



# From Acorn to Oak and Beyond

*An Update to the History*  
OF THE  
Healthcare Financial  
Management Association

*1991–2006*



hfma™

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# Foreword

In 1991, the Healthcare Financial Management Association was the beneficiary of a wonderful gift.

Robert M. Shelton, CAE, FHFMA, wrote a history of HFMA, the organization he served so well, which HFMA published to honor its 45th anniversary. That history, titled *From Acorn to Oak*, captured the energy and vision of HFMA's founders, as well as its growth from, as Bob stated, "a small company of hospital accountants" to a leader in the complex and crucial field of healthcare finance.



Bob Shelton

For Bob, the labor of love that was *From Acorn to Oak* was just one example of his commitment to HFMA.

Bob began his career in healthcare financial management at Mercer Hospital, Trenton, N.J., where he served as chief accountant. His tenure with HFMA began in 1950, when he joined the American Association of Hospital Accountants (later renamed HFMA). Bob served as president of the New Jersey Chapter of AAHA. He was elected to AAHA National Board of Directors in 1956, and for two years served as Chairman of the Board's Committee on Chapters. His career with HFMA accelerated in 1958 when he was elected President of the AAHA Board of Directors. In 1959, he was appointed as the executive director of AAHA National office, a position he held until 1978. Following a 1978 restructuring, Bob became HFMA's vice president. He retired in 1981, but remained active until passing away on September 22, 2003.

Bob represents why HFMA is such a special and important organization.

He was a *member* who felt a commitment not just to finance, but to healthcare finance—to making the resources available for the important mission of healing

and improving health. HFMA's members and their professional skill and dedication make HFMA strong and are its reason for being.

Bob was an active *volunteer*, devoting his time to leading an organization he felt had an important role to play in the nation. I continually am in awe of the time, effort, and talent HFMA's volunteers bring to this organization. HFMA could not function without them.

He was a dedicated *staff* member, devoting himself tirelessly to providing better services to HFMA's members. HFMA's staff continue to play a key role in developing and delivering HFMA's services.

Finally, Bob's devotion to HFMA exemplifies a quality that transcends his roles as member, volunteer, and staff—a devotion to his fellow toilers in the fields of healthcare finance that HFMA's 2003–04 Chairman David Canfield, FHFMA, captured best in his Chairman's theme, HFMA: It's Personal. HFMA is more than the sum of its members, volunteers, and staff. It is a personal connection among people, a way to give and draw strength as we pursue a shared passion to serve.

In honor of HFMA's 60th anniversary, we are delighted to offer you this update to Bob's HFMA history. This update covers the years 1991–2006—a period of unprecedented change for health care, and a period in which HFMA truly has grown into a leader—an indispensable resource for healthcare finance.



Richard L. Clarke, DHA, FHFMA  
Westchester, Ill.  
June 2007

# Introduction to the 2006 Update

In many respects, HFMA is not the same organization it was in 1991, when the first edition of HFMA's history, *From Acorn to Oak*, rolled off the presses.

HFMA has a larger membership. It speaks in a more authoritative voice to a more sophisticated group of professionals. It addresses issues that were barely blips on the radar in 1991, such as consumerism, electronic health records, the capital crunch, and transparency. And it has transformed the way the field looks at evergreen issues, such as the revenue cycle. HFMA also is more technologically savvy about how it reaches its members and helps members reach each other.

Navigating industry changes and challenges, HFMA has continuously moved forward, creating and improving products and services that help and inspire members to advance their careers and organizations. These products and services include educational content and vehicles, issue analyses, certification, online communications, and member forums.

HFMA also has undertaken landmark efforts to analyze and improve industry practices through projects, such as **PATIENT FRIENDLY BILLING®<sup>a</sup>** and **Financing the Future**.

Healthcare financial managers are more sophisticated today than they were in 1991. They wear more hats and have a voice in more decisions. They have a broader circle of professional colleagues, including clinicians. They know more about health care and can do more to help their organizations succeed.

However, in some respects HFMA today is the same as it was at its inception.

HFMA members express the same dedication, enthusiasm, spirit of caring, and resolve that animated HFMA's founders 60 years ago. Ask today's members why they work in health care, and most say, "It gives me an opportunity to make a difference."

a. PATIENT FRIENDLY BILLING® is a proprietary trademark of Healthcare Financial Management Association, Copyright © 2007, Healthcare Financial Management Association, All Rights Reserved.

They readily acknowledge that healthcare finance is a crazy business. In what other field do you perform the service, then ask for payment, and then maybe you get it and maybe you don't. And by the way, your largest payer pays below your cost. But these professionals are committed to the *real* business of health care: helping people. This commitment is both professional and personal, and it creates a strong bond among HFMA's members.

By tradition, the incoming Chairman of HFMA's National Board chooses a theme that will guide his or her leadership of the organization during the year. In 2003, David Canfield, FHFMA, picked a theme that, for many, has come to characterize what the Association is all about, HFMA: It's Personal. That is one facet of HFMA that will never change.



## CHAPTER 1

# Strategic Direction

If only two words could be used to describe how Healthcare Financial Management Association’s strategic direction has evolved from the early 1990s until today, those words would be “thought leadership.”

Today, HFMA is more market-focused. It is more intent on listening to its members and responding to their immediate needs and wants. But it is also more forward-looking—more what President and CEO Richard L. Clarke, DHA, FHFMA, calls a thought leader.

“As a thought leader,” said Clarke, “we can be a change agent on two different levels. One level is developing new tools and solutions for our members’ day-to-day problems. The other is looking ahead and planning for issues that are evolving.”

HFMA has changed in many other ways in the past 15 years. Perhaps the most obvious change is its size. Between 1991 and 2006, membership grew from 27,000 to more than 34,000, revenues grew from \$9 million to almost \$22 million, and magazine pages grew from an average of 120 to an average of 192. It is a more diverse organization with a broader range of more sophisticated products and services. Members on different professional levels in a wide array of settings can get practical information from traditional conferences and seminars. They can also participate in audio webcasts, event CDs, on-site programs, and e-learning without leaving their offices.

“One of the things that has always impressed me about HFMA is its willingness to change,” said Joanne Judge, Esq., FHFMA, CPA, partner with Stevens & Lee and HFMA’s 1991–92 Board Chairman. “It’s a very adaptive organization.”

## The Early 1990s

Anticipation of reform made the early to mid-1990s a highly dynamic period, with heightened competition, concern about costs, and extensive reorganizing and realignment as hospitals attempted to deal with prospective payment and the emergence of managed care.

As the decade opened, the growth in outpatient procedures and payer-directed access and utilization decisions; increased IRS review of tax-exempt organization compliance; and restrictive government funding, all dictated a new emphasis on quality. There was a new awareness that quality initiatives “will translate not only to greater customer satisfaction but to bottom line improvements,” said Judge at the start of her term.<sup>a</sup>

### Quality Initiative

Accordingly, Judge helped to launch HFMA’s own quality initiative, which included new education programs on managing chapter quality at the annual Leadership Training Conference, a new section on the subject in the chapter officers’ manual, and the first Annual National Institute conference linking quality and finance. The Association also invested in an internal continuous quality improvement process to analyze, measure, track, and improve member services. The “Quest for Quality” called for:

- A change in organizational culture, including development of a clearer vision of the future and increasing emphasis on HFMA values
- Management by fact and analysis
- Design and implementation of a cross-functional approach to process improvements
- Assuming a greater customer focus through problem tracking and new service standards
- Empowerment of staff and volunteers to own processes

For the first time, a vision statement appeared in HFMA’s corporate strategic plan: “The Healthcare Financial Management Association will enhance the delivery of healthcare services by serving as the primary resource to individuals who seek excellence in the financial management of healthcare organizations.”

Those individuals, the organization was coming to see, would need to come from other sectors outside of the acute care hospital if HFMA was to grow in size and maintain its value, and programming would need to cover more territory. In 1995, HFMA formed an advisory group to diversify HFMA’s reach.

a. Lumsdon, K. “News Profile: Invest in Personal Quality, Chairman Urges,” *hfm*, June 1991, pp. 20–23.

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**In 1993, the National Board of Directors made two changes to the Frederick C. Morgan Achievement Award: HFMA's highest individual award would now honor a lifetime of achievement rather than a single accomplishment, and would recognize outstanding contributions to the Association rather than to the profession.**

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At the same time, like its members' own organizations, the Association would need to do better with current resources in the challenging economic environment. Toward that end, it transferred its financial ratio database to a private owner and outsourced its book-publishing operation.

### *Reform*

Hoping to position HFMA at the front of the reform movement, the Environmental Assessment Task Force in 1982–83 developed a healthcare reform framework. With reform, said 1992–93 National Board Chairman Bonnie L. Phipps, FHFMA, CPA, “comes an expanded role for healthcare financial management. Fulfilling this new role will require financial managers to build on their education and technical backgrounds and become more proactive.”<sup>b</sup>

As part of its own proactive stance, HFMA decided to increase its advocacy efforts at the national level. “Those in the industry are being asked to find their way along a trail that is not well marked,” said 1994–95 National Board Chairman John P. McGuire, FHFMA, CPA. “We can be the association that helps provide the maps, the visions, and the leadership to guide people through their challenging new frontier.”

McGuire, then senior vice president at Jewish Hospital in St. Louis, was emblematic of the movement from individual hospitals to integrated systems. “Until Barnes and Jewish Hospital established our affiliation in November 1992,” he recalled in 1994, “there were no systems as such in St. Louis; just 42 independent hospitals. Just since then, two other groups have announced affiliations. . . . What makes everyone nervous is that we are seeing the consolidation of managed care companies occurring at the same time.”

As competition becomes more intense, he advised his peers, “it may be possible for you to actually set up a partnership with an insurance company. . . . The point

b. “Chairman’s Profile: Reform Means Growth, Says New HFMA Chairman,” *hfm*, June 1992, pp. 20–24.

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**In 1995, the Board approved an expanded scope of work for the Principles and Practices Board. In order to establish a consistent perspective for advocacy efforts involving accounting and financial reporting, and to facilitate a more timely response to emerging issues, it would begin preparing issues analyses in addition to statements. It would also develop responses to Financial Accounting Foundation, Financial Accounting Standards Board, Government Accounting Standards Board, and American Institute of Certified Public Accountants actions and positions.**

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here is not just to compete but to actually begin to form a bigger system, a more complete continuum of care that is not just a hospital product or a healthcare product or an insurance product.”<sup>c</sup>

Part of McGuire’s agenda that year was “to get people to think outside the accounting box. I had started in finance and then wound up being heavily involved in operations. In fact, when I was Chairman, I was not the CFO; I was the COO. So I worked on getting finance people to think bigger. ... At the national level, it would make us more flexible and better able to respond if the environment changed as a result of reform.”

The Association did turn its attention to broader operational issues and did become more flexible, but not as a result of President Clinton’s long-anticipated plan for reform, which was essentially dead on arrival. At the national meeting in Chicago that year, McGuire told attendees “how appropriate it was that we were in the Windy City, because the ‘winds of change’ we had been waiting for all year turned out to be a lot of hot air.” The market, primarily managed care, would be the primary instrument of reform after all.<sup>d</sup>

### **The Late 1990s**

There were trying days for hospitals and for HFMA in the wake of the Balanced Budget Act of 1997, as costs continued to rise but payment did not keep up.

Large integrated systems grew ever larger, as 1996–97 National Board Chairman Warren Hern, FHFMA, could attest. Hern was senior vice president and

c. “Chairman’s Profile: McGuire: A Keen Eye Toward the Future,” *hfm*, June 1994, pp. 28–36.

d. Telephone interview with John P. McGuire, 1994–95 HFMA National Board Chairman, Oct. 16, 2006.

CFO of Park Ridge Health System in Rochester, N.Y. When he had started there, the system consisted of a 194-bed hospital and a 120-bed nursing home with a \$25 million budget. By 1996, there were three nursing homes, another 65 beds added to the hospital, a major commercial laboratory, retirement housing projects, and low-income housing for the elderly. The budget was \$160 million.

Hospitals have become a mature business segment, Hern said then. “But there are, and will be, more HFMA members like myself who have larger responsibilities. I want to be able to look to HFMA to learn about all these components of the industry. ... One of the best ways HFMA can address this issue is to make certain the Board of Directors is representative of the diverse nature of the entire healthcare delivery system.”<sup>e</sup>

### ***Diversification***

Every few years, the HFMA Board appoints a Task Force on Organization, Governance, and Structure, which zooms in for a close look at the alignment between the way HFMA is set up to operate and its priorities, which shift with changes in the environment and in the Association’s goals.

Following through on Hern’s vision, the TFOGS recommended that the elected Board of Directors be expanded to take in three appointed members, who would vote, but not be eligible to serve as officers or on the Executive Committee. According to Clarke,

The appointed positions were an effort to pull in people from other disciplines where we felt we needed some experience. For example, we brought in Al Holloway, who was president of The IPA Association of America, when we were trying to expand our managed care presence. We brought in Charles Bracken (then executive vice president of Superior Consultant Company) because we wanted to make some major changes to our IT systems and he’s an IT expert. We typically didn’t have a lot of representation from investor-owned organizations, and Terry Rappuhn, CFO of Quorum Health Group, filled that gap for us.

Significantly, the Association’s vision statement changed terminology in 1996, the year HFMA turned 50. Instead of serving individuals who seek excellence in the financial management of healthcare organizations, it would serve such individuals in health *service* organizations. The Board also amended the bylaws to eliminate the distinction between members employed by a healthcare organization and those employed elsewhere.

e. “Chairman’s Profile: Hern: HFMA Must Reflect the Industry and the Needs of Members,” *hfm*, June 1996, pp. 22–31.

Following through on its enlarged vision, HFMA developed a Market Diversification and Penetration Plan, which featured four strategic initiatives:

- Signal the industry that HFMA is prepared to change/broaden to accommodate expanding membership
- Increase participation from other healthcare markets in HFMA leadership
- Seek partnerships with chapters and organizations serving chapters
- Become increasingly market-driven to create new products and services

Similar language made its way into a five-year Reorganization Plan, which would guide much of the Association's efforts in the last years of the century. Specifically, HFMA set out to:

- Provide tools and guidance to help chapters build consensus for change and diversification, including integrated networks, managed care organizations, medical group practices, long-term care, and home health
- Reposition itself as a resource for all health services settings
- Establish alliances with other organizations
- Refocus products and services for expanding markets
- Develop a professional resource center with its core in the Washington, D.C., office

To help make visible its new sense of mission and expanded scope, HFMA adopted a new tag line, Solutions and Opportunity . . . Now and for a Lifetime, designed to show HFMA as rooted in the new healthcare realities, focused on providing practical business solutions today, and capable of facilitating the lifelong professional relationships and knowledge base that ensure long-term success.

### **Deconstructing the Matrix**

Another structural change that came about through a TFOGS was the transformation of the complex National Matrix of interrelated councils and committees into Advisory Councils. This took place during the mid-1990s, as their own organizational pressures upped the premium on volunteers' time.

The primary purpose of the councils is to provide peer review of issues and feedback related to HFMA's marquee issues, products, and services. For example, in the early to mid-2000s, Revenue Cycle, Early Careerist, and Senior Financial Executives councils joined the lineup as a means of formalizing concerns about meeting the needs of members at different professional levels.

In 2006, the Advisory Council structure was streamlined to the essentials: Executive, Managerial, and Professional.

## **Hard Lessons**

One of the most difficult years HFMA ever experienced as an organization was 1998. “The draconian changes made to the Medicare payment policies in the Balanced Budget Act of 1997 caused a significant shortfall for many hospitals,” Clarke explained. “At the same time, managed care organizations had developed quite a bit of negotiating power, so it was becoming very difficult to get price increases on the commercial side. And one of the first things hospitals do when they get into financial difficulty is to cut memberships, travel, and education—and that’s what we sell.” For the first time, membership went down—a 10 percent drop in just one year.

At the same time, HFMA was launching a new business venture called HFMA Learning Solutions, Inc., designed to provide specialized, on-site training for frontline staff in all healthcare sectors. First up on the agenda was corporate compliance, in the form of a 12-hour course that covered key points in the Office of Inspector General’s Compliance Program Guidance for Hospitals.

The problem was, Clarke explained, that hospitals were not as interested in compliance training as HFMA had anticipated. “And they wanted low-cost options, while our system was quite elaborate. So we ended up missing the market on that.” In 2000, HFMA Learning Solutions was integrated into the organization’s business operation to better leverage brand identity, technological development, and technical content.

“We also tried to develop a fairly extensive inventory of books to augment our educational programs, and we lost money on that. Together, the reduction in membership, reduction in educational attendance, the faltering business venture, and a book business that didn’t go very well created the perfect storm.”

In response, HFMA retooled.

We ended up having to reallocate our resources and redirect the way we spend money. We laid off some people and we stressed customer service. We got better at listening and became much more market focused. We realized that our core was the hospital and health system marketplace. In the future, we would focus our energies there, while continuing to serve members from other sectors of the industry.

## **The 2000s**

Both the industry and HFMA entered a more stable period with the turn of the century. Despite widening gaps between haves and have-nots among hospitals, despite the unsettling move toward consumer-directed health plans, despite

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**In 2002, *Modern Healthcare* published its first list of the 100 Most Powerful People in Healthcare. HFMA President and CEO Richard L. Clarke, DHA, FHFMA, was on it, cited as the driving force behind the Patient Friendly Billing project. He was on it again in 2003, 2004, 2005, and 2006, at which point he was one of only 23 people who had been recognized on each list since its inception.**

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softening volume growth, soaring operating expenses, and labor shortages, the industry was enjoying more effective revenue cycle management, renegotiated payment rates, and more predictable Medicare payments. Ambulatory care continued to grow, even as ambulatory payment classifications complicated payment in that sector. There was a renewed emphasis on financial-clinical collaboration and corporate integrity and responsibility, as managed care suffered something of a backlash.

The Association entered the 21st century with a newly created Board committee for strategic planning and a newly formulated set of principles for success, based on lessons learned during the lean years:

- Focus on the individual member
- Be a learning organization
- Understand knowledge is our business
- Measure success by the success of members
- Commit to diversity
- Base decisions on facts
- Involve volunteers effectively
- Develop market-driven services rapidly
- Recognize change as a way of life

There was also something new in the corporate strategic plan: a purpose statement. The purpose of the Association, it said, was “to help members and other finance-related healthcare professionals excel, thereby improving the business performance of organizations operating in or serving the healthcare industry.”

### ***A New Direction***

Both its goals and its strategies were streamlined to help HFMA implement its new strategic direction. Developed through research and analysis by a committee established by the Board in 1999 and chaired by 2000–01 Board Chairman Connie S. Cape, FHFMA, CPA, the new five-year plan had five goals:



## New Look, New Rules



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To reflect its new image of itself, HFMA updated its corporate logo in 2001. It was part of a comprehensive corporate identity program to convey purpose, value, and processes through the use of contemporary color, type, imagery, and words.

The lowercase “hfma” was both more informal and more approachable; the new placement of the cross symbol expressed upward movement. The anchor colors, blue and gold, conveyed confidence/maturity and warmth/activity, respectively.

Also new that year was a change in the bylaws allowing the Board to “from time to time create additional classes of membership and varying dues structures” for people who may require only a narrow band of services, such as graduate faculty.

- To leverage in-depth technology and customer knowledge to increase the quantity, ease of access, value, and personalization of services for members and customers
- To continually seek new ways of meeting the evolving needs of individuals by providing career-long relationships that include networking, career assistance, information, leadership development, and knowledge transformation
- To improve the image and prominence of the Association among key audiences, including the senior financial executives, so that we become the most relevant and utilized resource for these and other individuals within their organization’s financial structure
- To demonstrate and communicate the value the Association provides to organizations that employ our members and with which we do business
- To achieve financial results that enable innovation, product and service development, and increased member value

Cape singled out three strategic imperatives she felt would be most important in achieving those goals: First, to implement a new digital strategy that defines how the Association will harness the value technology brings to the marketplace and that will improve HFMA’s effectiveness in communicating with members. Second, to ensure that the chapter structures are supportive of the overall system and meet the needs of members at the local level. Finally,

to structure the National office staff in such a way that it can have an intimate knowledge of the needs of HFMA members. “We will put in place the market assessment devices, surveys, and focus groups that will allow us to be as close as possible to our customers.”

“With its new mission, goals, and imperatives, HFMA will be stronger than ever,” said Cape, “offering increased value, enhanced relationships, and effective technology.”<sup>f</sup>

The organization’s target market apparently agreed. After two years of decline and two flat years, HFMA membership started to grow again in 2003.

### *Leaner, Not Meaner*

After several years, leadership had come to the realization that “we didn’t really want a two-tiered board, with certain directors elected by the members and others selected by the board itself,” said Clarke. “We also felt that, at 19 members, the Board was too large and that the two-year terms created too much turnover.” As a result of TFOGS recommendations in 2000, the Board was reduced to nine directors and four officers, the appointed positions were eliminated, and the terms were expanded to three years.

It was also decided that, rather than look for regional representation as in the past, the Association should simply pursue the best people available. “We loosened the requirement that nominees be certified,” said Clarke. “We gave more flexibility to the Nominating Committee to identify what kind of people we needed to balance the Board and to go out and find them. We were able to bring in someone like Beverly Wallace, who is president of the HCA Shared Services Group.” At the time, Wallace was on the Patient Friendly Billing project task force but was not a member of HFMA.

Today the yeoman’s work is done by the Governance Committee (formerly Nominating Committee), which changed its process from one of simply reviewing credentials to actually interviewing people. The Board is responsible for identifying for the Governance Committee appropriate competencies and criteria for new members. The Executive Committee is responsible for recommending those competencies and characteristics to the Board.

Part of the decision to downsize the Board was a structural change that accomplished another goal at the same time. To assure chapter presidents that their voices were being heard, said Clarke, “we significantly beefed up the responsibilities of what used to be called chapter liaison representatives and made them regional executives, with responsibility for managing the Davis Chapter Man-

f. Cape, C. “Imagining the Possibilities for Health Care and HFMS,” *hfm*, June 2000, pp. 45–52.

agement System. We gave them the authority to manage the incentive programs and to develop the policy. This removed the need to have regional representation on the Board.” Now every director represents the entire membership.

The 11 regional executives are elected each year by the chapter presidents-elect in their regions and serve as the chapters’ primary volunteer and policy link with HFMA National.

In 2006, there was a new corporate strategic plan, which was the result of numerous discussions of the Board and the Strategic Planning Committee, research analysis, and considerable feedback from members and key constituencies. It said that “HFMA’s core business will be focused on *knowledge transformation*—that is, converting data and information into useful tools and solutions that help members and customers improve job performance and thereby enhance their careers.” These core areas include:

- Memberships
- Continuing education and training
- Career development and certification
- Information analysis, perspective, and peer benchmarking
- Virtual and face-to-face networking

### *Strengths and Challenges*

After so much change, so much learning and growing, what lies ahead for HFMA? “More change, of course,” said McGuire, who underwent a change himself recently, “a cardiac event,” that left him with two stents. And yet, the more things change, he mused ...

I went in the hospital on a Tuesday, I was discharged on Thursday, and I was at work on Monday. Fifteen years ago, I would have had open heart surgery and been off for weeks, if not months. During the same time, the world of finance has changed. We’ve had various models of payment; recently we’ve seen the insurance companies consolidate. We’ve certainly seen economic pressures at the federal and state levels with the Medicare and Medicaid programs. It’s been a continual battle to satisfy insatiable demands with limited resources. That hasn’t changed at all. It’s just the rules of the game that continue to change.

Whatever challenges HFMA will face, however, it will do so from a position of strength. For Phyllis A. Cowling, FHFMA, CPA, president and CEO, United Regional Health Care System and Chairman of HFMA’s National Board in 2002–03, one of its greatest strengths today is its recognition and respect for healthcare finance as its area of expertise.

## **HFMA Today**

### ***Quality Statement***

Quality is the foundation of the Association and the keystone of its efforts to ensure member and customer satisfaction. HFMA's objectives are to:

- Consistently provide services and products that meet the quality expectations of its members, customers, and employees
- Actively pursue a program of continuous quality improvement that enables employees and volunteers to do their jobs right the first time

Quality is a major, strategic Association goal. It lies at the heart of everything done for members and customers. HFMA strives continually to improve the quality of services and products offered; the processes and procedures used to produce them; and the manner in which they are delivered.

### ***Values Statement***

- We believe that service to members is our highest priority.
- We believe in excellence in all that we do.
- We believe that teamwork is essential in meeting the objectives of HFMA.
- We believe in the importance of individuals.
- We believe in encouraging innovation and creativity.
- We believe in conducting HFMA with financial responsibility and a prudent approach to business.

### ***Code of Ethics***

As a member of HFMA, I will endeavor to promote the highest standards of professional conduct by:

- Practicing honesty and maintaining personal integrity, including avoidance of conflicts of interest with those of my employer or HFMA
- Striving for the objective and fair presentation of financial information
- Fostering excellence in healthcare financial management by keeping abreast of pertinent issues
- Maintaining the confidentiality of privileged information
- Promoting a greater understanding of financial management issues by others in the healthcare field, and seeking increased public understanding through communication about such issues
- Seeking to maintain a reasonable balance between the quality and cost of health care

We don't try to be all things to all people. We know what our niche is. That's not to say we don't broaden it from time to time. We're trying to provide healthcare finance resources to as many people as we can, but we're not trying to be the experts on nursing, for example. I also see our leadership structure as another major strength. We have a very passionate, involved Board of Directors; it's not just a hobby for them.

Raymond J. Cisneros, FHFMA, CPA, retired but still a member 25 years after serving as Board Chairman in 1981–82, concurs.

Over the past 15 years, HFMA has clearly come to its appropriate place and been recognized by the other organizations that wanted to keep their hands in on the financial side, as the organization you really have to go to for assistance when it comes to healthcare finance. The expertise that existed within HFMA far surpassed what other people could bring to the table.

Not surprisingly, many of the Association's volunteer leaders since Clarke became President in 1986 see his leadership as another of HFMA's greatest strengths. "He has boundless energy and great vision," said Judge. "He single-handedly has done more to change the face of the organization than anybody, in my view."

### **HFMA and Public Policy**

Passage of the Health Insurance Portability and Accountability Act in 1996 was a victory for HFMA, which had led the fight for administrative simplification provisions mandating uniform use of electronic transaction standards. The act contains language that was the direct result of work HFMA did with various legislative and regulatory groups over the years, including drafting bills, testifying, and providing analysis and commentary.

Ironically, the experience was a major factor in the Association's decision to pull back on government-relations activities, less than a decade after senior staff members had registered in Washington as lobbyists in 1991. Clarke explained the reasoning behind the shift.

It was primarily a question of where we could have the most impact. HIPAA took a lot of time, money, and energy, some of which was spent duplicating efforts of trade organizations that are better positioned to do that kind of work, such as the American Hospital Association, the American Medical Association, the Federation of American Hospitals, and the Catholic Health

Association. We felt that we could be more effective if we focused on trying to influence individual member actions as opposed to trying to influence policy.

So we took the expertise we had in the Washington office and used it to ensure that our members are benefiting from our technical expertise in the form of education programs and access to subject matter experts, toward developing creative solutions—in other words, being a thought leader.

For example, in the 2000s, HFMA surveyed its members' readiness to comply with HIPAA and generated many tools to advance the process, including checklists, needs assessments, online links to Centers for Medicare & Medicaid Services program memorandums, and a three-part audio teleconference series.

This approach also acknowledged the diversity of viewpoints within the Association's broad-based membership, which made lobbying a more political process. "As a result," said McGuire, "HFMA tries to take the higher road whenever it can by advocating for general principles that will benefit the industry as a whole. Most of the work it does now is behind the scenes, working with congressional staffers and committees to help them understand the issues and to provide them with objective data."

As a result, HFMA is viewed by many legislators and regulators as an important source of facts and opinions about issues connected to dollars and cents—which encompasses a broad swath of territory. Among the groups that have sought the Association's input in recent years are:

- U.S. House Committee on Ways and Means, on hospital chargemasters
- Committee on Energy and Commerce, on hospital pricing and billing
- U.S. Government Accountability Office, U.S. Department of Veterans Affairs revenue cycle issues, and capital financing through the U.S. Department of Housing and Urban Development Section 242 Mortgage Insurance Program
- Medicare Payment Advisory Commission, on cost-to-charge ratios

HFMA assembled a group of Patient Financial Services Forum members to help CMS with its Information Express project, a web-based system to track claims; co-founded the Medicare Technical Advisory Group; made recommendations to the U.S. Department of Health and Human Services Advisory Committee on Regulatory Reform; participated in establishing the Municipal Securities Rulemaking Board; and submitted dozens of comment letters, often in conjunction with other organizations, to Congress and to regulatory agencies such as the IRS and Office of Inspector General.

## Strategy in Action

The evolution of HFMA's strategic direction—reflected in all the activities described in this chapter—is equally evident in HFMA's core services: chapters, education, information, and research.

The following chapters in this book trace how each of these services has continuously improved from 1991 to 2006 in order to meet the challenges of the healthcare industry and to serve members more effectively.

### Chairmen's Themes

Every incoming chairman of the National Board of Directors selects a theme to guide his or her efforts in the coming year. These reflect both the orientation and background of the individual and top-of-mind industry issues.



**1991–92** *HFMA: Invest in Quality.* Joanne Judge, Esq., FHFMA, CPA. "Quality remains only a vague ideal unless it can be measured and compared to something else, a task perfectly suited to financial managers. . . . When you look at the cost of poor quality, it's amazing."



**1992–93** *HFMA: Accept the Challenge.* Bonnie L. Phipps, FHFMA, CPA. "With reform comes an expanded role for healthcare financial management; fulfilling this new role will require financial managers to build on their education and technical backgrounds and become more proactive."



**1993–94** *HFMA: Set the Course.* Christopher F. Weinheimer, FHFMA, CPA. "It means having a clear understanding of not only where you're going, but also how you're going to get there and knowing what indicators there are along the way to measure whether or not you're moving in the direction you want to go."



**1994–95:** *Gateway to the Future.* John P. McGuire, FHFMA, CPA. “Those in the industry are being asked to find their way along a trail that is not well marked. HFMA has the opportunity to be gateway to the future of health care.”



**1995–96:** *Pioneering Together.* William H. Nelson, FHFMA, CPA. “Our healthcare system is being redefined not by the government, but by the marketplace. We can be the pioneers of the creation of a new delivery system.”



**1996–97:** *Leading and Learning.* Warren Hern, FHFMA. “The responsibilities of healthcare financial managers will expand considerably in the coming years. People have to be out there absorbing new information and staying on the leading edge.”



**1997–98:** *From Opportunity to Action.* Ronald D. Anspaugh, FHFMA. “It’s not only an acknowledgement of our acceptance of the reformation activity occurring, but also our recognition that opportunities to move ahead exist for those prepared to grasp them.”



**1998–99:** *Community: Chapters of Change.* Lori J. Mitchell, FHFMA, CPA. “There is technology that we need to take advantage of, there are regulations we need to deal with, and there are things that need doing just because they are the right thing to do.”





**1999–2000:** *Leading with Integrity—The Bottom Line.* Richard J. Henley, FHFMA, FACHE. “The image of the healthcare industry is tarnished. My advice is to be proactive: Develop a culture that supports and mandates ethical behavior.”



**2000–01:** *Imagine the Possibilities.* Connie S. Cape, FHFMA, CPA. “Health care has taken a lot of hits lately. The goal for my term is to have our members turn an eye to the horizon and see all the new possibilities that exist.”



**2001–02:** *Leading @ the Speed of Light.* Ronald R. Long, FHFMA, CPA. “It means making mistakes but being able to recover and change direction as quickly as the environment changes. The successful financial leaders must be able to accept risk and understand how to manage it, rather than avoid it. A key component is flexibility.”



**2002–03:** *Create the Future.* Phyllis A. Cowling, FHFMA, CPA. “Labor costs are increasing, capital expense continues to grow, and the burden of regulatory compliance and its associated cost are on the rise as well. There is too much at stake simply to hope the future will turn out the way we want it.”



**2003–04:** *HFMA: It’s Personal.* David Canfield, FHFMA. “It all boils down to people. If you don’t have a good understanding of how people work and their needs, if you don’t care about people and you think you’re going to succeed, you’re just kidding yourself.”



**2004–05:** *Beyond the Numbers.* Joyce A. Zimowski, FHFMA, CPA. “We need to bring structure and market perspective that looks at where we are now, where we need to be, and what we need to do to get there ... to foster the strategic thinking needed to take our organizations to the next level.”



**2005–06:** *The Business of Caring.* Richard Rodriguez, FHFMA. “Bridging business and caring is an ongoing challenge. We need to raise awareness about the ways in which financial and clinical professionals can better work together.”



**2006–07:** *Courage in Leadership.* Joseph Fifer, FHFMA. “It’s time to step up—to go beyond what’s expected, to take a risk for the right reason, to do what is right because it is right.”

## CHAPTER 2

# Chapter Management

Chapters are the heart and soul of HFMA. The local groups are where almost all HFMA members make their first networking connections; they are the source for much of the guidance and support members seek and receive; and chapter leadership often is a stepping-stone to national leadership.

In 1993, the same year that the late Graham Lee Davis, an HFMA founder, was named to *Modern Healthcare's* Health Care Hall of Fame, the Association conducted its first thorough review in 40 years of the GLD program bearing his name. In line with a quality initiative HFMA was conducting on the national level, the Board adopted a "Statement on Chapter Quality," which formalized efforts to increase chapters' abilities to deliver high-quality services.

"Rather than focusing only on one leader's year," said John McGuire, 1994-95 HFMA Board Chairman, "we are trying to support chapters in making long-range plans, so that members will see not only consistency, but growth and improvement." Among other things, HFMA began to provide chapter leaders with assessment tools, benchmarking resources, individual consultation, and

### Community Service

In 1996, incoming HFMA Board Chairman Warren Hern chose "Leading and Learning" as his theme for the year. One example of this spirit was a nationwide community service initiative called "HFMA Serves America: Making Medicare Easy." It involved chapters working with local organizations to offer educational programs for Medicare recipients.

Within 12 months, 40 chapters had sponsored service programs that reached 35,000 senior citizens—and won an Award of Excellence from the American Society of Association Executives.

more education and training. Grants were awarded to 10 chapters for pilot projects to conduct specialized educational programming, address long-term care issues, target services to managed care professionals, and conduct market research in HFMA target markets.

And yet, HFMA President and CEO Richard L. Clarke recalled, “We found, at times, that chapters were protective of their best practices because of the incentives that winning an award created.”

### The Davis Chapter Management System

In 1995, the Board appointed a GLD Task Force to make recommendations for change. After two years of study, the task force introduced the Davis Chapter Management System, which went into effect in 1997 and replaced the GLD program. The DCMS program made several important changes.

Designed to “ensure effective delivery of services to members that support their professional growth and development while contributing to the growth of HFMA’s human and financial resources,” the system featured:

- A statement of purpose and principles
- Charter requirements to ensure minimum levels of service
- Chapter management practices to provide a foundation for generating products and services
- A peer practice exchange



The Robert M. Shelton Award

One of the most important features was a new awards program, which honored chapters for their own achievements without inducing competition against each other. Instead of focusing on the “number one” chapter, there are now awards at the bronze, silver, and gold levels of achievement that any chapter can earn. For example, any chapter that delivers a minimum threshold number of educational programming hours per member receives an award. HFMA still presents the much-valued Robert M. Shelton Award, which is given to a chapter that demonstrates five years of sustained excellence. In the first year of the revised program, chapters earned 152 awards; by 2005, that number had climbed to more than 275.

“As a result,” according to Clarke, “chapters stopped competing and started collaborating. Now we have a network of chapters working with each other

toward best practices. I think that was a major milestone and a major improvement in the way we worked with chapters.”

Meanwhile, HFMA was following through on its commitment to boost its support for chapters. It offered them models for newsletters, membership directories, and on-site education topics.

In 1999, HFMA was one of only six associations to be recognized in the American Society of Association Executives Chapter Relations Pyramid Awards of Excellence, earning an honorable mention in Chapter Development for the DCMS.

### **More Change**

In 2005, a Chairman’s task force was formed to take the DCMS program to the next level. In 2006, the Regional Executive Council adopted a number of the task force recommendations. The goal was to reduce variation in chapter performance in order to increase service quality to members. One of the key changes was establishment of a balanced score card, a tool the national organization had been using for several years.

The Chapter Balanced Score Card emphasizes key chapter performance elements that are directly aligned with HFMA’s strategic priorities and research findings on chapter effectiveness. They include:

- Registrant hours per member
- Membership retention
- Financial executive member count
- Percentage of provider representation among chapter officers and board
- Member overall satisfaction
- Minimum days cash on hand
- Maximum days cash on hand
- DCMS compliance
- Seamless system of service
- Chapter goal achievement

### **Going Electronic**

Electronics have made life a lot easier for chapters—and for staff communicating with them. Take labels, for example. Each month, HFMA provided labels for chapters to use in communicating with their members. Now chapters can download labels from the HFMA web site 24/7.

Prior to the beginning of each calendar year, the Regional Executive Council updates and/or confirms the CBSC elements, weights, and a threshold performance level, which serves as a minimum for award eligibility. Performance below that level will trigger actions intended to support chapter performance turnaround.

Another component of the DCMS was use of a new program planning tool, which creates the opportunity to integrate planning, monitoring, and support/intervention in the near term, and holds the longer-term potential to integrate with chapter budgeting. For example, chapters are no longer required to hold a certain number of programs annually; instead, they can use the new tool to set and achieve a registrant-hours-per-member goal, which they can meet however they want.

There was more to come in the new century:

- A web-based Program Chair Toolkit, which contains hot topics, sample program development and management tools, a sample speaker's kit, and a fully searchable speakers database
- An audio webcast service that enables chapters to reach an expanded audience for local programs (the Colorado Chapter reported that the new technology allowed many members to listen to a presentation by a speaker from the Colorado Health Institute at an otherwise sold-out program on the uninsured)
- Online registration and evaluation processing
- Web site hosting and development service
- Bookkeeping assistance

### **Chapter Advancement Team**

Since 1991, HFMA has offered chapters help with strategic planning and management in the form of a CAT (initially Chapter Assistance Team) program, which matches specific goals with the experience of a trained CAT facilitator. Chapters often turn to CAT for help in leadership development, succession planning, and goal setting. Typically, a project involves several conference calls and one or two on-site meetings over a one- to two-year period. Between five and eight consultants, drawn from national and chapter leadership ranks, are available at any one time.

In 2007, HFMA changed one of its long-standing communication tools. *Notes from National* is the monthly publication that HFMA uses to let chapters know about important events and deadlines, as well as to share successful practices and spotlight chapter achievements. The publication at one time was paper, but had transitioned to being sent electronically as a PDF file.

To take advantage of the flexibility that electronic publishing offers, HFMA began producing the newsletter in a more flexible and contemporary format. *Notes from National* now has a web page featuring excerpts from each of the month's stories, with each excerpt linked to the full story.

“Originally, as in many organizations, there was sometimes a bit of a disconnect between the chapters and the national office,” said Lawrence A. Laddaga, Esq., FHMA, attorney, Laddaga-Garrett, P.A., and a member of the Principles and Practices Board and HFMA’s Chapter Advancement Team. “Over the years since I became a member in 1983, the national organization has become more and more attuned to their needs, better able to provide a seamless web of services.”

### **Chapter Incorporation**

In 2006, the Regional Executive Council and the HFMA Board approved a recommendation to incorporate all HFMA chapters in Illinois, which added an extra layer of protection against potential liability for members and volunteer leaders. It also streamlined certain administrative chores. From the beginning, chapters operated as unincorporated associations of HFMA. Whenever a chapter amended its bylaws, it was required to comply with applicable state laws, which can vary considerably from state to state. Now chapters need to comply with the laws of only one state, which means they can be more consistent with each other and with HFMA.

HFMA developed standardized model chapter bylaws and took primary responsibility for processing administrative filings.

For a number of years, HFMA has surveyed its volunteer leadership—chapter presidents and regional executives—every year. In 2006, the satisfaction level was the highest ever—6.5 on a 7-point scale. Survey respondents consistently identify the most valuable HFMA resources as the Leadership Training Conference, the chapter leader area of the HFMA web site, and support from chapter relations staff.

Despite the many tugs at people's time, HFMA chapters continue to be a place where HFMA members make lasting professional and personal connections. David Canfield, HFMA's 2003–04 Chairman, recalls the first chapter meeting he attended: "Approximately 300 people were there. The quality of the presentations was excellent, and the people were so friendly and outgoing. From then on, I was hooked on HFMA." Canfield spoke for many HFMA members when he said, "The heart of HFMA's benefits is the opportunity to build relationships with other members. From those relationships flow the opportunities to learn, to grow in your career, and to feel part of a community."<sup>a</sup>

a. "Healthcare Finance is Personal for HFMA's New Chairman, David Canfield," *hfm*, June 2003, pp. 36–40.



# Education: Ideas and Tools

Given the growth in membership, you would expect the number of HFMA's educational offerings to have increased significantly over the past 15 years, and indeed they have, from 358,322 hours in 1990 (~14 hours per member with 27,000+ members) to 465,800 hours in 2006 (13.7 hours per member x 34,000 members). But this is hardly the whole story. During that time, programming had become more sophisticated—the range of subjects broader, the target audiences more clearly identified, the caliber of speakers higher—in keeping with the increase in professionalism within healthcare finance as a whole.

“The training, education, and job requirements of members keep going up,” said HFMA President and CEO, Richard L. Clarke. “CFOs are now truly strategic leaders, so we’ve ratcheted up the level of information for them. At the mid level, directors and managers need to operationalize strategies; they need to know how to manage change. And people at the beginning of their careers need to know the nuts and bolts, the how-to’s. We have training and information for all those levels.”

The Association expends considerable effort to find out what the professional development needs of all its members are—what they’re concerned about, what they want to know, what their organizations need. It conducts a member needs survey every year, and it looks at the number of hits it gets in different areas of its web site. It has learned to respond swiftly and thoroughly. But thought leaders have to do more than respond; they have to anticipate.

## Staying Ahead of the Curve

“So we look at the industry itself,” explains Clarke.

We talk with major decision makers, we track general trends. And we have a regular dialogue with our CFOs, particularly those in our Large System CFO Group, which tends to be a bellwether.

This allows our technical staff to say “There’s a major regulatory change coming and our members are going to need to know the new regulation inside and out.” That way, we can do some training, provide information, and develop tools.

Compliance is a good example. One of the darker chapters in the recent history of the healthcare industry concerned the revelations of corporate fraud and abuse in the late 1990s, heralded by headlines about whistleblower lawsuits, Medicare fraud charges, Office of Inspector General audits, fines, penalties, and jail time. One result was rapid growth in regulatory oversight.

“It was a situation that could have gone very badly,” reflects Lawrence A. Laddaga, Esq., Laddaga-Garrett, P.A. “But HFMA approached it proactively. Well before the Health Care Compliance Association was formed, HFMA was out in front, educating its members—providing them with the information they needed to develop and implement sound compliance plans, persuading them that this was something they needed to do.”

In 1997, the Association unveiled *The DRG Watch: A Multi-Phase Instructional Program for DOJ Compliance*, to help hospitals comply with settlement agreements on 72-hour window billing errors. In 1998, *Corporate Compliance and the Patient Financial Services Professional* was the title of a full-day program at ANI. A sold-out compliance conference in the fall was made available on videotape and followed by a second set of training tapes for acute care systems, medical group practices, and post-acute care facilities. The Association set up a new special interest forum for compliance officers and issued a new publication: *Compliance Watch*. The Principles and Practices Board released *Compliance with Laws and Regulations for Healthcare Organizations*.

Michael M. Allen, FHFMA, CPA, vice president and CFO, Winona Health Services, points to another example: the revenue cycle. Allen recalled that in the early 2000s, in the wake of the Balanced Budget Act, 9/11, and the stock market plunge, hospitals were struggling financially. “They realized that, in order to survive, they were going to have to make their operations as clean and efficient as possible, and they began to look much more closely at their revenue cycle.”

Again, “we saw that coming,” said Clarke. “We put out information sheets about the potential impact, tips on how to deal with it, audio teleconferences, and ANI sessions where we brought in top experts to talk to our CFOs from the business perspective.”

That effort is still going full-bore, as evidenced by the program lineups at ANI in 2005 and 2006, which included sessions on revenue cycle key performance

indicators, clinicians and the revenue cycle, quality and safety as revenue cycle drivers, outsourcing revenue cycle functions, linking revenue cycle and supply chain, and extreme revenue cycle makeover, among others.

If you go on HFMA's web site ([www.hfma.org](http://www.hfma.org)) today, you will find a range of educational products related to the revenue cycle that go well beyond the seminars and conference programs, including a Medicare Billing Updates database, reports and tools developed by the Patient Friendly Billing project, Customer Service Training for Frontline Staff (the newest in HFMA's Revenue Cycle Training Series), the *Revenue Cycle Strategist* newsletter, and the Patient Financial Services Forum.

Allen believes that HFMA "has really pushed and elevated the level of play in terms of the entire revenue cycle." In fact, he said, it has "elevated the dialogue in our industry relative to financial performance in the broad sense, and how that needs to fit in with our ultimate goals of achieving safety and quality. HFMA has also helped round out the financial professionals themselves; they've raised the level of professionalism."

### Peer Reviewed by HFMA



You might think of it as a Good Housekeeping® seal of approval for products or services used in the healthcare finance workplace. Since 2004,

when the peer review process was put in place, a number of companies have completed the process of having their products evaluated for quality and performance and have won the right to claim the use of the "Peer Reviewed by HFMA" mark. This means that, according to a panel composed of current and prospective customers and HFMA members and technical directors, they have met the following program criteria:

- The product provides a return on investment.
- The vendor can improve productivity or process effectiveness.
- The product is based on practical industry knowledge and proven experience.
- The vendor has demonstrated superior customer service and technical support and maintains a strong reputation for integrity.
- The vendor and the product are compatible with HFMA's brand and value statements.

Financial managers looking for a new product can start by looking for the "Peer Reviewed by HFMA" mark.

## The 1990s

Back in 1991, members were enjoying the ability of the new audio teleconference format to deliver up-to-date information; nearly 1,500 of them tuned in to hear three programs covering the American Institute of Certified Public Accountants audit, Medicare fraud and abuse, capital payments, and ambulatory payments. In another effort to speed up dissemination of crucial information, HFMA held its first Rapid Response program—one-day briefings held at airport locations—on Medicare’s Safe Harbor regulations. More than 100 CFOs listened to Gail Wilensky, PhD, then Administrator of the Health Care Financing Administration, and Constance Horner, then Deputy Secretary, U.S. Department of Health and Human Services, at the Association’s first Capital Conference.

It was the start of a decade of innovation for HFMA education. The 1992 ANI lineup reflected top-of-mind industry issues with a new seminar on managed care and the financial manager, and a program called “Developing Profitable and Competitive Ambulatory Surgery Services.” ANI’s Idea Exchange featured 100 exhibitors for the first time. In line with the widening range of member concerns, HFMA expanded by 50 percent, to 18, the categories available for educational programming by chapters. The Leadership Training Conference on which the officers and committee chairs of those chapters relied, took home top honors from the American Society for Association Executives’ national awards ceremony that year—the first time, but not the last.

The First Annual Certified Summit and the first Healthcare Industry Conference, cosponsored with the AICPA, took place in 1993.

The increasing complexity and importance of physician relations led to a new course track at the 1994 ANI. Attendees could now choose sessions from eight different tracks, including new directions in healthcare delivery, managed care, patient accounts management, and leadership development. HFMA was staking out new territory along with its members. That same year, it held the first annual Capital Finance Institute; the first Managed Care Institute; and, with the Center for Healthcare Information Management, the first information technology conference, called Information 2000.

As the pressures of increased competition, hospital consolidation, and cost containment combined to squeeze the industry, HFMA set up a scholarship fund that acknowledged the growing number of newly unemployed members in 1993. Money was made available for HFMA internships, study at accredited master’s

degree programs, professional development, and certification programs. The first of what would ultimately become 25 chapter scholarship programs was established that same year.

### **Constraints**

By the middle of the decade, that same squeeze was making it harder for some members to travel to attend educational programs; both time and money were growing short, in a preview of the financial straits the Balanced Budget Act of 1997 would impose. In response, HFMA offered new approaches: Instead of attending multiple programs at multiple times and sites, members could sign up for two-day, focused intensive practicums in managed care and healthcare finance. Even more convenient were self-study courses on quality management and capitation issues, introduced in 1994.

About the same time, HFMA and MMI Companies, Inc., teamed up to begin a three-phase Cost of Risk initiative, designed to create a comparative database, analyze changes in components over time, and offer best practices case studies. A pilot study validated the need for long-term data analysis and helped refine the survey tool. Phase 2 would gather cost-of-risk data from a large sample.

The industry was breaking off in new directions as providers and payers merged and realigned, beginning to jockey for position in response to inroads by managed care and in anticipation of government reform. Inevitably, membership followed. For the first time, HFMA felt the need to embrace significant numbers of finance people working outside of acute care, most prominently in managed care and in medical group practices.

“We must force ourselves to be intimately involved in the planning and implementation of the evolution of healthcare delivery,” said 1995–96 National Board Chairman William H. Nelson, then senior VP at Intermountain Health Care, one of the large integrated systems that were increasingly dominating the industry.

“There will be an increasing need for education to help members who are leaving hospital-based positions and moving into other areas of healthcare financial management. In effect, our customers are forcing us to change from a cottage industry to an economically and clinically integrated industry that is able to deliver packages of services at competitive premium levels.”<sup>a</sup>

At the same time, of course, hospitals were dealing with the fallout from the Balanced Budget Act, trying to cut back on membership, travel, and education.

a. “Chairman’s Profile: Nelson: Healthcare Financial Manager’s Role Will Change Drastically,” *hfm*, June 1995, pp. 32–42.

Membership slowed, actually decreasing for the first time in 1999. As Clarke put it, “We had the double whammy of really needing to be there to help our members deal with a significant environmental challenge at a time when they couldn’t pay for the resources we were offering.”

HFMA would go after new members, identify new services, and market new and old products to nonmembers in order to expand its influence and its revenue.

### **The 2000s**

As the new century got underway, HFMA was teaming up with online education vendors to offer members still another cost- and time-efficient way to boost performance and manage their intellectual capital: e-learning. Users could learn at their own pace in easily digestible bites—individual lessons were designed to take approximately 15 minutes—without even leaving their desks.

Eventually, online healthcare finance courses—in billing, compliance, HIPAA, managed care, accounting, patient financial services, and claims denial—would cover more than 500 topics. Over the next years, HFMA steadily upgraded the quality of the material available online, becoming more savvy about what e-learning has to offer as a learning platform and forming relationships with new distributors.

For the same reasons, more teleconferences than ever were being held, including one on Medicare’s ambulatory payment classification system that drew a record 564 people, and HFMA added a new APC Daily Update to its web site.

In the fall of 2000, HFMA made national programming available to chapters for the first time; 16 chapters participated, with another 22 joining in the spring. Within a year, the partnership had reached close to 1,000 members. The annual Conference on Managed Care was a collaboration with the Northern and Southern California chapters.

As new regulations mounted in tandem with rising costs and efforts to streamline the revenue cycle, HFMA began to develop more tools to complement its programming. In 2003–04 alone, it released technical documents on the Medicare Outpatient Prospective Payment System Final Rule for 2003, Medicare Payment Rates, Medical Malpractice Tort Reform, Inpatient Psychiatric Facility PPS Proposed Rule, Medicare Modernization Act Medicare+Choice provisions, Stark II Interim Final Rule, Phase II, and revised EMTALA Interpretive Guidelines.

HFMA also created an Interactive Claim Correction Form, A Self-Assessment Tool for Improving Claims Processing and Payment, and Tips for Reducing Payment

Delays and Improving Accounts Receivable, compliance checklists for durable medical equipment suppliers and pharmaceutical manufacturers, a privacy rule checklist and a set of downloadable worksheets on HIPAA's final security rule, and PowerPoint® presentations on Medicare PPS updates and Office of Inspector General activities, among other hot topics.

A new educational program that HFMA developed in 2006 heralded a trend toward performance-based products. *Excellence in Customer Service*, the first in the Association's new Revenue Cycle Staff Training Series, is designed for frontline employees and others with direct patient contact. It includes four hours of comprehensive training, a DVD with content and role play scenarios, a facilitator guide, and participant workbooks. For an additional fee, a representative from HFMA will come on-site to lead the training.

Although much of HFMA's training is geared toward mid level and senior financial managers, training frontline employees also is important for HFMA. Frontline staff are critical to giving patients a positive experience, and avoiding problems at that stage helps all other parts of the finance process work more smoothly.

According to long-time HFMA member Nancy Bell, FHFMA—now Senior Managing Director, Healthcare Finance, Stevens & Lee—all the new educational strategies have paid off. Several years ago, when she was with the Hospital and Healthsystem Association of Pennsylvania, she stated the following at an ANI general session: “When I'm looking for resources for our members, HFMA is often my first stop.” For example, when Bell served on a statewide advisory board on hospital uncompensated care, she “went to the HFMA web site and got the P&P Board statement on valuation of charity care. It helped shape the

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**“...I have gained much understanding of the requirements of the business processes we work to automate from the various HFMA educational events and special-interest forums I have participated in over the years. I credit HFMA resources for ongoing research and intelligence about what is going on in the industry and helping me stay current with regulatory issues and requirements. ...”<sup>b</sup>**

JOHN TRAVIS, CHFP, CPA, SOLUTION MANAGEMENT STRATEGIST  
FOR COMPLIANCE, CERNER CORPORATION

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b. “People: John Travis: HFMA Nurtures My Career Interests,” *hfm*, Oct 2005, pp. 132–134.

## Growth of Annual National Institute

In 2003, paid registration at HFMA's ANI pushed over 2,000 for the first time. The annual conference that had repositioned itself as a national event just 13 years earlier, had doubled its registration and now boasted 150 speakers representing accounting, finance, patient financial services, managed care, physician practice management, and other interests. It also had an exhibit hall packed with 285 vendors. In fact, the size of the exhibit now limits the number of cities that can host ANI.

John P. McGuire, 1994–95 Board Chairman, remembers making fruitful contacts with vendors at ANI on two separate occasions. "I was sitting at lunch one day with one group and we got to talking about their business, and 2½ years later I purchased their service—because of that contact. Another time, it was a former hospital CEO who had started a software company whose product we eventually purchased."

state's policy on this issue. That's just one of a slew of HFMA resources that keep me current for my discussions with legislators, regulators, and providers."<sup>c</sup>

## Certification

"I know firsthand how HFMA can build skills," 2003–04 National Board Chairman David Canfield told ANI attendees that year.

Back in 1985, I decided I should become certified in patient accounting. What better way to prove to others and myself that I was knowledgeable in my profession? I was so confident, I thought I'd not only pass the exam, I would be high scorer for the year. I certainly didn't need to study because I knew everything. Imagine my surprise when I learned that I wasn't one of the top scorers. In fact, I was six points short of even passing the exam! What a blow to my inflated ego. But I rolled up my sleeves and got down to business.

During the next several months, I attended certification coaching classes presented by our chapter and fellow HFMA members. I read and reread the study guide and reviewed the past three years of HFMA test questions. ... Something else happened while I was preparing to retake the test. I was learning about my chosen profession, but I was also experiencing the gifts of time and kindness from HFMA members who assisted me in the study process.<sup>d</sup>

c. Bell, N. 2003 ANI: The Healthcare Finance Conference, Baltimore, Md., June 22–26, 2003.

d. Canfield, D., 2003 ANI: The Healthcare Finance Conference, Baltimore, Md., June 22–26, 2003.



Certification is still a great way to learn about healthcare finance. It is even more valuable today. Research shows that certified members are the highest-compensated and most sought-after in the industry. “With all the emphasis on the credibility of the financial team today,” said 1991–92 National Board Chairman Joanne Judge, “anything you can do to demonstrate that you’ve made the effort to take your own knowledge base to a higher level is really important to employers and to your peers.”

In 1996–97, the program was revamped to reflect higher performance standards and to introduce specialty designations in healthcare markets other than acute care. In addition to the Core exam, there are now four specialty certification exams: Accounting and Finance, Financial Management of Physician Practices, Managed Care, and Patient Financial Services. A new Certified Healthcare Financial Professional designation was added as a first step toward fellowship status.

As a result of these changes and the higher profile of both HFMA and its members within the industry, the number of members who are certified has grown to 2,349 in 2006. More than 95 percent of certified members retain their status by earning at least 90 contact hours every three years, well above industry averages for other certification programs.

### **Enriched Topics and Channels**

For HFMA’s educational efforts, the period between 1991 and 2006 has seen an enrichment in the topics covered and the channels used. As HFMA’s members have needed to be more strategic in their professions, HFMA’s educational offerings have changed to provide that level of training. The past 15 years also have seen an unprecedented change in the way people get information, and HFMA has used those channels to make education more convenient and targeted for members.

These changes in topics and channels are not limited to what typically is classified as education. The other ways that HFMA provides information and tools—including publications, the Internet, and e-mail—have experienced a similar evolution in topics and channels, making the past 15 years an exciting time indeed for HFMA as it shares expertise with its members.



## CHAPTER 4

# Information: On the Internet, On the Printed Page

**R**ichard L. Clarke, HFMA President and CEO, devoted his July 1995 column in *Healthcare Financial Management* magazine to the launch of HFMA's new web site, using the URL as a headline.

“For those members who routinely cruise the information highway,” the column began, “the notation listed above should look familiar. It represents the address of HFMA’s World Wide Web page on the Internet. The web page and HFMA NET (HFMA’s electronic bulletin board service) represent the Association’s continuing efforts to improve service to members by making use of emerging electronic information distribution techniques.”

The problem was the URL. An editor of the magazine had contacted the person overseeing the new web site and said, “I don’t know what these symbols mean but I want to get this right: Are those forward slashes or back slashes?” The webmaster said, “Back slashes.” So that’s the way the column’s headline read: “`http:\www.hfma.org`.” Of course it was wrong, but that was a measure of how unfamiliar the Internet was at that time.

It was a minor glitch in an unstoppable drive to create an online resource for news, information, networking, and education.

### **HFMA on the Web**

The transformation of news delivery is a good example of the benefit HFMA and its members have enjoyed as a result of the revolution in electronics. “It used to be,” said Clarke, “pretty much the only time we would touch most members was once a month through the magazine and at any educational event they might attend. Today we are able to touch every member and many others as well every day through our daily updates to our web site and information delivered by e-mail.”

In 1990, members were getting their news about regulatory and policy developments through WASHLINE, a prerecorded phone message service prepared by HFMA policy analysts in the Washington, D.C., office. In 1993, the Association pilot-tested HFMA NET, an online bulletin board, accessed via personal computer via a toll-free phone number. The next year, it was opened to all members (although it was no longer a toll-free call!), and HFMA started down the information highway.

1995 was a watershed year: WASHLINE and WASHLINE+/FAX, a subscription service, were replaced with *HFMA Express News*, delivered by fax, and HFMA News Line, a pared-down version of WASHLINE that also allowed users to transfer directly to the Member Service Center. HFMA NET added e-mail and press releases, which chapters (and the media) could download as news occurred. And, oh yes, there was the launch of the home page, with those pesky slashes in the address.

The Association created a new position in 1996, vice president of decision support, to lead implementation of HFMA's new, five-year information technology plan, including a flexible management information system infrastructure, increased use of the Internet, and an online technology library. The grand opening of Virtual HFMA in 1997 included six virtual seminars, hosted in the Virtual Conference Center by healthcare experts. Members had access to HFMA resources, chapter program calendars, and peer networking via online discussion groups—24 hours a day.

And before anyone could say millennium, *HFMA Express News* had become a free benefit, sent by e-mail, which included Internet links to government web sites and other resources. Virtual HFMA got a new search engine and, in June 2000, the HFMA Knowledge Network went online. The new century was barely underway and already the HFMA web site was featuring an online version of the *Resource Guide*, weekly updates to classified ads, chapter member directories, APC Daily Update, and online ordering of products. Members with e-mail addresses were allowed to vote electronically in the 2001 election of HFMA national officers and directors, and 84 percent of voters did so—saving \$15,000 in postage and other costs.

New benefits piled up as the web site expanded and navigation became easier. Members could now visit reader-friendly focus areas in the Resource Center (Medicare Payment, The Business of Health Care, Patient Financial Services, Commercial Payment, Leadership/Management), each divided into sections specifying the type of resources available—articles, tools, authoritative sources,

relevant statistics, and compliance tips. The Resource Center was now home to hundreds of pages of information about industry issues, HFMA policies and activities, links to government resources, and *Federal Register* updates.

Along with the job bank, chapter resources, and the membership directory, the Resource Center quickly became one of the most popular areas of the web site. It offered broader search capabilities for current and archived material from *hfm*, *Express News*, and *HFMA Wants You to Know*, a biweekly e-mail newsletter that had a circulation of close to 70,000 by 2006. *HFMA Wants You to Know*, the first e-mail newsletter the Association presented in HTML format, features a single short article on a hot topic, accompanied by links to HFMA resources.

Meanwhile, the news delivery was changing. Because e-mail is more readily used for scanning than in-depth reading, it was decided to include excerpts of news stories in *Express News* along with web site links to full stories and document sources—saving longer treatment of stories, along with highlights of hot news and a summary of regulatory updates, for the magazine. Blogging software provided the flexibility required to post news as it happened and to present longer content when needed; it also allowed the launch of HFMA Views, a blog of opinion on healthcare finance issues.

The thing about the information highway, of course, is that it never stops or even slows down. And so at ANI 2006, the Association unveiled a new web site with even more intuitive navigation and an even more powerful search engine, complete with meta tags (electronic identifiers attached to specific words and phrases that make advanced searches more effective). The Resource Library (a new name) now includes lists of topics and content formats that make it even easier to narrow searches.

“HFMA is a vital resource to the healthcare financial industry,” said Clarke, “and as such, it is important that our members and other leaders in health care, business, and government have access to our publications, reports, and resources. The upgrades will make it easier for HFMA to serve the information needs of this diverse group by enhancing the functionality of the site.”

## The Magazine

*Hospital Accounting: Official Journal of the American Association of Hospital Accountants* became *Hospital Financial Management*, which became *Health-care Financial Management*, which became *hfm* magazine. Although the name of HFMA’s magazine has changed through the years, two elements have been

constant: It is HFMA's most visible and one of its most popular member benefits, and it has evolved to better serve members' needs.

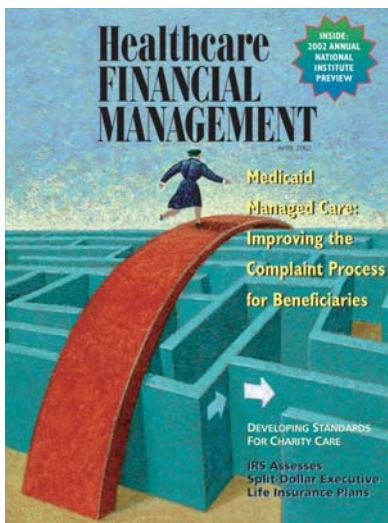
HFMA's magazine always has been a primary means by which members interact with the Association. Through the years, the magazine staff has worked to ensure that it provided members with the information and tools they need to fulfill their professional goals.

Authors of *hfm* magazine articles are experts, rather than journalists, because of their ability to provide the in-depth information that HFMA's highly knowledgeable members need. The articles go through a peer review process to validate their relevance and accuracy.

From the early 1990s through today, the magazine has taken advantage of several opportunities to better serve HFMA's members.

### *Closer Link to the Market*

HFMA has more closely aligned its research into member needs with the magazine's editorial planning, including identifying topics and specific approaches to a topic. Editorial staff actively pursue articles from experts on the identified topics and work with them closely developing the articles.



*Healthcare Financial Management and its successor, hfm.*

### *More Focus on Strategy*

As the roles of HFMA's members call for more strategy, the magazine also has increased its coverage of issues such as strategic financial planning, business development, technology planning, and the link between healthcare quality and business. In short, the magazine began to address financial managers as leaders. The magazine added a Commentary section to highlight such leading thinkers as Kaiser Permanente chairman and CEO George C. Halvorson, and Harvard Business School's Regina E. Herzlinger, PhD. The magazine also added a Q&A section to capture thoughts of other leading thinkers, such as presidential advisor David Gergen and Louisiana Senator John Breaux.

### *More Engaging Articles*

HFMA members have responded positively to the magazine's straightforward, fact-based style. However, given the rapidly rising number of information sources fighting for members' attention, the magazine has created more engaging headlines and editorial "hooks" to draw readers into the articles, as well as a more conversational style in some columns. Principally through a department called Etcetera, the magazine also has offered some humor and some stories about what makes HFMA members special.

Early in the new century, the graphic identity of the magazine changed significantly to correspond with the new graphic identity and branding of the Association itself. The new cover and text design is more inviting, less formal.

As a result of these changes, along with a shift in approach to advertising sales, the magazine experienced significant growth. In 1991, its average monthly page count was 120, while in 2006, its average monthly page count was 192. More important, readers say they spend an average of 58 minutes with each issue, which is high compared with the industry average.

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**The first *HFMA Resource Guide*, published in 1995, had information on 205 vendors. Two years later, the number had grown to more than 900. In 2006 it had 1,407 listings. In 2001, the *Resource Guide* went online.**

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In a parallel development, HFMA began to publish more special reports and roundtable discussions in the magazine, as stand-alone pieces, and on the web site. Twenty such sections were published in 2006. These special sections, underwritten by sponsors and advertisers, have provided HFMA members with a rich source of in-depth information on timely topics.

The magazine is a success, but never static. Editorial staff are always planning, reshaping, and introducing new features and content to engage readers and keep them on top of new developments in the industry. Recent additions have included *hfm* Toolbox, a regular department providing tools for assessment, planning, and tracking of financial performance; New Revenue Growth, a column that received a silver award from the American Society of Healthcare Publication Editors in 2005; and Strategy Challenge, which presents a scenario followed by a strategic question readers are invited to answer.

## Newsletters

The magazine is not the only regular publication HFMA uses to communicate with its members. Since 1990, a host of print newsletters have joined the ranks; the subject matter and target audiences are an indication of the shifting challenges facing HFMA's members:

- *Patient Accounts*, the venerable veteran that had been around since 1978, was filled with short how-to information for an important segment of HFMA's audience. In 2004, it morphed into *Revenue Cycle Strategist*, addressing the hottest topic for healthcare financial managers.
- *Managing the Margin* (2002) delivers strategies for increasing volume, reducing costs, and strengthening the organization's bottom line, as well as best practices that providers should keep in mind when benchmarking performance.
- *Executive Insights* (2002) talked management strategies to financial leaders. In 2006, it was transformed into *Strategic Financial Planning*, which focuses on facilities and real estate, capital, information technology, competitive strategy, and demand forecasting.
- *Supply Chain Solutions* (2005) deals with an area that may take up only a small percentage of a financial manager's time, but that has a huge effect on an organization's overall financial situation.
- *The Business of Caring* (2006) is one facet of HFMA's initiative to engage nursing in business planning. This training tool talks about core healthcare business concepts—such as how the prospective payment system works—as well as practical issues like how best to navigate an Excel® spreadsheet.



- *Big Business for Not-So-Big Hospitals* (2006), as the name implies, is written for rural and urban hospitals with fewer than 200 beds, which are most of the hospitals in the country and which have special issues of their own.
- *Consumer-Directed Healthcare* (2006) provides practical, real-life strategies and tools to help hospitals be financially successful in this rapidly growing business model.

## Going to the Source

As HFMA has expanded its coverage of issues crucial to healthcare finance, it is important to consider where this information comes from. Over the years, HFMA has cultivated an evolving group of content experts and sources to tap, with HFMA shaping and delivering the information in a way that targets the needs of specific member segments. Most of these sources are HFMA members, a fact that reinforces the collective value of the Association's members.



A collection of HFMA newsletters that focus on specific topics with targeted audiences.

Simultaneously, HFMA has refined and expanded its own content expertise, through the insights and experience of HFMA's technical staff and through HFMA's industry research. This combination has fed HFMA's web- and print-based information and also has led to a series of groundbreaking special projects, as the next chapter describes.

### **Old Wine in New Bottles**

*HFMA's Introduction to Hospital Accounting* hasn't been around as long as the Association, but close to it. The origins of the book date back to a mimeographed booklet developed by L. Vann Seawell and used in a correspondence course in hospital accounting offered by Indiana University and the American Association of Hospital Accountants. The success of the course led Seawell to write *Principles of Hospital Accounting*, first published in 1960. After revision and a new title, three more editions were published before a 10-year hiatus, followed, in 2002, by a fourth edition by Michael Nowicki, EdD, FHFMA, FACHE, and Steven H. Berger, FHFMA, CPA.

As part of its continuing commitment to introduce and maintain education materials that represent the body of knowledge about healthcare financial management, HFMA brought out a fifth edition by Nowicki in 2006, published by Health Administration Press, a division of the American College of Healthcare Executives.

# Research: Taking the Lead

**R**esearch has always been a critical component in fulfilling HFMA's broader vision of being an indispensable resource for healthcare finance.

The years since the early 1990s have seen a wealth of HFMA studies and surveys that have provided valuable insights and guidance to the field in key professional challenges, such as compliance, revenue cycle, labor costs, and capital access.

Research subjects mirror the issues that members are dealing with at the time. However, HFMA also sees its role as getting there ahead of its membership, anticipating the need—for regulatory guidance, for strategic alliances, and for changing policies and practices to fit new realities—and being ready with tools and ideas to meet it.

Among the questions HFMA sought to answer in the 1990s and 2000s:

- What are the benefits and impact of merging clinical and financial data at leading health networks nationwide?
- What are the costs of risk in healthcare organizations?
- How are members benchmarking their performance?
- How successful is the revised Medicare cost report audit process?
- What strategies are being used to improve value in health care?
- What are members doing to prepare for HIPAA—and what should they be doing?
- How is the role of healthcare benefits changing?
- What are the barriers and best practices related to supply chain management?
- What opportunities exist for improving the revenue cycle?
- How can organizations overcome the financial impact of labor shortages?
- How efficiently are operating rooms being run?
- How can the industry overcome barriers to adoption of electronic health records?

All the while, of course, the Association was constantly taking the pulse of its members: What are they worried about? What do they want and need to know right now? How much are they making? What career paths are they following?

Among the most significant research initiatives for HFMA in the past 15 years are the Financing the Future project and the Patient Friendly Billing project.

### **Financing the Future**

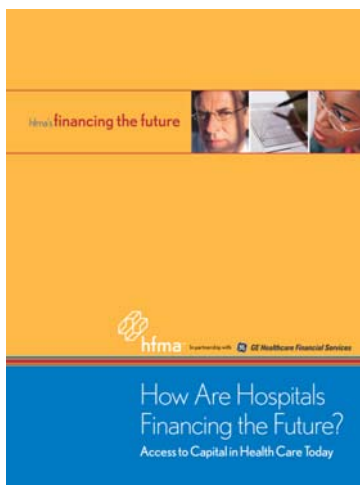
By the end of the 20th century, aging facilities, increased demand, and new technology had combined to make construction and renovation an imperative for many hospitals and health systems. But inadequate payment and rising costs begged the question whether hospitals would be in a position to access the capital they needed. In 2003, HFMA stepped in to help the industry understand the true situation with respect to capital need and access, as well as successful practices to fund needed capital projects.

Called “Financing the Future,” the project’s first series comprised six reports over 12 months that received extensive attention in the healthcare, news, and policy-making communities. Led by HFMA in partnership with GE Healthcare Financial Services and with research conducted by HFMA and PricewaterhouseCoopers, the series brought together key stakeholders to share knowledge about and produce solid empirical evidence of healthcare capital needs and availability, as well as factors associated with access. The series provided in-depth information that continues to be cited and used extensively in the healthcare industry.

Following are among the key research findings:

- The gap separating “have” from “have not” hospitals is widening. Between 1997 and 2001, the percentage of hospitals with broad access to capital declined from 42 percent to 36 percent, and the percentage of hospitals with limited access to capital rose even more sharply, nearly doubling from 11 percent to 19 percent.
- Many hospitals are no longer spending 100 percent of annual depreciation expense on capital spending. In 41 percent of hospitals, capital spending lags behind depreciation.
- Hospital CFOs expect to increase capital spending significantly, projecting annual increases of 14 percent during the next five years (compared with 1 percent increases between 1997 and 2001).

The first Financing the Future series began the process of highlighting strategies hospitals and other healthcare providers could use to improve access to capital through successful financial planning and execution. Financing the Future II continued this process. Its cornerstone principle, carried through in each of its six reports, is this: Adherence to a rigorous corporate finance process is critical to a hospital's ability to increase access to capital, make wise investments in the organization's future, and improve financial performance. Thus, the goal of Financing the Future II was to define, provide examples of, and encourage the implementation of a successful, corporate finance-based approach to financial management in healthcare organizations. By providing practical how-to information in the form of concrete strategies, tools, timelines, and other materials, the second Financing the Future series seeks to help healthcare organizations of all sizes raise the bar on financial performance.



Financing the Future

HFMA's partners for Financing the Future II were GE Healthcare Financial Services and Kaufman, Hall & Associates.

HFMA is continuing the project with a third series of reports to be launched in 2007. This series, also in partnership with GE Healthcare Financial Services, will address selected macro trends that can affect hospitals' capital positions, including payment system changes, need for new technology, unfunded liabilities, and creation of "hospitals of the future."

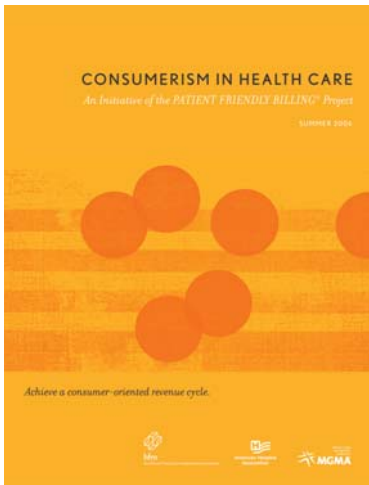
It wasn't just not-for-profits or organizations strapped for cash that mined these reports for much-needed perspective and tools. According to Beverly Wallace, president of Shared Services Group, HCA, and a member of HFMA's National Board of Directors, 2003-06, investor-owned hospitals may not use HFMA products and services to the same degree as non-investor-owned hospitals, but they find them equally valuable. "A good example," she said, "is Financing the Future."

“We do things differently inside HCA, and we have a full team of people that do all of our financing and the management of capital deployment, but we took that series and we enhanced our process. We made sure we were getting the best of the best. That’s how you can take something that is constructed based on the whole, all providers, and deploy it in different environments.”

Financing the Future raised the visibility of the HFMA, but most important, it raised important points for a long-overdue discussion by industry stakeholders.

### The Patient Friendly Billing Project

For most patients, hospital bills have not only been confusing, often enraging, but almost meaningless, in the words of Joanne Judge, HFMA’s 1991–92 Board Chairman. “Patients weren’t paying for them and in many cases never saw them. The system that evolved was really much more geared toward the Medicare program. But then as the payment mechanisms began to change, individuals became much more focused on their bills.”



Patient Friendly Billing project

Judge continues, “HFMA realized early on that bills were not something the average person was capable of understanding, that we were not providing a good service.”

Having done his doctoral dissertation on the effort to correlate patient satisfaction with financial success, HFMA President and CEO Richard L. Clarke knew intimately the high cost of dissatisfaction—the mildest word that could be used to describe patients’ general feelings about hospital bills. He learned first-hand what it felt like when, after his father’s death, he tried to help his mother with the paperwork. There were separate bills and statements from the 20 different

providers that had been involved in his father’s treatment, none of which, he said, bore any apparent connection to the others. Clarke’s 86-year-old mother could understand none of it. Neither could Clarke.

“I actually had to build a spreadsheet to try to track the bills. It really brought home to me the absurdity of the current system.”

## Principles and Practices Board

The P&P Board was established by HFMA in 1975 to reevaluate, clarify, and establish accounting principles and financial reporting practices of health service organizations. It also acts as a liaison with the American Institute of Certified Public Accountants, the Financial Accounting Standards Board, and the Governmental Accounting Standards Board. The P&P Board's 12 members have demonstrated technical excellence and outstanding personal and professional qualities. Since its inception 35 years ago, the P&P Board has issued 25 statements and analyses on industrywide challenges.

Between 1990 and 2006, the P&P Board released the following statements:

- No. 15. *Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Healthcare Providers* (1993). Updated in 2007.
- No. 16. *Classifying, Valuing, and Analyzing Accounts Receivable Related to Patient Services* (1993)
- No. 17. *Assessments and Arrangements Similar to Taxes on Tax-Exempt Institutional Healthcare Providers* (1994)
- No. 18. *Public Disclosure of Financial and Operating Information by Healthcare Providers* (1994)
- No. 19. *Transactions Among Affiliated Entities Comprising an Integrated Delivery System* (1996)
- No. 20. *Healthcare Mergers, Acquisitions, and Collaborations* (1997)

Between 1990 and 2006, the P&P Board released the following issue analyses:

- Acquisition of Physician Practices (1995)
- Assessing Managed Care Contracting Risk (1997)
- Compliance with Laws and Regulations for Healthcare Organizations (1998)
- Recognition of Other-Than-Temporary Decline in Investments for Tax-Exempt Organizations (2002)
- The Relationship of Community Benefit to Hospital Tax-Exempt Status (2005)

The P&P Board's most recent statement was a groundbreaking approach to one of our industry's long-standing challenges—consistent valuation and reporting of charity care and bad debt.

And so it was that HFMA came to spearhead the Patient Friendly Billing project, a collaborative endeavor with support from the American Hospital Association, the Medical Group Management Association, and dozens of leading provider and professional organizations. Their purpose: to develop recommendations for corrective actions that could be implemented by hospitals and healthcare systems now without waiting for legislators to act first.

The first task force meeting was called to order in 2001. Five years and five reports later, Patient Friendly Billing was still going strong, still pursuing the same objective: to create clear, correct, concise, and caring bills.

The project began its work by conducting focus groups of patients and healthcare workers, who verified, loudly and clearly, that patient billing was a significant problem for all parties. “Billing is a fairly narrow area, but the concept really applies to all areas of the patient’s financial experience, from the time they make their first appointment through the final resolution of their bill,” explained project leader Terry Allison Rappuhn, CPA, then CFO of Quorum Health Group, one of the sponsoring health systems. In 2002, Rappuhn took over as project leader for Patient Friendly Billing.

“Our work says that if you design the process around what the patient is experiencing, you get better outcomes for the provider—more productivity, quicker payments—as well as the patient.”

### ***Task Forces***

The project pulled together different task forces around specific issues involved in that process, including a vendor task force that looked at ways to use technology to create a consumer-friendly system that consolidates or coordinates communications and payments from providers, payers, and employers.

Technology was the focus of the project’s third report, following the initial report on focus group findings and another, six months later, on approaches used by medical group practices. In 2005, came discount and collection issues with the uninsured and underinsured, and then a report on consumerism in health care, which Rappuhn considers to be the next generation.

“All the prior reports were the building blocks, the philosophy, and some robust examples. But this is a new way of thinking. It goes beyond producing a bill that’s easy to read. It goes to the vision of what we should be doing five years from now.”



## The Future of Electronic Health Records

Electronic health record systems hold the promise to address the two most crucial challenges to the U.S. healthcare system: controlling costs and improving quality. As such, it is a natural area for HFMA to address through a major report in 2006: *Overcoming Barriers to Electronic Health Record Adoption: Results of Survey and Roundtable Discussions*.

Among its findings: The most significant barriers are lack of national information standards and code sets, lack of available funding, concern about physician usage, and lack of interoperability. The majority of hospitals are looking to the government to facilitate development of national and code sets, provide grant funding and payment incentives, accelerate investment in regional networks, and simplify the Medicare payment systems. In the meantime, providers are participating in regional information networks, exploring connectivity and financing solutions with vendors, and identifying physician champions, among other leading strategies.

In addition to the five major reports, the task forces have produced a wealth of practical tools, including sample patient education brochures, communications flow statements, checklists, patient FAQs, a patient glossary of billing terms, and a moderator's guide for focus groups.

"Some of the states took the issue and tried to do their own initiatives," explained Wallace. "But because HFMA got out in front of it, a company like mine that does business in 30 states isn't having to do it 30 different ways. We actually did patient satisfaction surveys before and after implementing the project standards, and we saw reduced cost and increased patient satisfaction."

Having proposed an approach to meaningful price transparency in the *Consumerism in Health Care* report, in 2007 the Patient Friendly Billing project turned its attention to the pricing system, which contributes so significantly to the problem with providing stakeholders with meaningful price information. The 2007 report will identify principles of an ideal pricing system, research findings about barriers to such a system, and steps providers can take now toward rational pricing in an illogical environment. Subsequent efforts of the project will identify steps toward consensus among all stakeholders in a new pricing approach. Future HFMA projects also will tackle the payment system

with the goal of identifying fair, efficient, and effective ways to distribute funds from payers to providers.

For its leadership of the Patient Friendly Billing project, HFMA was added to the 2003 Associations Advance American Honor Roll by the American Society of Association Executives. HFMA and Clarke also were recognized by the American Hospital Association by receiving its Board of Trustees award in 2004.

## CHAPTER 6

# Networking

Networking has consistently been recognized as one of the primary benefits of belonging to HFMA. Seasoned veterans and newcomers alike wax eloquent about their fellow members being ever ready, willing, and able to help out: to inspire, to share, to collaborate, to commiserate. “You will never find nicer, warmer, more helpful people anywhere” is a theme with a thousand variations. “It’s not just professional,” says one member after another, “it’s personal—these people are my friends.”

They are also, in every sense of the word, colleagues. Networking is about making contacts with people who can help you do your job better—or help you find a better job. In recent years, HFMA has added a number of components to facilitate both facets.

### *Forums*

The first two special member groups, for CFOs and patient financial services managers, were established in 1990. Member-only services include roundtable discussions, “hot topic” information (shared by fax at first), peer directories, newsletters, and an opportunity to have input into the Association’s advocacy efforts; within a few years, the Internet would make it easier to exchange news and views with dedicated web sites, e-mail groups, and audio webcasts.

Managed care was next, as a changing payer scheme led HFMA members into new areas and settings in the mid-1990s. The Association developed a resource kit to help chapters recruit members from managed care, exhibited at managed care conferences, added a managed care column to the magazine, introduced the first new certification designation since 1969 (Certified Managed Care Professional) and, in 1995, established the Managed Care Forum.

Two new forums, for compliance officers and post-acute care services, were set up in 1998 and 1999, respectively. A Forum Advisory Council was formed to guide the focus of the forums.

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**“I’ve worked in four different organizations, in four different communities, and HFMA has been the constant, the rock in my professional life. As I progressed in my career and changed roles and organizations, I always knew where I could go to get connected and find information and familiar faces.”**

MICHAEL M. ALLEN, FHFMA, CPA, VICE PRESIDENT AND CFO,  
WINONA HEALTH SERVICES

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The number of forums has stayed at four, but the resources are continually augmented, updated, and refined. In 2004, forum newsletters were redesigned to focus on peer-to-peer interaction and real-world solutions to top-of-mind topics.

### *Communities of Practice*

The Future Leaders Community of Practice debuted at ANI 2006. This subscriber-based virtual community was designed as a way for members to connect with others who are passionate about developing their knowledge and skills in a given specialty area—in this case, preparing for greater leadership roles.

The technology allows individuals to enjoy real-time, focused information sharing of all kinds. Members can:

- Design their own learning events, including face-to-face meetings at HFMA conferences and meetings, conference calls, audio webcast meetings, and virtual seminars with industry experts
- Post news documents for the entire community to read and use
- Network with other HFMA members in diverse settings to share strategies
- Post resources and tools to further a specific discussion

There are currently two other communities of practice (for Medicare payment, and small and rural providers) and two planned (for accounting and finance leadership).

### *Other Resources*

Other milestones in HFMA networking in the past 15 years include the following:

- The first annual Patient Accounts Exchange was held in tandem with the CFO Exchange (1991).
- The first annual exchange with Canadian financial managers took place in Banff (1991).

- The annual exchange of delegates from HFMA/U.S. and HFMA/U.K. continues.
- The first patient financial services Forum Directory was distributed to members (1992).
- The first Leadership Directory was published, picturing and listing directors, chapter liaison representatives and presidents, and members of the National Matrix (1993).
- The Forum Advisory Council was redesigned to streamline volunteer efforts (2004).
- Forum newsletters were redesigned to focus on peer-to-peer interaction and real-world solutions to top-of-mind topics (2004).

### ***Founders Points***

The Founders Merit Award Program, which was established in 1960 to acknowledge volunteer contributions at the chapter level, underwent something of a transformation in the past decade or so, eventually coming full circle back to its origins.

In the mid-1990s, the Board authorized a shift in the program that linked founders points to the professional development process. Members could earn

### **Heard and Acted On**

Recently, the benefit of access to the diversity of thoughts and experiences that HFMA provides really came home to me. After Hurricane Ivan, which devastated many working poor in our community, we were looking for ways to redesign our financial assistance process to provide more help to those most in need. I had heard one of my colleagues at an HFMA event talking about the experiences of his organization's leadership team when they redesigned their program. They found that their collections were not hurt when they increased the income level at which they provided help to those above 150 percent of the poverty level, which was their historical threshold.

We no longer provide a sliding scale discount off charges for those under 150 percent of the poverty level. Instead, for those who are up to 400 percent of the poverty level, we ask for payment that provides at least a 30 percent discount but that computes an amount due based on the patient's income above the poverty level. We are excited with the early results.

*Michael R. King, FHFMA, vice president, finance, Baptist Health Care, Pensacola, Fla.*

points for attending meetings or educational events, pursuing certification, participating in audio teleconferences, or e-learning. Among other consequences, this action added considerably to the administrative burden of the program's contact at each chapter. More important, Association leaders came to see over time, it diluted the original purpose of the program. Something was lost. In 2003, the Board authorized the Regional Executive Council to find it and bring it back home.

The program now awards founders points for volunteer activities at the chapter, regional, and national levels, including activities such as writing articles for national and chapter publications, volunteering as a speaker or panel member at an educational program, serving on a chapter committee, regional council, or chapter advancement team, proctoring a certification exam, or writing a book review for *hfm*.

Managing founder points was made easier with an online reporting system that makes detailed historical information by member, chapter award lists, and complete chapter membership lists with point totals accessible 24/7.

### **Association to Association**

Just as individuals find great value in networking with their peers in HFMA, so too does HFMA itself—its peers being other associations and agencies with a similar concern for the well-being of the healthcare industry. In recent years, as integration of the clinical and financial facets of health care has moved from experiment to bedrock principle, HFMA has reached out more aggressively to collaborate, to offer and ask for help, and to make common cause.

### ***Health Leadership Alliance***

“The strongest relationships,” said HFMA President and CEO, Richard L. Clarke, “are the ones we have with our sister organizations, which are the other personal membership groups”—the American College of Healthcare Executives, the Medical Group Management Association, the American College of Physician Executives, the Healthcare Information and Management Systems Society, and, most recently, the American Organization of Nurse Executives. In 1999, the six groups that serve the C-suite, which had been meeting informally since the start of the decade, came together to form the Health Leadership Alliance. Among other projects that have come out of the Alliance are a joint member satisfaction benchmarking study, an annual study of membership re-credentialing and retention trends, and joint educational programs.

## Moving On Up

How far can networking take you? All the way, according to David Canfield, president of Canfield & Associates and HFMA National Board Chairman in 2003–04. “I have never interviewed for a job,” he said. “Networking—along with being in the right place at the right time—has taken me from the ground floor, literally, to being president of my own company.”

Canfield started as janitor at a local hospital right out of high school, moved up from housekeeping to the accounting department, and then kept right on going: billing and collections, computerized collections, collection manager, business office manager, and director of patient accounting. “And this is where HFMA entered the picture. I found each one of my next positions through HFMA contacts—business office manager at two different hospitals, then corporate director of patient financial services for two hospitals. All without ever interviewing!”<sup>a</sup>

In addition to myriad opportunities for making and nourishing valuable professional friendships, HFMA has offered targeted resources for members seeking leads on healthcare finance jobs: an online resume referral service for senior-level executives, called Exec-U-Trak Career Network (1990–2002), and the biweekly *Career Opportunities* e-newsletter (2006), which also offers career and professional development tips.

Most recently, the Alliance produced an online, interactive tool called the HLA Competency Directory, which identifies 300 professional competencies across five major domains of healthcare management: leadership, communications and relationship management, professionalism, business knowledge and skills, and knowledge of the healthcare environment. In development from 2003 to 2005, the directory is now being used by all six member organizations.

“These aren’t standards,” said Clarke, “but we use them in the development of education programs and to enhance the certification process. It includes not just the technical things we’re known for but also some of the softer leadership skills, which are critical for healthcare executives in this environment.”

### ***American Hospital Association***

One of the most visible of HFMA’s relationships is with the AHA. “There are obviously times when a major trade association and a major professional membership

a. “Healthcare Finance is Personal for HFMA’s New Chairman, David Canfield,” *hfm*, June 2003, pp. 36–40.

association are going to be working on some of the same things,” said Clarke, citing recent examples of consumerism, price transparency, and pricing.

“At times in the past, our relationship with AHA has been difficult, with both of us concerned about consistency and overlap in our interests, but I think they have a high level of respect for us now, by virtue of the fact that we’ve gotten better at doing certain things and also because of the work we’ve been doing together on the Patient Friendly Billing project.”

Dick Davidson, immediate past president of AHA and winner of the 2000 HFMA Board of Directors Award, agreed. “HFMA has been a great partner, providing expertise and consulting with us, especially on the Patient Friendly Billing project.”

In fact, even before the formation of the National Uniform Billing Committee, HFMA worked closely with AHA and the federal government to develop a uniform hospital bill.

Other examples of the two associations pulling together for the common good include the 1998 Campaign for Coverage—A Community Health Challenge, a national drive to reduce the number of uninsured, launched by AHA and cosponsored by HFMA; and the creation of *Black Ink*, a weekly news and education series addressing topics such as workforce recruitment and retention, disaster management, and capital trends and analyses, in which HFMA and AHA joined forces with GE Healthcare Financial Services.

### ***Financial Accounting Standards Board***

In 1993, HFMA members helped FASB field-test exposure drafts of guidance on financial statement display by not-for-profit organizations and on accounting

#### **9/11**

When the terrorists struck on September 11, 2001, one member of HFMA was lost, one saved. Ian J. Gray, a principal with McBee Associates, Inc., was a passenger on American Airlines Flight #77, which crashed into the Pentagon. Deborah White, MD, senior medical director of quality for Empire Blue Cross/Blue Shield, who was a National Board member at the time, walked down from the 24th floor of Tower 1 to safety.

The National organization donated \$1,000 to a fund established for Gray’s daughter. Many HFMA chapters contributed to relief funds.



and financial reporting of contributions. In 1996, HFMA testified at a public hearing on the reporting model developed by the General Accounting Standards Board and presented updates to both organizations. The Association's positions were part of the American Institute of Certified Public Accountants *Healthcare Audit Guide* that came out that year.

In 2003, the Financial Accounting Standards Board's Emerging Issue Task Force cited an issue analysis prepared by the Principles and Practices Board as a resource for its background work for a statement on the meaning of other-than-temporary impairment and its application to certain investments. The analysis was one of the first efforts within the financial reporting community to address this difficult topic. "The P&P Board knew it was important to get something out quickly that clarified this topic for our industry and membership, because the effects were likely to be significant," said then P&P Board chairman Kelly Barnes, CPA.

### ***Other Relationships***

In the late 1990s and early 2000s, HFMA:

- Formed a strategic alliance with The IPA Association of America to examine financial and operational characteristics of the integrated physician association industry
- Launched HFMA Serves America II: Making Medicare Easier, in partnership with the Society of Actuaries Foundation, expanding the scope of the project from Medicare recipients to their entire families
- Joined ACHE, American College of Physician Executives, and AHA in forming the National Information Center for Health Services Administration, which produced information for members of all four groups
- Teamed up with more than 100 hospitals, associations, and businesses to create the Coalition to Protect America's Health in an effort to help shape the healthcare debate; in its first year, the coalition achieved additional relief from the Balanced Budget Act
- Helped found the National Alliance for Health Information Technology, which testified before the FDA on the use of bar-coding technology for human drug products and before the National Committee on Vital and Health Statistics on how to coordinate the work of both organizations
- Rejoined the National Uniform Billing Committee
- Established a committee with the American Association of Health Plans (now known as AHIP, America's Health Insurance Plans) and the National Coalition of Specialty Societies to identify ways to improve efficiencies related to eligibility issues and duplicate claims

- Joined with 18 other organizations to develop an electronic central post office, which will make it easier for bond issuers to file secondary market disclosure documents
- Joined the Operating Rules Committee, an industrywide initiative to develop operating rules for transmitting eligibility and benefits information, building on the HIPAA 270/271 transactions for eligibility benefits
- Hosted one of CMS's live open door forums during ANI.

The Association cosponsored numerous educational programs, including an Integrated Healthcare Conference: Managing the System (with the Medical Group Management Association and ACHE); the 1999 Healthcare Symposium (with ACHE, ACPE, Association of Perioperative Registered Nurses, and HIMSS); and Managed Care and Claims Processing: Improving Communications Between Health Plans and Providers (with the AHIP). At the 5th Annual Non-Profit Investor Conference, which it cosponsored with AHA and Citigroup, HFMA released a white paper, *Electronic Health Records Investments: The Value Case for Senior Healthcare Financial Executives*.

Looking ahead, HFMA agreed to partner with the National Patient Safety Foundation on the NPSF Value Proposition Template Initiative, which will make the business case for various solutions in terms that are relevant to chief clinical and administrative executives. It also plans to support the Association for Healthcare Resource & Materials Management in preparing an important benchmarking tool for the industry.

“With tighter and tighter profit margins being the rule rather than the exception, control of supplies and supply-related expenses is vital to any successful financial strategy,” said Clarke. As a member of AHRMM's Benchmarking Task Force, “HFMA is pleased to collaborate in helping to define this important standard.”

### **Strength in Numbers**

A core value of any association is its ability to bring people together. HFMA has done so in a multitude of dimensions, but with a single purpose: helping healthcare organizations have the resources to provide excellent care. That has been done on the smallest scale—one member having a discussion with another—and on a large scale—multiple organizations determining competencies for health administration. No matter the scope or scale of the interaction, HFMA has devoted much care to the development and nurturing of these relationships. After all, HFMA *is* personal.

# Conclusion: The Voice of the Members

One theme that runs through this history is the importance of members. HFMA activities are designed to reflect member needs and are designed to give members skills and opportunities they can use to make a difference.

Therefore, we conclude this book by listening to the voices of our members as they tell us what HFMA has meant to them.

## Building Leaders

In 2004, Phyllis A. Cowling, president and CEO, United Regional Health Care System, and HFMA National Board Chairman in 2002–03, made the move from being CFO of one organization to being CEO of another.

I will tell you that it is pretty rare. There's no question that my involvement with HFMA provided me with the skills and the confidence to do that. HFMA helped me develop strategic planning skills, professional-relationships-building skills, creative thinking, and public speaking. Without a doubt, my leadership within HFMA also helped give my new board the confidence to take that risk on an unproven CEO. HFMA builds leaders.

Another HFMA leader who rose to CEO is HFMA's 1992–93 Chairman Bonnie L. Phipps, who is now president and CEO of Baltimore-based St. Agnes Health System.

“Being Chairman of HFMA, and the steps leading up to that role, allowed me to experience the breadth of expertise that an executive must have in an organization to make it successful. I also understood very quickly that you don't need to have all of those talents yourself, but can develop a staff that will complement and support you as you lead an organization.”

Richard J. Henley, HFMA 1999–2000 Board Chairman, also found that his progress from CFO to CEO was helped by, and continues to benefit from, his involvement with HFMA. Henley is president and CEO of Pocono Health System in East Stroudsburg, Pennsylvania.

I feel privileged to have had the opportunity to serve as HFMA’s National Chairman in 1999–2000. My term as Chairman, as well as the years I served as a director and officer, enabled me to hone my leadership skills, allowing me to advance in my professional career from CFO to COO to CEO while being engaged with HFMA at the chapter and national levels. Leading a board of outstanding professionals from all parts of the country offered me a broader national perspective, from small hospitals to large healthcare systems. This has enabled me to cultivate relationships with seasoned industry professionals, which is crucial for the success of a senior healthcare executive in these challenging times.

William H. Nelson, president and CEO of Intermountain Healthcare and 1995–96 HFMA Chairman, also credits HFMA’s role in his move from senior financial executive to CEO.

I greatly value the years I spent in leadership at HFMA, especially when I was Chairman. It gave me national perspectives I hadn’t had before, and it gave me perspectives on health care and different ways of evaluating health care that have been critically important to me in my role as CEO. I valued the experience I had working with people of different backgrounds and circumstances in their healthcare organizations. Plus I made many wonderful lifelong friends whose perspectives I admire and who have been helpful to me in discussing issues and challenges. Overall, my year as Chairman has been incredibly meaningful for all I’ve done since then.

### **The View from the Small Side**

HFMA works hard to ensure that it covers issues of interest to all hospital and health system settings. Perhaps the most challenging setting to address is the small hospital, where a CFO might have to mow the lawn, as one former HFMA Chairman put it. According to Winona Health Services’ Michael M. Allen, whose facility has 99 beds, HFMA succeeds.

As a resource, HFMA is even more important to me than it might be to a CFO in a really large facility or system. I have three HFMA members in my organization: the CFO, director of accounting, and revenue cycle director. We

don't have 20 management-level finance people, we just have the three. The Association becomes an extension of who we are when we need something more, because we won't have it internally.

### **New to the Field**

In 2003, Miccole Bowen, FHFMA, was a newcomer to HFMA—a member for less than two years. At that time she was patient accounts supervisor at St. Luke's Hospital of Kansas City, yet she already had some great experiences with HFMA, which she shared with then-Chairman David Canfield at ANI:

HFMA has given me great opportunities to learn about leadership. And I'm especially grateful for the mentors I've had. Although I'm new to HFMA, I became co-chair of our chapter's Membership Committee. Just the other month, we were looking for a way to learn more about member needs. Donna F. Findley, FHFMA, one of our board members, had the idea to conduct focus groups. Once Donna made that suggestion, she stepped aside and let me run the groups. But any time I had a question, she was there. She stayed involved, but never took over. So not only did the experience teach me about member needs, it was a leadership experience that was only possible because of a great mentor. The opportunities my HFMA mentors have provided me are invaluable.

### **New Perspectives**

HFMA can be a way to make connections that can change one's perspective of the profession and of health care. Ronald Barrow, FHFMA, member liaison at ShareCor in Baton Rouge, Louisiana, had such an experience.

Quite a few years ago, my boss at Blue Cross and Blue Shield of Louisiana thought it would be a good idea to send someone from our provider contracting department to a meeting of a hospital-focused organization. That organization was HFMA. The intent was to create some goodwill and do a little 'fence-mending.' I was designated to attend, and I must say I was more than a little apprehensive. For the first time, I would be meeting face to face people I had previously dealt with concerning contracting, billing, and payment issues only by phone or mail.

The first person I met at the HFMA meeting, much to my surprise and delight, was a friend and former Blue Cross Medicare auditor, who had since joined a hospital and was quite involved in the Louisiana Chapter of HFMA. I was also impressed at the warm reception I received from the chapter members.

By the end of the meeting, my preconceived fears were gone. My perception of how hospitals operate and how essential ongoing communications are had all changed. We actually had fun talking about all sorts of issues that were prevalent at the time. Our discussions also resolved many problems that were then merely miscommunication issues.

I left the meeting committed to become a member and help the chapter form a Blue Cross/Medicare Liaison Committee that would discuss problems from different points of view and report our committee recommendations at regular chapter meetings. Over the next few years, our committee proved to be a great communications tool and no doubt changed the course of many healthcare issues in Louisiana. The many friendships that have evolved among the members of diverse organizations in health care have resulted in better communication and understanding other points of view, which, in turn, has led to more equitable decisions for all.

Although I have retired from Blue Cross of Louisiana, I am very thankful that that first HFMA meeting I attended those many years ago has resulted in an appreciation of different perspectives and many long-lasting friendships.<sup>a</sup>

### Doing the Right Thing

With his 2006–07 Chairman’s theme of “Courage in Leadership,” Joseph J. Fifer reminds us that a core value of HFMA is making courageous decisions about important matters.

It’s very difficult to make the right decisions—to have the courage to do what’s right in a challenging environment. It would be a lot easier to stick to crunching numbers and wait for the government or the market or some other force to make decisions for us. But who’s going to stand up for our patients and our communities if we don’t?

Courage in leadership applies to all of us. Courage in leadership can be as simple as speaking up when we disagree with the majority or speaking up when others don’t. As the healthcare financial leaders in our organizations, we need to have courage and to be bold. We need to get out in our communities and talk about difficult issues, such as pricing or the hidden tax of governmental payments less than costs.<sup>b</sup>

a. “People: Bringing Diverse Groups Together to Resolve Issues,” *hfm*, Sept. 2005, p. 170.

b. Fifer, J.J., “Courage in Leadership,” *hfm*, June 2006, p. 32.

## Making a Difference

Active involvement in HFMA is a critical way for healthcare finance professionals to make a difference in their profession, according to HFMA's 2007-08 Chairman Mary Beth Briscoe, FHFMA, CPA.



Mary Beth Briscoe,  
FHFMA, CPA

We impact people on numerous levels—at home, in our communities, and professionally. ... Our work serves a larger purpose: to ensure that we have appropriate health care for generations to come. HFMA is a respected industry leader, and our work has been acknowledged nationally by numerous external organizations. Participating in HFMA makes you part of a nationwide effort to improve healthcare finance in this country.<sup>c</sup>

## Profession with a Purpose

What is the purpose of healthcare financial management?

On the last evening of HFMA's 2006 ANI, the attendees at the Chairman's Banquet heard as good an answer to that question as they are ever likely to hear. Fred J. Lucky, FHFMA, senior vice president of the Kansas Hospital Association, explained that purpose—and the role of HFMA—in the remarks he made upon receiving the 2006 Frederick C. Morgan Award, HFMA's highest individual honor.

To have your name even considered for this award is honor enough—to actually be chosen is beyond thinking for someone from Kansas whose daily goal is just trying to make every day a little easier for a number of hospitals, many of which, on a good day, have fewer than five patients and struggle to meet their weekly payroll....

I want to leave you with some final thoughts—thoughts that I think about every day on my drive to work.

We work in a noble profession, perhaps the noblest of all. I think about the miracles that happen in hospitals every day and I am in awe. Yet we are under constant scrutiny and criticism from business and political leaders that think

c. Williams, J., "Making a Difference," *hfm*, June 2007, p. 61.

we are too expensive and too costly, provide low quality, are not transparent enough, and take advantage of the uninsured. It's enough to wear you down. Yet I think about all of those miracles, all of those babies being born in need of neonatal intensive care and having it available, all the trauma and burn centers that need the most sophisticated equipment and highly trained and skilled individuals in cities all across this country, all the critical access hospitals in towns and communities that might wither up and die if they weren't there, and of the tender and compassionate care of our hospice workers, who bring dignity to the last hours of a patient's life—and I rejoice that I'm a part of it, however remotely.

Most of us in this room tonight are a lot alike. We can't provide the care and compassion for patients that I just mentioned, but we can help provide the means, we can doggedly fight for adequate funding, we can try to correct a massively flawed payment system that appears about to become even more so if CMS has its way. That's why membership in HFMA is so important. It makes my job so much easier and rewarding and I know it does yours as well.

Let me end with this quote from Winston Churchill: 'We make a living by what we get, but we make a life by what we give.'

### **The Value of Members**

That sentiment applies to HFMA as well. HFMA is a successful organization because of what its members give. That was true in 1946 and it is true today. And the commitment of HFMA's members is the reason HFMA will continue to thrive long into the future.







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