the general public, but a little known fact is that millions of patients are automatically identified and enrolled in hospital sponsored charity care programs nationwide. It is unlikely that your patients understand much about a hospital's generosity, let alone the technologies that automate its community benefit programs. These charity care systems enable hospitals to execute their community benefit programs more effectively, providing medical services free of charge or at a significantly reduced rate to qualified patients - amounting to billions in savings annually to U.S. consumers. This practice is at the core of the mission of our nation's not-for-profit healthcare networks.

Unfortunately, it can be difficult and time consuming to manually identify all qualified patients and efficiently enroll them in a hospital's charity care program. Doing so without automation is wrought with errors and inconsistencies, so many hospitals have taken a new approach for improved accuracy and consistency.

These systems have greatly impacted the lives of millions of patients and their families over the years who otherwise may not have received charity care. The following are excerpts from actual thank you notes from hospitals and patients who have seen the benefits of these systems first-hand:
'Our automated charity care screening system approved two patients yesterday-one's wife shed tears of gratitude. We were also able to approve another just now, a child whose father lost his regular job recently, and is now making $9 per hour. This is a wonderful service that we are providing. The staff feels good and the patients are truly grateful that the financial stress has been lifted and they can focus on their health.'

Automation = More Charity Benefits for your Patients
Since 2001, it is estimated that more than five million low income patients have been enrolled in charity care programs through automated solutions from third party providers.

These solutions rapidly identify patients who meet the criteria for a hospital's charity care program, Medicaid or other financial assistance programs. Using data from third party service provider ensures that each patient's need is assessed on their financial situation, eliminating factors such as age, race, gender, etc. from the process.

More and more hospitals are having these systems routinely check all incoming patients to see whether or not they are qualified for their community benefit program. This ensures that all qualified patients are identified and eliminates any bias.

Automated qualification and enrollment processes connect patients with the programs that were designed to help them. This process saves the patients money, but just as importantly, it preserves their dignity by eliminating concentrated collection efforts.

Saving Time and Money for Patients and Hospitals
Hospitals need to reduce costs across their organizations, but wish to do so without negatively impacting their services or the patient's satisfaction. Third party charity care solutions are one of very few methods that offer a win-win scenario for the hospital and the patient alike by:

- **Reducing Enrollment Time:** Automating this step reduces the enrollment process to just minutes, instead of the hour or more needed to manually process an application -- saving a hospital's financial counselors hours of time spent on paperwork. Likewise, patients find out immediately whether or not they qualify, eliminating added stress from their medical situation.

- **Improving Compliance with Government Regulations:** Hospitals need to demonstrate their commitment to serving their communities. Charity care solutions provide the results and reporting needed to comply with the IRS' 990 Form Schedule H and other state and local requirements.

- **Stopping Unproductive Collection Efforts:** Hospitals can save on their collection processes by eliminating any collection activities on patient accounts that qualify for charity care. Its efforts can be better focused on those who have the ability to pay. In addition, patients enrolled in charity care programs eliminate the anxiety often caused by collection efforts on hospital bills that they are truly unable to pay.

continued on page 10

Hospitals Provide More Charity Care

Curing a Nation's Misperception
Hospitals have been wrongly portrayed as organizations focused more on money than care. Those of us in the healthcare industry know that this is just not true. How can we prove that we are living up to our mission? The clearest answer is by demonstrating community benefit.

Unfortunately healthcare networks are often unable to publicly demonstrate their mission of serving their communities. Manual and inconsistent qualification and enrollment processes offer varied results that often understate their level of generosity.

Using automated charity care solutions, healthcare networks can provide reliable statistics showing their community benefit through the number of patients they have aided, both medically and financially, and the cost of these services absorbed by the healthcare network within their charity care program. Positive public relations are critical to every hospital.

Today's public is mostly unaware of the healthcare industry's generosity to those in need through their unique charity care programs. To address this issue, smart hospitals are implementing strict processes and technologies to enroll all quailed patients and use this information to show their communities their commitment to their mission.

Automating charity care programs is good for the patient, the hospital, and our nation. Thank you notes from patients and hospital staff are just the tip of the iceberg of the appreciation and impact of these systems.

- Bruce Nelson, Vice President,
SearchAmerica, A part of Experian

It's Our Turn To Protect and Serve "Them".

Starting on Thursday October 1st, 2009, a coat drive to honor the U.S. military will begin! We are asking all members to donate gently used or new coats, windbreakers, jackets, and pullovers. These coats will then be given to the Birmingham Veteran's Hospital and distributed to veterans in the area who are in need.

The coat drive is in conjunction with the Fall Institute which occurs on November 12th and 13th at the Wynfrey Hotel. At the Institute the coats will be donated as a special honorarium and thank you to the Birmingham Area Veterans and the Veterans Hospital for all their work and dedication. Veterans Day is on November 11th -so this is an excellent and appropriate community service event.

Since the birth of our country, soldiers have fought for our freedom, and still today, many continue to voluntarily serve as the barrier between us and foreign dangers. When the soldiers return home, it is then our turn to protect and serve them. Not only is this a great opportunity to service others and the community, but it is a great way to thank those who have sacrificed so much to keep our country safe from harm.

THE SUCCESS OF THIS EVENT STARTS WITH YOU AND WE NEED YOUR HELP!

DROP OFF POINTS

Drop Off Location	Address
MedAssist Inc.	1 Perimeter Park South, Suite 300, Birmingham, Alabama 35243
Andalusia Regional Hospital	Collection container located at the front of the hospital
Callahan Eye Foundation Hosp.	1720 University Blvd, Birmingham - call 205-325-8540

The Financial Crisis and Health Reform: Six Strategic and Management Requirements for Hospital Leaders

Executives working in the hospital sector are living through and headed toward what might be the most interesting 20 or 30 years in the history of U.S. healthcare. Although the implementation of Medicare in the 1960s had a large impact on the nation's hospitals, such impact is unlikely to hold a candle to the combined effect of the current financial crisis and forthcoming healthcare reform. The intersection of these forces can be expected to reshape the way healthcare is organized and delivered in this country.

The financial crisis and market events have changed core assumptions and dependencies upon which hospitals operated for decades. As a result, hospital and health system executives now confront a set of strategic and management requirements that are more critical than ever. This article addresses how the key events of the past two years altered basic capital market-based assumptions, impacting hospital balance sheets and operations, and the essential leadership requirements going forward.

What Happened: Its Impact on Hospitals and Core Assumptions

It's now month 23 of the crisis1 and no clear end is in sight. The subprime mortgage crisis sent major shocks through the capital markets, leaving all sectors of the economy affected in some way, most of them negatively. Much talk centers on the stock market, bank capitalization efforts, and whether Federal initiatives to aid ailing companies will turn the situation around or sink the U.S. Treasury into such deep debt that recovery will be impossible for generations to come. The root cause of the crisis, namely bad assets on the balance sheets of many of the nation's leading financial services companies, has been well documented, but lessons learned are emerging ever so slowly.

What is known is that the subprime mortgage problem set off an unprecedented chain of events which sent the stock market tumbling from an S&P 500 of 1468 in January 2008 to 752 on November 20th, 2008-its lowest close since early 1997. Figure 1 provides a time line of the key events.

The Federal government's decision to let Lehman Brothers fail rather than engineer a rescue or a bailout was the sentinel event of the 23-month period-an economic shock too severe for the world's markets to absorb. The U.S. stock market basically collapsed on September 14th when Lehman Brothers filed for bankruptcy, triggering the second-worse market crash since 1932. All types of investments fell simultaneously and dramatically. The firewall that normally protected against losses-i.e., investment in a diversity of stocks that would typically ensure that if one type of stock decreased, the other was likely to have increased-completely buckled, and every stock moved in the same direction, exhibiting what statisticians call a "correlation to one." The market continued to decline into early 2009, reaching a low of 676 on March 9th.[2]

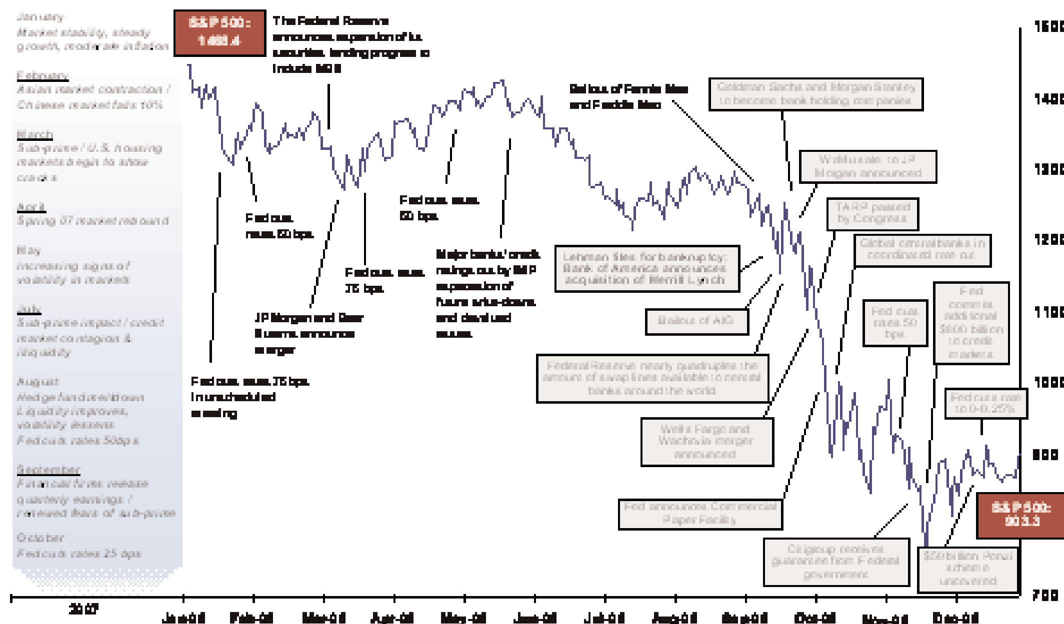

Figure 1. The Unprecedented Chain of Events
Sources: Federal Reserve, U.S. Treasury, Bloomberg, Goldman Sachs.

The decline has had severe effects worldwide, including widespread de-leveraging across the capital markets, falling asset values, dysfunctional credit markets, balance sheet stress for most companies and organizations, and a massive reduction in the capital available for investment. U.S. economic production is slowing; job losses are mounting and unemployment is growing.

Four basic capital-markets assumptions, which have buttressed healthcare finance for the last 40 to 50 years, are no longer valid. This is reflected in a long list of miseries for the nation's not-for-profit hospitals and health systems-a list that is particularly problematic given the fact that the miseries occurred, and are continuing to occur, simultaneously.

Capital Access

Assumption 1: Cheap, dependable capital access would be facilitated by a fully functioning marketplace. The market is significantly compromised and certainly not functioning at any level that could be considered normal. Banks are trying to raise their own equity capital in order to survive. Investment banks, which up through last year could purchase hospital bonds when retail and institutional investor interest fell short of target issuance amounts, are not able or willing to do so now. Hospitals have no "back stop."

Hospital borrowers with strong credit ratings ("BBB+" and higher) are able to sell their bonds, but capital access by many organizations continues to be restricted. After complete closure in late 2008, the public tax-exempt debt market-the primary source of capital for hospitals-is coming back, but improvement is uneven and halting. The cost of capital has increased for all organizations and credit spreads are wider. Overall, the average size (par/issue) of hospital bonds sold since the September 2008 meltdown is smaller, reflecting organizational willingness and ability to take only small bites of new capital rather than proceeding with major recapitalizations. We estimate that approximately 75 percent of client hospital/health systems' current bond sales are for refundings and 25 percent for new money.

Assumption 2: Credit enhancement would be readily available to improve market access and lower cost. Up through mid 2007, bond insurance or bank letters of credit expanded the potential hospital bond buyer universe even for mediocre and unsophisticated credits. Alternative products and structures, with ostensibly lower cost and full commitment, further increased access.

At this point, confidence in bond insurance as a form of credit enhancement is severely shaken; bank-supported letters of credit are a much scarcer commodity. Fixed-rate bonds provide the sole form of fully committed long-term capital for hospitals. Many hospitals have only their own credit rating to support capital access.

Investment Earnings

Assumption 3: Cash retention and creation would generate net investment returns to smooth operating dips and support higher credit ratings. For many years prior to mid September 2008, not-for-profit hospitals borrowed in the tax-exempt municipal market to retain cash on their balance sheets and invest such cash in a variety of investments. Because investment returns exceeded the cost of tax-exempt capital, there was a net positive return. This provided additional profitability for hospitals. For some organizations, such profitability contributed significantly to the creation of capital capacity and the organization's overall financial success. Net negative returns experienced in 2008 and 2009 drew a large amount of profitability and capital capacity out of the industry.

As is true for many investors, hospitals experienced huge asset-side losses with the market's decline, whose plunge was equal to or worse in only 2 of the 183 years since 1825 (Figure 2). Loss of income from diminished cash reserves and pension and endowment portfolios is leaving hospitals without the dollars they regularly depend upon to support operations, bolster "bumps in the road," and maintain higher credit ratings. Most hospitals are significantly poorer than they were in early September 2008. Although the final numbers are not available, hospitals and health systems likely lost 25 to 30 percent of their liquid assets.

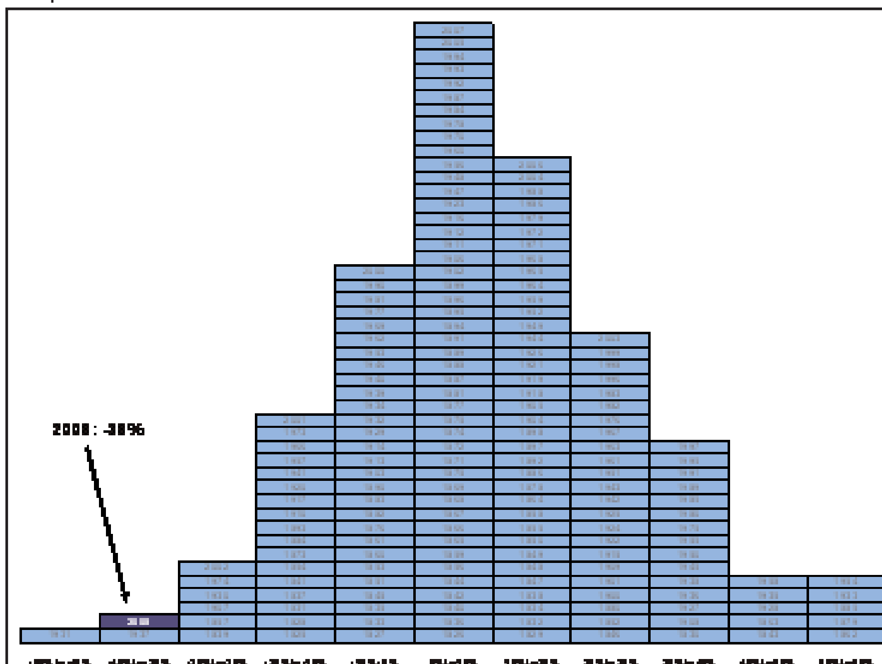

Figure 2. Just How Bad Was 2008?
U.S. Equity Returns by Year Since 1825
Sources: Investment Strategy Group, Yale University; Goldman Sachs.

Calls on Capital

Assumption 4: Funding for large strategic and facility plans would always be readily available, and the only uncertainties associated with access to investor dollars were cost, covenants, and security. Hospitals clearly can no longer rely upon the full cooperation of the capital markets. At this point, capital is available only to strong credits; weaker credits may have no access or access only at a cost that they may be unable to afford.

As a result, by the first quarter of 2009, the majority of hospitals had reduced capital spending. Nearly half had scaled back projects planned or already in process, and more than half deferred planned projects not yet started.3 A large share of these involved facility projects, and more than half involved clinical technology and information technology projects. Given the Obama Administration's emphasis on healthcare IT as a means to improve care (by reducing its variation), to monitor results, and to trim costs, this trend is particularly troublesome.

The support of physician services is a rapidly increasing expense for many hospitals. As physicians' personal and practice cash flows and balance sheets weaken, the trend toward physician employment and increased practice subsidies by hospitals is accelerating. In many markets, physician employment by hospitals is the only vehicle that can assure the availability of physicians to serve the community and support the hospital. Physician strategies represent an additional call on hospitals' scarce operating capital; the physician-support "spigot" cannot easily be turned off.

Unexpected calls on capital to fund defined-benefit pension funds and collateral postings on fixed-payor swaps are further draining hospitals' unrestricted liquidity. Declining liquidity and leverage ratios, particularly days cash on hand and debt service coverage, are threatening to trigger or have already triggered bond and letter of credit covenant defaults for many hospitals. Remediation needs are increasing and are much more difficult to resolve given restricted access to capital.

Loss of Operating Revenue

Volumes have softened in many areas of the country, particularly for elective surgeries in inpatient and outpatient settings. Some hospitals are reporting 2 to 8 percent declines in admissions. With volume loss, hospitals are experiencing lower revenue from commercial payors and increasing expense related to bad debt and uncompensated care for the nation's increasing uninsured and under-insured populations. Typically 4 to 6 percent of revenue, bad debt for some hospitals is now 7 to 8 percent of revenue. When bad debt increases, net income and profitability generally decline on a dollar-to-dollar-basis. This is making recovery of bottom line dollars exceedingly difficult. As state economies try to stem budget deficits and the federal government shapes health reform, uncertainty around future payment levels from public sources is exacerbating hospitals' revenue concerns.

Pressure on Credit Ratings

All of the above is placing downward pressure on hospital credit ratings. In fourth quarter 2008 and first quarter 2009, Moody's Investors Service downgraded 45 hospital bond ratings, while upgrading only 8. The effects of lowered credit ratings-diminished access to capital and higher cost of capital if it can be obtained-are immediate and almost always harmful for a significant period of time. Because healthcare is a capital-intensive industry, organizations must have access to capital to be successful in meeting their missions. Long-term strategies cannot be funded on operating income alone. Given events of the past year, the credit of the entire hospital industry has declined and is continuing to decline substantially.

Crisis-Driven Strategic and Management Requirements

Strategic and management requirements in the new financial era are more pressing than ever for hospital executives; the Administration's promise to enact comprehensive health reform this year exerts additional pressure on all healthcare providers.

Requirement 1. If at all possible, don't allow the hospital's credit rating to be downgraded. The competitive and financial health of providers nationwide depends on the preservation of the highest possible credit ratings. With limited or no availability of credit enhancement, hospitals are only as strong as their own credit rating. This is a "domino environment." Executives should do everything possible to avoid knocking over the first domino. Downgrades can trigger bond and bank document covenants. Remediation, if even possible, most likely results in higher fees and costs.

Requirement 2. Reduce fixed costs. The Obama Administration has suggested that healthcare reform cannot work without a $1.2 trillion dollar cost reduction during the next 10 years. Hospitals' contribution to this effort will require a reduction in actual fixed costs. Nibbling at variable costs, which hospitals have done at various points over the last decades, will not likely be responsive to the challenge issued by the Administration. Hospital management teams and boards will have to look at the hospital's fixed costs and ask really tough questions about whether each building, FTE, piece of equipment, and clinical service can be justified.

Requirement 3. Aggressively and proactively reassess the hospital's strategic and financial position. The spring issue of the Kaufman Hall Report fully describes the key questions to be addressed during the reassessment process.4 Executives must assure the accuracy of the economic underpinnings of financial projections for all major strategic initiatives. Extremely thoughtful and conservative financial planning is

required.

Requirement 4. Consider consolidation trends. Many weaker providers have been pushed over the edge by the financial crisis and now are turning to divestiture as a survival strategy. Strong, independent providers are now re-evaluating their ability to stand alone-particularly those in need of significant capital. Larger, stronger systems are looking at the downturn as a time to re-evaluate their portfolio of operations and are pursuing possible opportunities to consolidate the market. Executives should have a clear understanding of where their hospitals stand in their markets. And, market definitions are changing, as regionalization-involving acquisition by systems of hospitals across state lines-is now occurring with increasing frequency.

Requirement 5. Consider risk. By not understanding total enterprise risk-which includes operating, interest rate, financing, project, and event risk-hospital leadership teams can inadvertently assume more risk than their organizations can handle. Executives must understand how the risk equation changes with strategy selection, cost of capital, and marketplace events beyond the organization's control. Total risk taken must equal the financial ability to accept such risk.5

The recent business press often inaccurately equates all debt with risk; reducing debt ("de-leveraging") does not necessarily reduce risk. Some organizations may have too much debt and need to de-leverage, but this is not always the case. A debt capacity analysis is a good idea at this point. Based on past performance data, expected future performance, and cost of capital, such analysis indicates the level of debt an organization can support at a given credit rating. The analysis uses rating agency medians at selected rating levels as targets for debt ratios. Debt service coverage, debt to cash flow, cash to debt, and debt to capitalization ratios should be used and weighted to reflect the perceived importance of each approach.

Requirement 6. Consider the potential effect on hospitals when the financial crisis intersects with healthcare reform; think the big think. As best as possible, hospital executives should be learning about the potential outcome of healthcare reform. Reform initiatives and the financial crisis drive at least two hospital priorities at this time:

- IT infrastructure and systems that allow the hospital to succeed and prosper under healthcare reform: Central to this will be an effective electronic health/medical record that links physicians, hospitals, other providers, insurers, states, and the Federal government. Quality/care outcome reporting achieved through the transmission of data captured with electronic health records will be vital to any effort to implement disease management and preventive care programs. The Administration is committed to both.
- A physician strategy, particularly related to primary care, and integrated physician-hospital organizations should be front and center on leadership radar screens. As enunciated by Office of Management and Budget Director Peter R. Orszag, Ph.D.,6 the Administration believes that the best way to both improve healthcare and cover the costs of insuring the uninsured is to increase the efficiency and effectiveness of the healthcare delivery system. This will require a high degree of integration between hospitals and physicians. Given current economics, hospitals are likely to employ more physicians in the future. Assuring workable employment/compensation models that benefit hospitals and physicians is critical.

It appears that payment policy changes would be expected to force delivery system changes. How payment to providers will work is a major unknown at this time. The concept of bundled payments to hospitals, physicians, and other providers for episodes of care is receiving considerable attention as a major change driver.

In anticipation of major delivery system and payment transformation, proactive hospital leaders will be "doing the big think." Issues they will address include definition of their organizations' distinct competencies, what they will need to compete in the restructured provider landscape, and alternative delivery models that might best position their organizations for ongoing success as a core delivery platform.

- Kenneth Kaufman, Managing Partner
KaufmanHall

For more information, Ken Kaufman can be reached at 847.441.8780 or kkaufman@kaufmanhall.com.

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5. For more information, see Kaufman, K.: "Managing Risk in a Challenging Financial Environment." hfm, August 2008. Available at kaufmanhall.com.
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HFMA's 3rd Annual Thought Leadership Retreat, Payment Reform: Leading the Way to Change

HFMA held their 3rd Annual Thought Leadership Retreat in Washington D.C. on September 24-25. A group of approximately 100 members from HFMA are invited each year to be a part of this retreat. I was very honored to be one of the members invited from Alabama. I was not real certain what to expect, but as usual, HFMA puts on a first class event and the two day trip to D. C. was well worth the time.

The centerpiece of HFMA's efforts over the past several retreats is to focus on reform of the payment system. With healthcare reform such a high priority for so many stakeholders, it is time to look beyond the structure of reform and begin to consider and plan for the changes that providers, payers and consumers will be making in order to create a high performing and sustainable healthcare system for our country and its citizens.

The agenda included discussion and presentations by experts in their fields, and then a breakout group session in order for the participants to discuss and confer the critical changes that stakeholders must make to create a sustainable healthcare system. As you can imagine, there were multiple opinions and potential solutions, as the groups included hospital executives, physician office executives, payors, as well as vendor representatives from many companies that providers partner with each day.

To me, the centerpiece of the program was the presentation by Robert Galvin, MD., the Executive Director of Health Services and Chief Medical Officer for General Electric. Dr. Galvin is a founding participant of the Leapfrog Group, Bridges to Excellence, and the Center for Payment Reform. Dr. Galvin was very engaging - he really" brought to light" the issues companies face as healthcare costs continue to rise for companies and their employees. I think it was the first time I really tried to put myself in the shoes of a corporation and try to see their side as it relates to healthcare costs and the reform needed to continue to have the ability to provide healthcare benefits for employees.

Dr. Galvin discussed the concept of "hurry up, but take your time". We all know changes are needed, but are we working at the correct speed in order to ensure the best decisions are made to create a win-win for all stakeholders. Most of us heartily agreed with this concept. It really challenged the group to think about what your individual organization is doing in order to effect changes that will positively benefit your community, which includes all stakeholders for your city, county, state, and even nationally.

After a long and thought-provoking day; the group was treated to dinner at Top of the Town, which overlooked the river, our Nation's Capitol and the Washington Mall. It was a spectacular view that we all enjoyed. There was a lot of networking going on as well, before and throughout dinner (of course with some SEC football discussion thrown in!).

On Friday, we had presentations on Pay for Performance as well as the move to ICD-10 in the next several years. Both topics, give most of us heartburn, but are coming our way nonetheless. It is time to concentrate on the hard topics and come up with answers for all of our organizations.

Before we knew it, noon had arrived and it was time to head to the airport. It was a speedy two days that enlightened me a great deal on current issues we are all dealing with and also the opportunity to make new friends in healthcare and HFMA. If there is anything comforting about the current healthcare environment, which we are all living in, it is that there is security in numbers and there are a lot of us across the nation experiencing the same challenges and anxieties that you feel each day in facing what is coming next in the ever-changing face of healthcare.

I challenge each of us in the Alabama chapter to be vocal and be a part of the healthcare reform rather than a victim of the changes in our industry. If we are not leaders of the change, who will be?

- Kim Shrewsbury, CPA, FHFMA
Vice President, Finance and CFO,
Decatur General Hospital

MEMBERSHIP COMMITTEE

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Annette Baker, Blue Cross/Blue Shield
Jonathan Bedell, MedAssist, Inc.
Megan Elliott, Warren, Averett, Kimbrough & Marino
David Hattaway, Waldrop & Associates
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Make it Count is the national slogan for the HFMA and we are COUNTING on our current members to help grow our Membership.

$25 Cash Card
when you recruit a new member.

$50 Cash Card
when you recruit a Sr. Financial Executive

Welcome to all our new members and transfers. I look forward to meeting you at our Fall Institute in Birmingham at the Wynfrey on November 11-13.

Lonnie Younger, Membership Chair

Alabama Chapter moves forward with going Green, saving the environment as well as those green dollars

I'm sure many of you are experiencing changing times and having to look at how you can make your organization more efficient, effective, offer the same quality product at less cost.

Well your Alabama HFMA Chapter is no different. We want to offer quality education, up-to-the-minute information, and opportunities to stay connected in a most efficient manner. After several of us attended numerous meetings, and then talking as a board, we feel it is best that the Bama Chatter continue it's same quality newsletter, but cut back on the costs. The Bama Chatter will now come to you 4 times a year via the web site.

As each edition is ready for 'print" you will receive a web blast alerting you that the news is "hot and ready" for your perusal on the web site. A link will be included in the blast giving you immediate access to the newsletter, then you will have the opportunity to view the entire edition on line, print the entire edition, or even pick and choose the sections you want to review (and I KNOW you will want to go to the Editor's section immediately).

We appreciate your understanding. Those of us who are the matures and the baby boomers may be going aw man - but we've got to step up to the plate join the 21st century, get the info to you, save some pretty significant dollars - and do our part of Going Green.

If you have any questions, give me a call, we're happy to see you.

Libby

Central Florida Health Alliance, a two-hospital (309 bed Leesburg Regional Medical Center &198 bed Villages Regional Hospital), private regional provider health system located just north of Orlando has engaged Witt/Kieffer to identify candidates for their number two finance position. The Controller has over 350 experienced, board certified physicians offering the most specialized care in the state.

Reporting directly to the System CFO, the ideal candidates will ideally have a CPA and a graduate degree. In addition, complex hospital accounting experience and strong presentation and problem-solving skills are a must.

Interested candidates should send resumes to:

CentralFloridaController@wittkieffer.com
Carson F. Dye, FACHE and Paige Westhoff

Message from Region V

Mitzi Winters, FHFMA
Region V 2009-10 Regional Executive

Recently, I had the pleasure of participating in the Fall President's Meeting (FPM) with representatives from Region V Chapters. In attendance were the five Presidents and Presidents-Elects of the Alabama, Florida, Georgia, South Carolina and Tennessee Chapters along with representation from the HFMA National Board. The time was well spent discussing items that are a priority for not only National, but also for all of the chapters; which ultimately is centered around 'you' the 'membership'. Their number one goal is to make sure they are to providing the Value to you which is even more important today through communication and education opportunities, whether it be in workshops, seminars, teleconferences, publications or websites. Everyone shared what was working and what wasn't working in their chapters and was eager to benefit from each other's knowledge and experience.

Since the FPM, I have also participated in calls with the Chapter's Leadership and attended several of the Chapter Board meetings. Although I already knew it, I am even more convinced of the Strengths of the Chapter in Region V and the dedication of your Chapter Leadership. The time they spend on voluntary work to keep their chapters not only running, but to make it even better with less, is amazing. If you aren't participating in your chapter in some form, I would highly encourage you to get involved. Every chapter is reaching out to their membership through committees to engage members in their areas of interests. Sometimes, I think our problem is that we make it look too simple. You come to an event and all goes smoothly (hopefully) and you don't realize the number of hours and the number of people that worked behind the scenes making it happen. Trust

me; you would be amazed in most cases! From Jerry Smith's efforts on the Fall Institute for November, to Tavie Bender's work on the Insurance Road shows recently - lots of behind the scenes work. Libby Bailey is always looking for help on the newsletters and for interesting articles - Lonnie Younger has a great group working on the Membership Committee. Volunteer month is coming up in February and I know Linda Maddox is looking for people to help……………..

Being a member of the Alabama HFMA Chapter since 1989, I have had the pleasure of direct participation and it is a fulfilling feeling. So think about what you'd like to do or maybe an area that you feel needs concentration and contact a Board member and MAKE IT COUNT.

- Mitzi Winters, FHFMA
Region V 2009-10 Regional Executive
Medassist, Inc.

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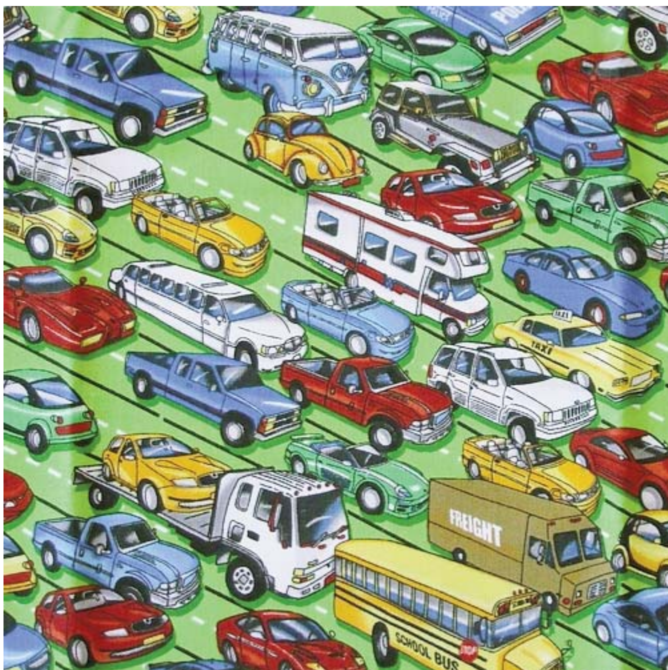
Jammed Access: Widening the Front Door to Healthcare - A Summary
By Bill Orrell

Access to healthcare in the United States is jammed and universal insurance coverage is only part of the solution. This summary will give an introduction to the major points of an article published by the Health Research Institute at PricewaterhouseCoopers.

"By several measures, access to care is jammed for many Americans, both insured and uninsured. As health reform in Massachusetts has demonstrated, access to coverage does not translate into access to care. Almost immediately, after health reform brought near universal coverage to that state, residents began complaining about long waits to access care. If universal coverage meant that Massachusetts, a state with the highest number of physicians per capita, was wracked with physician shortages, then what are the implications for the rest of the nation?

As Congress discusses ways to provide the universal coverage other nations have, discussion of access to care must follow closely behind. Indeed, the ultimate issue is how to expand access without increasing costs. The United States now spends more on healthcare than any nation and has a record number of clinicians in the workforce. Instead, solutions will lie in new models of care and in using technology, incentives and in behavior change to unclog the jammed access points. A consumer survey conducted by PricewaterhouseCoopers' Health Research Institute shows that the current system has numerous jammed access points, but that consumers and some providers are "open to changes".



The Emergency Department as the Front Door

Utilization of the Emergency Department (ED) is at an all time high. There were 121 million ED visits in the U.S. in 2007, which represented a 30% increase over ten years. At the same time visits were going up, the number of EDs has gone down, declining 5% over the same period. The healthcare consumer survey revealed that less than half of patients went to the ED for what was perceived as an emergency.

ED overcrowding, frequently blamed on the uninsured patient population, was found to be a result of patients with health insurance. Additionally, analysis of data from the American Hospital Association and the Kaiser Family Foundation revealed an inverse relationship between uninsured population by state and emergency department visits. States with high ED utilization per capita tend to have a low uninsured population. For example Massachusetts, which has the lowest uninsured state population, is in the top ten for ED utilization per capita. One possible explanation is that as insurance coverage expands, capacity becomes strained in other areas such as physician offices and the ED becomes the only available access point.

Medicaid patients, in the consumer survey, reported the greatest difficulty in accessing providers. One in three Medicaid patients reported waiting 30 days or more for an appointment with their assigned primary care provider. Forty-four percent of Medicaid respondents reported an ED visit in the last 12 months compared to twenty percent of uninsured patients. Medicaid patients were also more likely to use the ED for non-emergent care than other respondents.

The survey results lead to a significant strategic decision for most hospitals. As more Americans become insured under proposed healthcare legislation, combined with a national primary care provider shortage, increased crowding in the nation's Emergency Departments may result.

Additional Jams in the System

A growing shortage of mental health providers has congested access to care. Hospitals reported a 70% increase in psychiatric admissions from 1986 through 2004, while mental health bed capacity declined by 35% from 19 to 14 beds per 100,000 people. A mental health bed shortage has contributed to an ED average length

of stay that is double that of other ED patients and results in boarding of mental health patients waiting bed placement.

Americans generally wait to become involved in their own healthcare until they are diagnosed with a chronic illness. This creates additional jams in the system as chronic care is much more resource intensive than preventative care. Survey respondents also reported that chronic care was much more difficult to obtain than emergent care, urgent care or preventative care. Over forty percent of Americans have one or more chronic illnesses and due to lifestyle choices, many historically adult chronic diseases are now diagnosed in younger populations. This is shifting the healthcare demand curve, and resultant expense, to earlier in our lives.

Finally, one of the greatest impediments to healthcare access is healthcare organizations are working hard but not necessarily together. A typical primary care provider interacts with 229 other physicians to coordinate care for their patient population. The complexities of patients, coupled with lack of information sharing, results in redundancy in testing and procedures.

The Openings

Organizations are working on unclogging the healthcare system by focusing on new or improved pathways to care that increase access, lower costs and are easily replicated. At the same time, consumers are showing an interest in participating in alternative delivery methods. Presently, only 3-5% of physicians utilize email to communicate with their patients while, based on survey data, the most popular methods of communication for consumers were internet and telephone. Accessing the internet for care and not just information is becoming more commonplace. Presently, consumers access the internet for health related information through blogs, support groups and disease specific information. Some progressive health systems and health plans have moved to web-based scheduling and personal health information portals.

Online care has become a valuable resource in some parts of the country. The Hawaiian Medical Services Association recently launched an online care program that charges members a small fee for an online consultation with a network physician. This program is a result of a desire to solve healthcare access issues for rural members living on neighboring islands. The majority of consultations are for primary care, non-urgent issues but can also be utilized by providers to manage patients with chronic disease.

Telehealth and low-cost mobile technology are increasing access to much needed specialists and increasing self-care for consumers. The American Telehealth Association defines telehealth as, "the use of medical information exchanged from one site to another via electronic communications such as videoconferencing, transmission of still images, e-health including patient portals, and remote monitoring of vital signs ". The healthcare consumer survey revealed that seventy-three percent of consumers would be interested in remote monitoring provided through telehealth services. In the near future, remote biometric monitoring will have a significant impact on health promotion and disease management through the use of sophisticated, inexpensive mobile technology.

Many organizations are utilizing alternative points of care, in workplace and retail clinics, to provide convenient access for consumers. Retail clinics total approximately 1,200 nationwide and have served over 3.5 million individuals in the last 8 years. Large retail chains such as Walmart, Walgreens and CVS have rapidly expanded their footprint in this industry. The most prevalent use of retail clinics are for minor conditions such as colds, earaches, and sore throats but some are piloting specialized services such as vaccinations for seasonal conditions.

Finally, based on survey results consumers prefer a team of practitioners who understand their social, medical, and general health needs. The medical home model has been described as one solution to team care, but there is no consensus on who should lead the medical home and multidisciplinary team. Medicare is providing payment incentives for coordination of care between physicians and hospitals. The aim of these incentives is to promote coordination and accountability for populations or at least an individual through their episode of care.

While these solutions are providing improved access for consumers there is not one "best" plan for providing access and a combination of efforts may be the key to healthcare access for all.

- Bill Orrell RN, MSN, MBA
Health Industries Advisory,
PricewaterhouseCoopers

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Certified Patient Account Representative

It's that time again to begin preparation and coaching for the Fall Session of the 2009 Certified Patient Account Representative (CPAR) Exam.

On May 16th, sixty-four participants tested throughout the state. We had forty-eight to pass.

You, your staff, and your organization can benefit from participation in the CPAR program. We encourage you to sponsor CPAR by actively supporting your staff's participation. Coaching sessions are held in locations throughout the state.

I encourage your staff to register online for this educational, interactive session. The Coaching session will provide study techniques, chapter reviews and sample questions.

The CPAR committee is working to update the CPAR manual at this time in an effort to give all CPAR members the latest information at their fingertips. If you are interested in working with our team, please contact me directly @ 205-599-3846.

Please visit our website for at www.alabamahfma.org for more information.

Over the past couple of years, we failed to honor our recipients in the Bama Chatter. At this time, we want to take this opportunity to list all of those recipients from Fall 2007 through Spring 2009.

Fall 2007

Cynthia Franklin - Baptist Health Montgomery South
Juanita Pollard - Baptist Health System
Lisa Parnell - Brookwood Medical center
AmeCherie Thomas - Brookwood Medical Center
Antoinette King - Brookwood Medical Ctr
Nile Brown - DCH
Rodney Cannon - DCH
Rachel Durrough - DCH
Rhonda Steele-Rice - DCH
Jil Sumners - DCH
Ruby Davis - Glenwood, Inc
Sharon Gates - Grove Hill Memorial Hospital
Annette Brown - Holloway Credit Solutions
Adrienne Calloway - Holloway Credit Solutions
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Stephanie Doss - Holloway Credit Solutions
April Payne - Holloway Credit Solutions
Richard Powell - Holloway Credit Solutions
Thomasina Willis - Holloway Credit Solutions
Stacy Gunter - Jackson Medical Center
Shaye Pugh - Jackson Medical Center
Nicole Pugh - Jackson Medical Center
Laura Reynolds - Jackson Medical Center
Sheila Simpson - Marshal Medical Center South
Ashleigh Hallman - Marshall Medical Center North
Jennifer Bashaw - Marshall Medical Center South
Janice Bruce - Marshall Medical Center South
Doris Lang - Marshall Medical Center South
Wendy Walters - Marshall Medical Center South
Freita Erkins - Medical Center Barbour
Renae Fleming - Medical Center Barbour
Cheryl Hatfield - Medical Center Barbour
Leisa Rogers - Medical Center Barbour
Amanda Biggs - Mobile Infirmary
Holinda Martin - Mobile Infirmary Medical Center
Jennifer Barnhill - Northport Medical Center
Mathew Butler - Northport Medical Center
Rachel Constant - Northport Medical Center
Latia Johnson - Northport Medical Center
Faith McKay - Northport Medical Center
Dianne Rogers - Northport Medical Center
Tammy Strickland - Northport Medical Center
Pamela Warbington - Northport Medical Center
Carla Brackett - Proxsys
Latosha Mushatt - Proxsys corp
Teresa Cantrell - Southeast Alabama Medical Center
Tina Dean - Southeast Alabama Medical Center
Mackenzie Simmons - St. Vincent's Birmingham

Fall 2007, continued

Vanessa Adams - St. Vincent's Birmingham
Lakea Postell - St. Vincents East
Jennifer Paxton - St. Vincent's Hospital
Shannon Whitaker - St. Vincents Hospital Birmingham
Brandy Dawson - St.Vincent East
Janetta Clackley - St. Vincent's Health Systems
Stephaine Posey - St.Vincent East
Barbie Walker - St. Vincents St. Clair
Teresa Davis - Summit Hospital
Letasha Rush - Summit Hospital
Kesha Scurry - Summit Hospital
Jennifer Thompson - Summit Hospital
Terry Beard - Trinity medical center
Carol Chaffin - Trinity Medical Center
Lynda McLean - Trinity Medical Center
Tabrielle Swanson - Trinity Medical Center
Larry Hodnet - Trinity Medical Center
Kimberly Jones - Trinity Medical Center
Melissa Belton - UAB Hospital
Roosevelta Brooks - UAB Hospital
Renita Pruitt - UAB Hospital
Josette Patton - UAB Hospital
Tonya Bates - Wiregrass Medical Center
Gloria Cross - Wiregrass Medical Center
Norma Danley - Wiregrass Medical Center
Gayle Dixon - Wiregrass Medical Center
Kay Durant - Wiregrass Medical Center
Brenda Fountain - Wiregrass Medical Center
Dorothy Arlene Gill - Wiregrass Medical Center
Dartha Henneberger - Wiregrass Medical Center
Sheila Ingalls - Wiregrass Medical Center
Ruth Yeagley - Wiregrass Medical Center
Anthony Jones

Spring 2008

Kelly Allen - Baptist Medical Center
Vanessa Stacks - Baptist Medical Center
Patricia Daniels - Brookwood Medical Center
Christina Elmore - Brookwood Medical Center
Kelly Mosley - Citizens Baptist Medical Center
Seneca Murner - Citizens Baptist Medical Center
Joyce Cate - DCH Regional Medical Center
Paula Cook - DCH Regional Medical Center
Joyce Doss - DCH Regional Medical Center
Miriam Leftwich - DCH Regional Medical Center
James Naraisse-Cowar - DCH Regional Medical Center
Sharon Ott - DCH Regional Medical Center
Mary Kathryn Walker - DCH Regional Medical Center
Kimberly Perrine - Grove Hill Memorial Hospital
Ashley Anderson - Holloway Credit Solutions
Kris Arnold - Holloway Credit Solutions
Kristina Bacos - Holloway Credit Solutions
Ayshea Howard - Holloway Credit Solutions
Ashley Ryals - Holloway Credit Solutions
Dawn Sanders - Holloway Credit Solutions
Linda Dowdey - Marshall Health System
Jessica Gosselin - Marshall Health System
Amanda Hopper - Marshall Health System
Queen Carter - Northport Medical Center
Ashley Edwards - Northport Medical Center
Willie Miles - Physicians Medical Center Carraway
Susan Amorin - Proxsys
Valerie Hicks - Proxsys
Elizabeth Salem - Proxsys
Jennifer Sliman - Southern Medical Business Serv
Christine Butler - Springhill Memorial Hospital
Pamela Prine - Springhill Memorial Hospital
Cheryl Wiggins - Springhill Memorial Hospital
Adrieanna Weldon - St. Vincent's St. Clair
Valisa Jennings - St. Vincents East
Candi Crocker - St. Vincents Health Systems
Phyllis Sisson - S.t Vincent's Health Systems
Benita Pullom - St. Vincent's Birmingham
Barbara Smoot - St. Vincent's Birmingham
Johnathan Bedell - St. Vincent's Health System
Sonya Buchanan - St.Vincents
Melanie Davis - St Vincent's St. Clair
Jeanette Dunn - Trinity Medical Center
Carole Cash - UAB
Nikisha Loftin - UAB
Santrice Moody - UAB Hospital
Arleita Carter - UAHSF

Fall 2008

Roshanda Gulledge - AAPC
Leighanne Riner - Baptist Health System
Susan Cuchetti - Bradford Health Services
Brittany Williams - Bradford Health Services
Jacqueline Milam - Citizens Baptist Medical Center
Christina Elliott - DCH
Shaterrian Henry - DCH
Nancy Howell - DCH
Trenna Norwood - DCH
Brian Pendley - DCH
Crystal Thomas - DCH
Elisabeth Fischer - Enterprise Medical Clinic
Veda Godwin - Enterprise Medical Clinic
Kimberly Jinright - Enterprise Medical Clinic
Mary Noble - Enterprise Medical Clinic
Nicole Padilla - Enterprise Medical Clinic
Heather Allday - Grove Hil Healthcare
Emily Steadham - Grove Hil Healthcare
Carol Aiken, CMM - Huntsville Hospital
Trina Threatt - Lifeguard Ambulance
Rebecca Stokes - Marshall Medical Center
Adrianne Smith - Mobile Infirmary
Annette Wampler-Rivera - Mobile Infirmary
Jenny Buck - Mobile Infirmary Medical Center
Heather Foster Garcia - Mobile Infirmary Medical Center
Jeronica McGhee - Proxsys
Quentana McGinnis - Proxsys
Michelle Pickett - Proxsys
Kimberlyn Swank - Proxsys
Ebony McKinney - Proxsys Corporation
Misty Howard - Proxsys, LLC
Denise Anderson - SAMC
Jessica Andrews - SAMC
Stephanie Brannan - SAMC
Martha Callins - SAMC
Copelynn Foster - SAMC
Crystal Gibson - SAMC
Sharla Lauderdale - SAMC
Rhonda Peterson - SAMC
Keesha Rhodes - SAMC
Stephanie Tolbert - SAMC
Tamara Davis - Southeast Ala Medical Center
Jennifer Sierke - Southeast Ala Medical Center
Genice Glover - Southeast Alabama Medical Center
Marilyn Lisenby - Southeast Alabama Medical Center
Eliabeth Taylor-Harris - Southeast Pain Management
Jaline Thomas - St Vicent's Health Systems
Jennifer Woods - St. Vincents Blount
Sharon Petty - St. Vincent's East
Jodie Williams - St.Vincents East
Bridget Gober - St. Vincents Hospital
Sylvia Walker - UAB Highlands
Burnita Mobley - UAB Hospital
Delaine Robinson - UAB Hospital
Angela Sullivan - UAB Hospital
Tracey Cunningham - University Health System
Jennifer Jones
Tangela Reynolds
Angelica Wright

Fall 2009 CPAR Certification Exam

Testing

The CPAR test will be held on Saturday, November 14, 2009 from 8:30am to 1:00pm. The deadline for registration is Friday, October 30th . The CPAR examination is pass/fail and **no scores will be released**.

If you have any questions, please contact Tavie Bender @ 205-599-3846 or via email @ tavie.bender@trinitymedicalonline.com

Register online today!

To sit for the CPAR Exam, you must attend one (1) coaching session. We encourage you to register online. When registering, you are required to select one (1) coaching location date and one (1) test site location for the CPAR Institute Agenda. If you register online, you do not need to print and mail in registration forms. You will receive an email confirmation that will include the locations you selected.

Applications will be available to print and mail in along with deposit. To ensure your application is legible, please print!

Fees

Total fee: $50.00
Deposit: $15.00 due at the time of registration. The remainder ($35.00) is due by November 14th. You may pay the remainder on the date of the test. We encourage you to register online. You may register and pay online via **credit card**. If you pay online using your credit or debit card, you will be required to pay in full.
Due to the administrative cost in handling returned checks, **we will no longer accept personal checks**. If you are a Hospital or other Healthcare provider and you are making payment on behalf of employees sitting for the CPAR exam, we will accept a company check.

Coaching Sessions and Test locations

Mobile Infirmary Medical Center
5 Mobile Infirmary Circle
Mobile, AL 36607

Coaching Dates and locations:

Thursday, October 29th at Hearin-Chandler Auditorium from 5:30pm-7:30pm, **Coach will be Jennifer Bartlett**

Saturday, November 7th at Hearin-Chandler Auditorium, from 9:00am-11:00am, **Coach will be Janet Wilson**

Saturday, November 14th at SSI Corporate Offices, CPAR Exam Registration at 8:30, testing from 9:00-1:00, **Proctor will be Jennifer Bartlett**

Test Site Location:
The SSI Group Training Room
4721 Morrison Drive
Mobile, Alabama 36609

Marshall Medical Center South
Jo Ann Hudspeth - joann.hudspeth@mmcenters.com
Marshall Health System
227 Brittany Road
Guntersville AL 35976
Phone: 256-894-6631 Fax: 256-894-6643

Coaching Dates:
Saturday, October 17, 2009
8:00 AM - 4:00 PM

Coaching and Test Site Location:

Marshall Medical Center South
POB Classroom
2505 AL Hwy 431 North
Boaz, AL

DCH Health System
(DCH Regional Medical Center)
Michael G. Wilson - MWilson@DCHSYSTEM.COM
809 University Blvd East
Tuscaloosa, Al 35401
Phone: 205-343-8500 Fax: 205-759-6397

Coaching Dates:
Wednesday, October 28th (4:00 PM - 8:00 PM)
Wednesday, November 4th (4:00 PM - 8:00 PM)

Coaching and Test Site Location:

Willard Auditorium at DCH RMC
809 University Blvd East
Tuscaloosa, Al 35401

Grove Hill Memorial Hospital
(Conference Room of Hospital)
Elaine Averett - enaverett@yahoo.com
295 South Jackson Street
Grove Hill, AL 36451
Phone: 251-275-3191 Fax: 251-275-4281

Coaching Dates:
Saturday, October 24th (8:00 AM - 12:00 PM)
Thursday, November 5th (5:00 PM - 8:00 PM)

Coaching and Test Site Location:

Grove Hill Memorial
295 South Jackson Street
Grove Hill, AL 36451
Conference Room of Hospital

Southeast Alabama Medical Center
Erika Chancey - emchancey@samc.org
Ross Clark Circle
Dothan, AL 36301
Phone: 334-793-8827

Coaching dates:
Southeast Alabama Medical Center
Monday, October 19th (5:30PM - 8:30 PM) Auditorium Conference Room
Thursday, October 22nd (5:30 PM - 8:30 PM) Auditorium Conference Room

Coaching and Test Site Location:

Ross Clark Circle
Dothan, AL 36301
Auditorium Conference Room

Trinity Medical Center
Tavie Bender - Tavie.Bender@trinitymedicalonline.com
School of Nursing Group Floor Harris Auditorium
720 Montclair Road
Birmingham, Alabama 35213
Phone: (205) 599-3846

Coaching Dates:
Saturday, October 24th (9:00 AM - 12:00 PM)
Thursday, October 29th (5:30-p.m. - 8:30p.m.)

Coaching and Test Site Location:

Trinity Medical Center
School of Nursing Group Floor Harris Auditorium
720 Montclair Road
Birmingham, Alabama 35213

Northeast Alabama Regional Medical Center
Bruce Turner - bturner@rmccares.org
400 East 10th Street, PO Box 1380
Anniston, AL 36202
Phone: (256) 235-5860

Coaching Dates:
Wednesday, November 4th - 5:30PM - 8:30PM
Tuesday, November 10th - 5:30PM - 8:30PM

Coaching and Testing Location:

400 East 10th Street, PO Box 1380
Anniston, AL 36202
1st floor classroom of The Tyler Center

Baptist Health Montgomery
Corporate Administration Building
301 Brown Springs Road
Montgomery AL 36117.

Coaching Dates:
Tuesday, October 13th (8a.m. - 12 Noon)
Tuesday, October 13th (1p.m. 5p.m.)
Thursday, October 15th (5p.m. - 9p.m.)
Saturday, October 31st (9a.m. - 1p.m)

Coaching and Testing Location:

Corporate Administration Building
301 Brown Springs Road
Montgomery AL 36117

Editor's Note

A Note from the Editor

The 4 H's - Holidays, Help, Healthcare Reform and HFMA

HOLIDAYS: As November approaches, we all begin to turn our thoughts to the holidays - Thanksgiving, Christmas, the Iron Bowl, New Years and the Super Bowl (yes some people think football is a holiday). Holiday season means different things to different people. It is time to be with family and friends, it is a little time off from work, it's good food and lots of calories, naps, football, shopping, decorations, and probably even some debt.

But what does all this have to do with HFMA? As folks working in the healthcare field, our ultimate goal is to be sure our patients receive the best possible care; they go away from our entities knowing that we helped them; we made a difference in their lives. Whether you are the financial executive, the compliance officer, the revenue cycle director, a vendor, or an exhibitor, we all can do our part. We are in our field because we want to make what we do count - we want to reach out and touch human lives.

Feeling a little down at work lately, because maybe your bottom line isn't where it should be or you want it to be? You having to make some tough choices and decisions that keep you awake at night, or cause you to have heart-burn or pull your hair out? Well, as usual, your HFMA chapter is giving you the opportunity you need - you can "make a difference" and make the "easy" decisions.

HELP: As a part of our Fall Institute, we are doing a coat drive for our Veterans and their families. The meeting kicks off on Veterans Day - and we ask that everyone wear something red, white, and blue to show our patriotic spirit. The easy decision for you is: bring something for those guys and gals that can make a difference in their lives, by helping put your arms around them and keeping them warm. Many of them have served in areas where the temperatures go from one extreme to the other - very very hot to very very bone chilling cold. Let's be sure they don't get cold this winter.

I will admit, I probably didn't have as much an appreciation for our men and women that served our country until my son-in-law was one of those guys. Matt served in Iraq just as the war with them was beginning. Fortunately he made it home safe, but not without some physical and mental scars (some too painful he cannot and has not completely gotten over). I now see how much it means to Matt when someone publicly thanks him for what he did, and I also see how much it hurts him when people just think "whoopee, get over it - it's your job, you use our tax dollars - so you are just doing what is expected of you".

Libby Bailey, CPA, FHFMA

So we need to step up to the plate-help these guys receive the recognition they deserve.

HEALTHCARE REFORM: Speaking of defending our country and our freedom, now we have this little thing over our heads called "health-care reform". I'm sure none of us will disagree that something needs to happen, but oh my gosh - talk about making some tough decisions. Kim wrote a very interesting article (see page 15) from her meeting she attended in Washington and I think there was a very strong point in there - what are "we as health-care managers" doing to be sure our patients, our entities, and our communities are protected from bad decisions made from lack of input from those "in the know" or because of incomplete data?

HFMA: So from a HFMA perspective - do what you do everyday - take care of those around us:

- **HOLIDAYS** - enjoy them
- **HELP** - keep someone warm for the winter, and
- **HEALTHCARE REFORM** - get involved so that we make what we do count, and the decisions that are made are the right ones- the ones that will instill confidence in our healthcare system, and assure us that all of the wonderful hospitals, clinics, EDs, nursing homes, physicians, etc. around our nation are still standing much as our veterans do "up tall, shoulders back, head high" knowing that our duty of leaving "safe and secure" healthcare to all citizens has been accomplished.

- Libby Bailey, CPA, FHFMA
Newsletter Editor
Callahan Eye Foundation Hospital

Editor's Note

As editor, it is my prerogative to have 2 articles this time: But you'll enjoy this article, because it involves $$$$$$$$$$$$.

We constantly need someone to write articles for the Bama Chatter. We have decided not to "print" the Bama Chatter anymore - so the good news about that is - we can use as many articles as we want, and they really don't have to be "kept short" - well unless you want to write a book, then I might have to pull an ole editor's decision to paraphrase. For every article you send us over the next few months, your name will be put in a drawing for $50, which will be drawn at the Annual meeting in Destin. You do not have to present to win this prize - and the more articles you submit, the more times you get your name in the drawing.

Also, when you read the Bama Chatter - send me an email ebailey@uabmc.edu and tell me what you liked about the November issue (or didn't like) or just that you read it - and your name will go into a $50 drawing at the Fall Institute. You do not have to be present to win.

Moral to the story: READ THE CHATTER - IT MIGHT REALLY MATTER (to your wallet at least).

- Libby Bailey, CPA, FHFMA
Newsletter Editor
Callahan Eye Foundation Hospital

Editorial Mission

The ***Bama Chatter*** supports the mission of the Alabama Chapter by serving as a key resource for individuals involved or interested in the financial management of health care.

Editorial Policy

Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Alabama Chapter, the Healthcare Financial Management Association, or the Editor. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated.

Publication Objective

The ***Bama Chatter*** is the official publication of the Alabama Chapter of HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

Article Submission

The ***Bama Chatter*** encourages submission of material for publication. Articles should be typewritten and submitted electronically to the Editor. The Editor reserves the right to edit, accept or reject materials whether solicited or not. HFMA Founder Points are granted for any articles published in the Bama Chatter.

Interested in Advertising in the *Bama Chatter?*

The ***Bama Chatter*** is a quarterly, four-color publication. All four issues are e-letters and are emailed to our entire membership roster.

The ***Bama Chatter*** is also archived on our website for our membership and outside interested parties to access the information.

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Please refer questions to our editor:
ebailey@uabmc.edu

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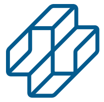

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