
FROM ACORN TO OAK



**A History of the Healthcare Financial
Management Association**



Robert M. Shelton, FHFMA, CAE

Elected AAHA/HFMA Presidents and Chairmen of the Board

Presidents

AAHA

1945-48 (a)	Frederick T. Muncie	Chicago, Ill.
1949	Charles F. Mehler	Erie, Pa.
1950-1951 (b)	George H. Long, Jr.	Philadelphia, Pa.
1952-1953 (b)	John M. Stagl	Chicago, Ill.
1954-1955 (b)	Sister Mary Gerald, CSC	Notre Dame, Ind.
1956	Robert H. Reeves	Rochester, N.Y.
1957-58 (c)	C. Henry Hottum, Jr.	Memphis, Tenn.
1958-59	Robert M. Shelton, FHFMA	Trenton, N.J.
1959-60	H. Ray Everett, FHFMA	Charleston, S.C.
1960-61	Sister Loretta Marie, FCSP, FHFMA	Great Falls, Mont.
1961-62	Ernest C. Laetz	Ann Arbor, Mich.
1962-63	Harry C. Humbert	New York, N.Y.
1963-64	Clifford C. Losberg, Jr., FHFMA	New Orleans, La.
1964-65	Sister Mary Assunta, S.C.	Colorado Springs, Colo.
1965-66	Robert L. Schultz, FHFMA	Des Moines, Iowa
1966-67	Harold Hinderer, FHFMA	St. Louis, Mo.
1967-68	Joseph D. Clancy, FHFMA	Lynn, Mass.

HFMA

1968-69	Jeff H. Steinert, FHFMA	Greenville, S.C.
1969-70	Sister Mary Bertrand, CSC, FHFMA	Denver, Colo.
1970-71	Charles H. Anderson, FHFMA	Decatur, Ga.
1971-72	William C. Van Lopik, FHFMA	Grand Rapids, Mich.
1972-73	Ronald R. Kovener, FHFMA	Cincinnati, Ohio
1973-74	Ida Milanese Fernandez, FHFMA	San Jose, Calif.
1974-75	Arnold P. Silver, FHFMA	Phoenix, Ariz.
1975-76	Bernard C. Scott, FHFMA	El Paso, Tex.
1976-77	Clarence F. Legel, FHFMA	Spokane, Wash.
1977-78	Joseph P. McCue, FHFMA	Boston, Mass.

Chairmen of the Board

1978-79	Herman H. Guenther, FHFMA	Colorado Springs, Colo.
1979-80	Tom F. Satterfield, FHFMA	Atlanta, Ga.
1980-81	Gerald W. Fuller, FHFMA	Waterville, Maine
1981-82	Raymond J. Cisneros, FHFMA	Boston, Mass.
1982-83	Park H. Haussler, FHFMA	Rochester, Minn.
1983-84	C. John Pattillo, Jr.	North Miami, Fla.
1984-85	Paul M. Long, FHFMA	Mount Holly, N.J.
1985-86	Herman A. Kohlman, FHFMA	Jasper, Ind.
1986-87	Kenneth A. Hews, FHFMA	Bangor, Maine
1987-88	Richard S. Blair, FHFMA, CMPA	Minneapolis, Minn.
1988-89	Glenn J. Black, Jr., FHFMA	Marietta, Ga.
1989-90	Sister Geraldine M. Hoyler, CSC, FHFMA	South Bend, Ind.
1990-91	David H. LeMoine, FHFMA	St. Louis, Mo.
1991-92	Joanne M. Judge, FHFMA	Lancaster, Pa.

KEY: (a) October 1, 1946, to December 31, 1946.

(b) Served two calendar year terms.

(c) Term of 17 months January 1, 1957, to May 31, 1958;
all others June 1 to May 31.

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Management Association



Robert M. Shelton, FHFMA, CAE



HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

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CIP

"People are the common denominator of progress."

John Kenneth Galbraith



This accounting is dedicated to the many thousands of members who have contributed to the continuous cultivation of this professional association, particularly its founders, its national and chapter leaders, and its staff.

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FOREWORD



How did we become who we are?

That question is asked by individuals of themselves, children of their parents, and members of organizations of their leaders. It is a difficult question to answer, because the development of a person or an organization is affected by many things. Decisions made, friendships formed, and the environment can have a dramatic impact on development.

HFMA's history was prepared with this spirit in mind. It was prepared not to dwell on the past, but rather to understand the forces and people that formed this organization. Understanding where we came from helps us understand where we are going.

The principles established by the association's founders continue to provide guidance today. Forty-five years after its founding, HFMA remains dedicated to member service by providing quality educational, informational, and networking opportunities.

This history was written by the thousands of volunteers who have given their time and talents to move the Association forward. Bob Shelton was asked to recall their efforts and his own to produce this history. Perhaps no other member is better qualified to undertake this task.

For more than 40 years, Bob has been an active member of HFMA. He served as the elected head of the association in 1958–1959, and led the staff as executive director from 1959 to 1978. He was certified as a Fellow in 1957. Bob was an integral part of HFMA's development and is as proud of what HFMA has become as a parent would be of his child in seeing its growth "from an acorn to an oak."

To Bob and the thousands of volunteers that made this organization what it is today, a hearty thank you from HFMA's more than 29,000 members.

Richard L. Clarke, FHFMA
President, Healthcare Financial Management Association

November 1991

PREFACE



A written history of the Healthcare Financial Management Association has always been in the minds of many of the association's leaders. In 1957, Robert H. Reeves, a member of the Organizing Committee of the American Association of Hospital Accountants (the association's original name), chairman of AAHA's first nominating committee, and the association's president in 1956, turned over to then President C. Henry Hottum, Jr., a collection of documents with the admonition that "at some future time they may prove to be interesting and valuable."

Frederick C. Morgan, who from 1949 to 1955 served as the association's secretary-treasurer and voluntary executive head, was a faithful guardian of correspondence and documents of the early years. These papers, as well as the written evidence of his busy, progressive tenure, were shipped to Chicago in 1956, where they remained intact until uncovered for this effort.

A Committee on History with the pioneer Robert Reeves as chairman was named by President H. Ray Everett in 1959. The committee recommended investigating the engagement of a qualified individual to write the association's history in the manner of the historical chronicle written for the American College of Hospital Administrators, but the board of directors believed that the time was not yet ripe and directed that a very brief history be written for publicity purposes and that the executive director maintain a historical reference file.

In 1968 as the association looked forward to its 25th anniversary in 1971, the board of directors authorized a study of the feasibility of commissioning the writing of a history. Although the study presented positive findings, the emergence of Medicare in that year caused the board to table the history project in favor of concentrating on the evolution in hospital accounting that ensued. The board did authorize the executive director to tape interview Reeves and Morgan at a convenient time, and this was accomplished in 1968 in Rochester, New York. The tape and the records provided by these gentlemen have been especially helpful in capturing the events of the association's early years.

At the outset of this assignment, I wrote to all of the association's past presidents and asked for their input in the form of recollections of their presidential tenure. I am indeed grateful for all of the assistance I received.

The original manuscript for the book took it to the year 1981, but through a review of board of directors minutes and other sources, I was pleased to update

it to the year 1991. Acknowledgment is given to Joyce Flory for her condensation of the earlier manuscript to ensure that linkages were accurate and that the book might be of a more readable length. Many members of the HFMA staff gave their willing cooperation, and most particularly Ronald E. Keener and the Communication Division.

Finally, I am grateful to all of those thousands of individuals—members of the association—who have provided the *raison d'être* for the existence of the Healthcare Financial Management Association.

Robert M. Shelton, FHFMA, CAE
Westchester, Illinois

November 1991

FOLLMER LETTER



The following is William G. Follmer's letter dated August 28, 1945, to the 16 Organizing Committee members of AAHA that served as a follow-up to the organizing meeting held at Indiana University on June 17, 1945.

Gentlemen:

To some of you the subject contained in this letter will be new while to others, it may seem like a rehashing.

A group of us at the last Accountants' Institute in Bloomington, Indiana, discussed to great lengths the formation of a National Association of Hospital Accountants. Needless to say, some were not entirely in agreement with the outlined program, while all were agreed that such an association be formed.

Hospital accounting, as you are well aware, is a specialized field when compared to industrial or commercial accounting, and while there are several accounting associations, not one has presented more than a few addresses at its meetings; or papers in its bulletins; on material which could be used by you.

Outside of a few articles in our hospital magazine and several accounting institutes sponsored by the American Hospital Association and the University of Indiana, you have had no common ground for exchange of ideas or consulting with your fellow accountants.

You have no immediate interpretation of new developments as they arise in hospital accounting; books of reference become obsolete; magazine articles are laid aside or lost; and manuals have not kept pace with ever-changing accounting requirements.

Then too, something must be done to elevate the position of hospital accounting to its proper plane and the important part it plays in hospital finance.

Opportunity must likewise be given personnel of the accounting departments to increase their knowledge of hospital accounting requirements.

Therefore, the following is set down for your comments and approval:

1. That a National Association of Hospital Accountants be started.

2. That the Association be incorporated as a non-profit organization under the laws of the State in which it will be incorporated.
3. That the affairs of the Association be governed by the membership through their representative who shall be a Director of the Association, who shall in turn nominate and elect its officers and appoint committees in their various functions.
4. That the Association encourage the formation of State or local chapters for advancement within that territory of the Association.
5. That the surplus funds of the Association be distributed to the chapters by a method similar to that of the National Association of Cost Accountants.
6. That three (3) ratings of membership be given:
 - a. *Senior Membership*—to have voting power and composed of hospital accountants or those directly connected with hospitals and accounting, such as Hospital Associations and Councils; or those whose right to Senior membership shall be agreed to by a membership committee.
 - b. *Junior Membership*—no power to vote, but shall have full opportunity to advance to Senior membership. Composed of Hospital Associations and Councils.
 - c. *Associate Membership*—no power to vote. Composed of those who are not directly associated with hospitals.
7. That the membership rating shall be a responsibility of the committee with the member granted privilege to contest the rating given him.
8. That the membership year start at one time for all members upon which date annual dues shall be paid, with dues of new members pro-rated according to the months remaining before the start of the new year.
9. That membership be discontinued upon:
 - a. Request of member.
 - b. Dues three (3) months in arrears.
10. That membership be reinstated by:
 - a. Payment of dues in arrears; or
 - b. Reapplication for membership at the stipulated fees; whichever is less.
11. That an application fee of \$5.00 be charged and submitted at time of application to be returned if membership is denied.
12. That the annual dues for membership be
 - a. Senior Members—\$10.00
 - b. Junior Members—\$5.00
 - c. Associate Members—\$5.00
13. That the Association publish a bulletin for the benefit of its members and to encourage articles by its members.

14. That the Association provide a common ground for the interchange of ideas.
15. That the Association will cooperate in all ways with the American Hospital Association, State Hospital Associations, and local groups or Councils in their endeavor to promote uniformity of hospital accounting.

These are the high points in the organization of an association for hospital accountants. Your comments on the purposes and methods of fulfillment will be greatly appreciated.

As soon as your replies have been received we shall combine them in drawing up a constitution and by-laws which will be sent to you for further comments and suggestions.

With prompt action by all of our group we may be able to start the ball rolling very soon.

The proposals enumerated, remain in your power—may we hear from you in the near future?

Sincerely yours,

(signed)

William G. Follmer,
Consulting Accountant
ROCHESTER HOSPITAL COUNCIL, INC.
800 Reynolds Arcade Building
Rochester 4, New York

August 28, 1945

A MESSAGE FROM OUR PRESIDENT



From Volume I, Number 1, *Hospital Accounting*, June 1947

To Friends in the Hospital Accounting Field Everywhere:

No higher honor or rarer privilege could fall to the lot of anyone than that of bringing this message of greeting to men and women engaged in the high calling of hospital accounting, wherever they may be.

The completion of the organization of The American Association of Hospital Accountants is the fruition of the hopes, dreams, aspirations, and planning of many serious minded hospital accountants who conscientiously believe that the hospital accountant and his profession deserves a prominent place in the constellation of other hospital specialities. To the indefatigable efforts of these individuals should go the praise and thankfulness of every hospital accountant who believes that his job is one of the earth's noble professions. It may appear now to be a bit of vain prophecy, but in the exuberance of our enthusiasm, we believe that the formation of the American Association of Hospital Accountants is an epoch-making event in the hospital field.

The hospital accountant has been denied the rightful recognition he so justly deserves much too long, because there has been no articulate organization of his speciality to which he might belong. The hospital accountant has long since emerged from the category of a necessary evil. We believe that he now makes a major contribution in the economic life and existence of America's great hospital system.

There has been a recognized need for a closer co-operation among hospital accountants and hospital organizations to the end that uniformity and efficiency in hospital accounting might be promoted, and that the hospital accountant might serve a greater usefulness to the individual institution and to the hospital field in general. There has also been a noted absence of any coherent, organized scheme providing for the interchange and dissemination of ideas and material relative to hospital accounting in which all hospital accountants might participate. Furthermore, all hospital accountants who manifest a sincere interest in their profession need encouragement, and in so far as possible should have assistance in increasing

their education in all branches of that field. These principles incorporated into the constitution of the Association it is believed, are self-evident and paramount.

The organization of the American Association of Hospital Accountants is, therefore, a praise-worthy achievement in which all of us may take a justifiable pride. The high aims and purposes for which it was created present a challenge to all hospital accountants if these aims are to be fully realized. But this is only the beginning. While much of a worth-while character has been accomplished, much still remains to be done. It will require the unified support and assistance of all hospital accountants everywhere to bring the association to the highest fulfillment of all its aims and purposes.

Since there is but little existent perfection, the American Association of Hospital Accountants, in its infancy, is not the essence of perfection which we hope and expect it to be ultimately. Were it perfect now there would be neither the incentive nor the opportunity to add improvements which the future is sure to bring, and it would soon die of inaction. It would hold no attraction for broad-visioned, purposeful men and women.

The organizing committee could not possibly obtain the counsel and opinion of every hospital accountant in the field. They did, however, attempt to corral opinions from a large number of prominent hospital accountants so that the organization in its present form represents the composite opinion of many rather than that of one or two individuals. The terms of the constitution and by-laws are not irrevocable. Ample provision has been made for changing them. There is little doubt but that the future will see many changes, all of a beneficial nature.

While the wisdom of the nominating committee who settled upon your humble servant for president might be seriously questioned, I have accepted this high honor with a keen realization of the grave responsibilities incumbent upon me, and with the avowed determination that no obstacle, however formidable, shall deter me for a single moment, in devoting all the resources at my command, to the accomplishment of the objectives incorporated in the charter of the Association.

If you are intrigued by a challenge of worthy motives, or attracted by an opportunity to elevate your profession to a high plane, I can without equivocation commend The American Association of Hospital Accountants for your serious consideration as an embodiment of as worthy principles as were ever incorporated into any organization.

To all those who unswervingly devoted their time and their talents to bringing the American Association of Hospital Accountants into being, and to those who shall espouse its cause, I pledge my unending gratitude, and my devotion to the promulgation of all the lofty aims and purposes for which it was formed.

Frederick T. Muncie, CPA
President

ONE

A Seed Is Planted



*And some fell into good soil and grew,
and yielded a hundredfold.*

Luke 8:8 RSV

Nineteenth century French sociologist Alexis de Tocqueville once observed that “Americans of all ages, all conditions, and all dispositions constantly form Associations” and “seem to regard [associations] as the only means of acting.”

For more than a century, the healthcare field has thrived on the American tradition of creating trade and professional associations. In 1898 a small group of hospital superintendents came together to launch the American Hospital Association (AHA), the premiere trade association for the not-for-profit sector of the healthcare industry. In 1933 a tiny band of administrators met in Chicago’s Palmer House and created the American College of Hospital Administrators (now the American College of Healthcare Executives), an international professional society of more than 21,000 senior healthcare managers. And slightly more than a decade later, in 1946, a small company of hospital accountants founded the American Association of Hospital Accountants (AAHA), now entitled the Healthcare Financial Management Association (HFMA).

In the early 1940s hospitals represented the nation’s sixth largest industry with a capital investment of several billion dollars. Despite health care’s contribution to the gross national product, its accounting methods were primitive. If organizations developed financial problems, accountants relied on their own judgment or on the knowledge of public accountants who rarely understood the intricacies of hospital management. Neither executives nor academicians—as well as their associations—viewed hospital accounting as a distinct discipline or profession. Hospital accountants who joined professional societies such as the National Association of Cost Accountants (later the National Association of Accountants) received little personalized attention and had few references to consult when problems arose. Although the American Hospital Association published a manual entitled *Hospital Accounting and Statistics* in 1929, it waited 12 years before making

any revisions in the book. Because hospital administrators often viewed accounting not as a valuable tool but as a troublesome and necessary evil, many hospital accountants lacked respect.

IU Institutes as Catalyst for National Association

By the end of World War II, the attitudes of executives and professional societies had changed. Hospital management realized that accountants could save operating dollars and invest these resources in capital improvements and equipment. Indiana University (IU) had created an annual institute on hospital accounting in 1941, and now it began to bring new credibility and status to the profession.

These annual institutes were started by Stanley A. Pressler (then associate professor of accounting at IU) after he learned of the woeful state of accounting at a local hospital. Turning to the AHA for information, he was referred to Graham L. Davis, chairman of AHA's Committee on Accounting and Statistics. Together, they planned and conducted the first hospital accounting institute.

Disturbed by the accounting profession's lack of interest in the unique features of hospital accounting, leaders at IU's institute began to explore the merits of a national association that could address the specialized needs of hospital accountants. On June 17, 1945, William G. Follmer, consulting accountant for the Rochester Regional Hospital Council, Rochester, New York, assembled a small group of 16 colleagues to discuss the idea. Later that summer, he crafted a formal written plan for a national association and shared his plans with this group.

Decrying the state of hospital accounting and its lack of reference material, Follmer also emphasized the inadequate attention that accounting functions received from hospital administration when he wrote:

Something must be done to elevate the position of hospital accounting to its proper place and the important part it plays in hospital finance.

The 16 persons addressed in this letter of 1945 represented a broad cross section of individuals, both geographically and positionally, in the hospital field. Stanley Pressler was already committed to the need for such an organization of hospital accountants. So, too, was Graham L. Davis, who, as institute director, had been part of the general discussion in prior years. An elected officer of the American Hospital Association, Davis was the hospital director for the W. E. Kellogg Foundation in Battle Creek, Michigan. Frederick T. Muncie, CPA, was comptroller of St. Luke's Hospital in Chicago. Charles G. Roswell was consultant in accounting to the United Hospital Fund of New York and was chairman of the Committee on Accounting and Statistics of the AHA. Leslie Reid was assistant superintendent of the Presbyterian Hospital of Chicago. Robert H. Reeves was controller of Rochester General Hospital, and Seward Smith, CPA, was controller of Genesee Hospital, both in Follmer's home city of Rochester, New York. William A. Dawson was director, South Baltimore General Hospital in Maryland, and Percy F. Riggs was assistant superintendent at Hollywood Presbyterian Hospital in Los Angeles. Major Floyd C. Freeman was associated with the Finance and Audit department of the Salvation Army in New York City. M. Ray Kneifl was executive secretary, Catholic Hospital Association, in St. Louis. William F. Voboril was associated with

American Association of Hospital Accountants

Founder Stanley A. Pressler

Stanley A. Pressler's contributions in education were essential to the growth of the American Association of Hospital Accountants.

Pressler's career in accounting began in the 1930s. After receiving his CPA designation in 1938 and following a three-year stint at Northwestern University, he went to Indiana University as an associate accounting professor. While there, he worked with the American Hospital Association to publish *Accounts and Forms for Small Hospitals*, participated on AHA's Committee on Accounting and Statistics under the chairmanship of Graham L. Davis, and worked with Davis to develop and organize the institutes at IU beginning in 1941.



Pressler joined the AAHA in 1945 as a member of the Organizing Committee that was responsible for developing the association's constitution, bylaws, charter, and membership qualification profile.

Pressler's dual relationship with IU and the AAHA continued, and in 1949 he agreed to have AAHA cosponsor institutes at the university. The association was accepted and the partnership continued until 1962. During the 1950s, Pressler played a key role in forming three correspondence courses in hospital accounting that were offered to the association through Indiana University's Department of Adult Education Correspondence.

When the AAHA began to develop the fellowship examination program, designed to enhance the stature and recognition of hospital accountants, Pressler provided guidance that included an annual review of the final draft of the eight-hour exam.

Pressler's contributions to the AAHA were appropriately recognized in 1950 when he was granted Life Membership in the association and again in 1971 on the occasion of the association's 25th anniversary, when the newly created Board of Directors Award marking the association's silver anniversary was conferred on Pressler. In 1981, the annual High Scorer Award was named for him. In 1982 the Indiana Chapter of HFMA changed its name to the Indiana Pressler Memorial Chapter in tribute to him.

Professor Pressler died on July 23, 1979.

the Greater Boston Community Fund, and Louis Hehemann was auditor of Christ Hospital, Cincinnati. Everett D. "Ed" Witham was superintendent of Jewish Hospital in Louisville, Kentucky, and Norman Wigglesworth was comptroller, Rhode Island Hospital, Providence.

Having heard from 12 of the individuals addressed, Follmer issued a nine-page progress report on September 26, 1945, which incorporated verbatim the answers received. The conclusion: Move ahead! Stanley Pressler delivered a list

American Association of Hospital Accountants

Founder Graham L. Davis

Graham L. Davis's expertise and advice on hospital accounting and administrative issues provided essential guidance during the formation of the American Association of Hospital Accountants. Davis was associated for many years with W. K. Kellogg Foundation.



Davis was active in many voluntary leadership roles when he joined Stanley A. Pressler in 1941 to organize Indiana University's institutes on hospital accounting. Prior to the initiation of the institutes at Indiana, Davis was involved in the organization of two regional hospital conferences, the Southeastern and the Carolinas-Virginias. He was the first editor for *Southern Hospitals* magazine and orchestrated the South's first institute for hospital administrators at Duke University.

Davis served as chairman of the American Hospital Association's Council on Administrative Practice and Committee on Accounting and Statistics, spent two months in 1935 studying hospital contributory funds in Great Britain, served as delegate to the annual conference of the British Hospital Association, and in 1948 was elected president of the American Hospital Association.

During preliminary discussions about creating a professional association for hospital accountants, Davis was one of the first to offer full support to the project. He was a member of the Organizing Committee that was responsible for developing the AAHA's constitution, bylaws, charter, and membership qualification profile. He also served as one of six directors-at-large from 1946 until 1948.

The new association was originally to be called the "National Association of Hospital Accountants," but Davis wanted to include Canadians in the membership and the name was changed to the "American Association of Hospital Accountants."

Davis's work for the AAHA was appropriately recognized in 1953 when the association named, in tribute to him, the Graham L. Davis Award for Chapter Achievement, presented each year to the outstanding chapter of the association.

Mr. Davis, born in 1893, died July 4, 1958, from injuries received in an auto accident in North Carolina.

American Association of Hospital Accountants

Founder William G. Follmer

William G. Follmer's contributions were instrumental in forming the American Association of Hospital Accountants. As early as 1944 he saw the need to create an association to address the needs of practitioners in the specialized field of hospital accounting.



While attending the fourth annual institute on hospital accounting at Indiana University in 1945, he gathered a group of colleagues together to discuss the benefits an association for hospital accountants would have for the educational advancement of the profession. Based on the results of that discussion, he formulated a plan of action and began to organize the AAHA.

Follmer was born in Montoursville, Pennsylvania. He and his family moved to Rochester, New York, where he attended grade and high schools. After high school he took courses in office management and basic and advanced cost accounting.

He began employment in 1943 as an accounting consultant for the Rochester Hospital Council. In 1948 Follmer joined the Hospital Association of Pennsylvania in Harrisburg as a consulting accountant, and in 1950, he was employed by the Pennsylvania General State Authority.

Follmer established the AAHA's 16-member Organizing Committee in 1945 that was responsible for developing the association's charter, constitution, bylaws, and membership qualification profile. He was elected to the AAHA's office of secretary-treasurer in 1946 and served until April 1949. Follmer was presented with the Certificate of Life Membership in 1950, and in December of that year was killed in a highway accident.

Follmer's contributions were acknowledged in July 1960 when the AAHA created the William G. Follmer Merit Award to recognize individual members for their meritorious service at the chapter level. In 1986 this award became part of the four-level Founders Merit Award Series to recognize increasing levels of chapter service, the first of the four levels being renamed the Follmer Bronze Award.

of registrants at all past institutes, and a letter was mailed to them on October 1, 1945, announcing that "a movement is underway" to form an association of hospital accountants.

As an employee of the Rochester Regional Hospital Council, Follmer sought support of the AHA's Committee on Hospital Accounting and Statistics in a personal appearance before the committee in late October. Although the committee sanctioned the idea on a philosophical level, it deferred a formal commitment until Follmer could produce statistics on the association's membership

American Association of Hospital Accountants

Founder Robert H. Reeves, FHFMA

Robert H. Reeves, FHFMA, worked closely with William G. Follmer in the early days of the American Association of Hospital Accountants. Reeves helped to draft the first constitution and bylaws, was the chairman of the first Nominating Committee from 1946 through 1951 that selected the association's officers and directors, and was elected president of the AAHA in 1956.



From 1950 to 1953, Reeves served as associate editor of the AAHA's journal *Hospital Accounting*. In addition to his duties as editor, he regularly wrote feature articles for the journal and coordinated a journal section entitled "The Question Box" by answering technical questions from readers. As part of the journal's 15th anniversary in 1962, he served as honorary editor.

After completing his term as president, Reeves continued to work with the AAHA and helped to develop such programs as the Frederick C. Morgan Individual Achievement Award and the William G. Follmer Merit Award. Reeves successfully sat for the fellowship examination in 1960.

From 1927 to 1946 Reeves was employed by Rochester General Hospital as chief accountant. In 1946 he moved to Philadelphia to become comptroller for Pennsylvania Hospital but returned to Rochester, New York, in 1947 to take the position of accounting consultant for the Rochester Regional Hospital Council.

From 1941 to 1946, Reeves served on the American Hospital Association's Committee on Accounting. He also served on the faculty at many accounting institutes at Indiana University.

Reeves' efforts were duly acknowledged in 1947 when the AAHA created the Robert H. Reeves Merit Award to recognize individual members for their increasing levels of meritorious service at the chapter level. This award became part of the four-level Founders Merit Award Series in 1986 to recognize increasing levels of chapter service, the second of the four levels being renamed the Reeves Silver Award.

Robert H. Reeves died in April 1984, at age 84.

potential and operating budget. George Bugbee, AHA's executive director, reminded committee members that the AHA had no provision for associations composed of department heads.

Follmer's Priorities: Constitution, Bylaws, and Membership

Assured of strong support from the field, Follmer's next order of business was to develop a constitution and bylaws through the 16-member Organizing Committee; many of the members had made suggestions for inclusion. While the

Organizing Committee reviewed final changes in the constitution and bylaws, Follmer's attention turned to membership as a top priority. His initial plan was to recruit 200 members from among the states and provinces who would each recruit at least 50 other individuals or organizations. To establish a strong visual identity for the profession, the association also commissioned the design of a membership certificate. To fulfill the association's membership goals, members of the Organizing Committee filled out the new membership form, enclosed their annual dues check for \$20, and sent them to the association's new address at Rochester General Hospital (Reeves' address). When application forms were mailed out, it was announced that "your dues will carry you through August 31, 1947." However, because the organizing process was slow and to comply with the fiscal year now provided for in the bylaws, this date was extended to December 31, 1947.

The newly adopted bylaws provided for three membership classifications. A *senior member* could be a hospital chief accounting officer, an assistant accounting officer with supervisory responsibility, a hospital administrator with accounting background, or an accountant affiliated with a hospital association. A *junior member*, in contrast, could be an employee in the accounting department of a hospital, hospital association, or council. Finally, an *associate member* could be any person interested in the association's goals and programs.

Contributions of the Early Leaders

Leadership also emerged as a key issue. Among the individuals who agreed to serve as officers for the first year of the association's history—and later the second year as well—were president Frederick T. Muncie, first vice president Percy F. Riggs, second vice president Percy Ward, and secretary treasurer William G. Follmer. In addition, the association sought out 12 regional directors and 6 directors-at-large who, together with the 4 officers, would become members of the association's board of directors.

In the summer of 1946, the association held its first meeting at Indiana University. The seven board members who attended discussed membership recruitment, the appointment of editorial consultants, publication of a quarterly bulletin, developing a backlog of publishable articles, and designing an appropriate emblem. By November of that year, the association appointed committees to oversee the editorial, nominating, and membership areas. The letter mailed to IU registrants in October 1945 had produced fewer than 100 responses, and these persons were called Organizing Members. In July 1946 President Fred Muncie addressed a letter to this same audience to enlist Charter Members. As of September 30, 1946, the extended date for membership recruitment, AAHA boasted a total of 284 members.

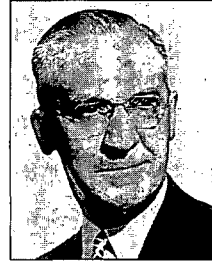
But progress wasn't as rapid as association leaders had expected, and several problems arose. Several regional directors remained unappointed; postwar paper shortages delayed the production of membership certificates; and production problems indefinitely delayed the first issue of the association's journal.

From the moment that he accepted the presidential reins, Fred Muncie rolled up his sleeves and began active participation along with Bill Follmer in furthering the aims of the association. Muncie appointed Helen Yerger to head up publicity

American Association of Hospital Accountants

Founder Frederick T. Muncie

Frederick T. Muncie was part of the original group called on by William G. Follmer to discuss the possibility of forming a national association specifically for hospital accountants.



Muncie began his active involvement with the American Association of Hospital Accountants (AAHA) as a member of the first Organizing Committee having responsibility for creating the association's constitution, charter, bylaws, and membership qualification profile. He also played a key role in bringing together Chicago area accountants to form the First Illinois Chapter of the AAHA in 1948.

In 1946, Muncie was elected the AAHA's first president, and he served aggressively in that position. He was responsible for the AAHA's first joint educational institute conducted with IBM, arranged for AAHA to cosponsor Indiana University's annual accounting institute beginning in 1949, and assumed overall responsibility for planning the institutes at Indiana University in 1950.

Muncie was born in southern Indiana. After high school, he studied law and accounting and received his CPA designation in 1924. He joined St. Luke's Hospital in Chicago in 1929 as comptroller. During his 17 years at St. Luke's, he developed an impressive hospital accounting system that drew accountants from all parts of the country to Chicago to confer with him. He left St. Luke's Hospital in 1946 to establish his own Chicago area accounting firm, where he worked until his death on December 4, 1950.

Muncie served for three successive years on the faculty at the hospital accounting institutes at Indiana University and lectured at Northwestern University's and St. Louis University's hospital administration programs.

His efforts were appropriately acknowledged in 1969 when the AAHA created the Frederick T. Muncie Merit Award to recognize individual members for their increasing levels of meritorious service at the chapter level. This award became part of the four-level Founders Merit Award Series in 1986 to recognize increasing levels of chapter service, the third of the four levels being renamed the Muncie Gold Award.

efforts after Follmer mentioned that she had assisted him and Bob Reeves "in preparing a lot of stuff the past year in getting this association going." Muncie, however, was constantly disappointed as problems and delays arose, and was generally disillusioned with the young association's lack of progress.

The initial issue of *Hospital Accounting*, intended to serve as a membership recruitment device throughout the country, was planned in June 1946, printed with a June 1947 date, but was not mailed until September 1947 because of mailing

American Association of Hospital Accountants

Founder Helen M. Yerger

Helen M. Yerger joined William G. Follmer and Robert H. Reeves in 1946 to assist in the formation of the American Association of Hospital Accountants.

Yerger began her career in hospital accounting in 1932 as accountant and assistant superintendent of Park Avenue Hospital in Rochester, New York. In 1950 she moved to the Arnold Gregory Memorial Hospital in Albion, New York, as an administrator, where she worked until her death.



Yerger served the association as director of publicity and public relations. She developed the membership certificate, prompted Frederick T. Muncie to cosponsor the first AAHA institute with IBM in 1948, authored the lead article in the first issue of *Hospital Accounting*, and was a frequent contributor in later issues of the journal. She helped design the association's first seal and played an active role in the formation of the Rochester, New York, area chapter of the AAHA. Yerger also served on the faculty at Indiana University's institutes on hospital accounting.

In 1949 when Follmer resigned his office as secretary-treasurer, Yerger stepped in. She was asked to continue in the position for another term and accepted, only to have to resign a short time later to assume her new position at the Arnold Gregory Memorial Hospital.

Yerger was educated at the University of Chicago and Columbia University, and was a Fellow of the American College of Hospital Administrators. Yerger's commitment to making the AAHA a reality cannot be over-emphasized. She continued to push herself and push Follmer and Muncie to keep at the work of forming the association even when faced with what seemed to be insurmountable obstacles.

In 1984 the journal's best article award was named in her honor. The award is given annually for the best article published in *Healthcare Financial Management*.

She died August 6, 1965.

problems. Membership certificates, designed to portray an association seal designed by Yerger, were delayed for months because of paper shortages and problems in manufacturing the die for the seal. Muncie insisted that Follmer write to members explaining the lack of membership cards, certificates, and publications. The membership certificates were finally mailed in June 1947, signed by President Muncie and Secretary-Treasurer Follmer.

With this mailing accomplished, and Volume 1, Number 1, of *Hospital Accounting* distributed across the nation, Yerger composed a press release that was the source of the article in a Rochester newspaper on September 26, 1947, under the caption "Hospital Accountants Realize Dream of National Group."

Because there was no money in the association's treasury, officers and directors had not met in official session, and Muncie made an appeal for them to attend the 1947 institute at Indiana University at their own expense to enable a meeting. Only two persons attended. Muncie then suggested a meeting during the American Hospital Association convention in St. Louis in September, but this effort also failed. In November, he wrote to the directors requesting assistance, commenting that "neither I nor Bill Follmer have a monopoly on good ideas." He received only three replies. In December, members were still waiting for the second issue of the journal.

Greatly disheartened, Muncie unburdened himself in a year-end letter stating, "I feel very guilty in that I haven't been able to inject more spirit into the organization. . . ." With his term as president due to expire at the end of 1947, Muncie had asked Follmer to activate the Nominating Committee and present a new slate of officers. When Follmer questioned this decision, Muncie qualified his notion about "definitely" wanting relief of his position by admitting "there is but one reason that I would like to retain the presidency for another year and that is to make certain individuals swallow some of their words." Muncie's decision was complicated because Bill Follmer announced to the officers and directors that he was leaving Rochester to take a position in Harrisburg in January 1948 as consultant on accounting for the Hospital Association of Pennsylvania.

The Nominating Committee, through an exchange of letters, acted to select all incumbents to fill officer and director positions for 1948.

Meanwhile, in 1947 Robert Reeves had taken a hospital position in Philadelphia, but on hearing of Follmer's resignation from the Rochester Regional Hospital Council applied for and obtained the post of accounting consultant.

In his new position in Harrisburg, Follmer was unable to devote as much time to his responsibility as AAHA secretary-treasurer, and in April 1948 the second issue of the journal had not yet been published, despite the appointment of an editorial committee that had promised results. Muncie had left his hospital position in 1947 and was coping with establishing himself in his own accounting business and meeting "overwhelming business demands." Again, Muncie seriously considered resigning from the presidency.

Hearing of this possibility through Muncie's letter, Helen Yerger wrote to Muncie expressing disappointment with his letter and wondering whether his motivation stemmed from being ashamed or from real discouragement. "But," she said, "I would like to feel that your motives were from the former, for then you will do something constructive about the deplorable mess the AAHA is in." Sensing that her response was a last ditch effort to retain a spark of life in the association, she proceeded to chastise all of the officers and directors for failing to fulfill their elected roles satisfactorily.

Acknowledging that the journal was "vital to the association, it is paramount," she forcibly stated her position that a meeting of officers and directors was essential to "know all the members of this group and how they feel about AAHA." At this point in time, all association business had been carried on by mail, much of it unanswered. Yerger emphasized her belief that "when the officers and directors gather around a table and honestly 'let their hair down,' it will be a day when the AAHA will show signs of living again."

Driving home her point, Yerger reiterated,

The stimulus which this meeting will produce is bound to receive action. You will agree there is a need for AAHA. Hospital accounting in some of the smaller hospitals is in a terrible mess. Those of us who have been in the field a long number of years should lend ourselves to this cause.

Fred Muncie had already committed himself to a great challenge when he accepted the mantle as AAHA's first president, and he could not now turn his back to this new challenge, hurled by a woman who had witnessed the slow agonizing sprouting of the seed. Previously, Muncie had advised the board of an IBM institute scheduled in Endicott, New York, in August 1948, but again no favorable responses had been received. Muncie made arrangements for AAHA cosponsorship of this program, and promoted attendance of most of the officers and directors, whose employers had only to underwrite travel expenses because IBM would cover all on-site expenses. The meeting of these association officers for the first time was a turning point in the fortunes of AAHA.

Several months later, the association announced its new slate of officers and directors at large:

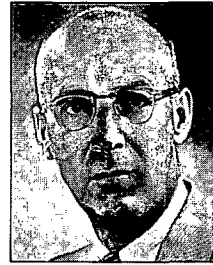
President	Charles G. Mehler, comptroller Hamot Hospital, Erie, Pa.
First Vice President	George H. Long, Jr., comptroller Hahnemann Hospital, Philadelphia, Pa.
Second Vice President	Edgar H. Boroff, business manager St. Louis City Hospital, St. Louis, Mo.
Directors-at-Large	Marguerite Humes, office manager The Jewish Hospital of St. Louis, St. Louis, Mo. Charles F. Warfield, chief accountant Alexian Brothers Hospital, Chicago Frances M. Hernan, chief accountant Massachusetts General Hospital, Boston David H. Spanier, hospital cost analyst U.S. Public Health Service, Washington, D.C. Charles H. Clifford, controller The Brooklyn Hospital, Brooklyn, N.Y.

As agreed at the "new-life" meeting at Endicott, the newly elected officers met in Philadelphia in December 1948 to plan 1949 activities. The directors did not attend, although each was given an assignment with instructions to report to one of the two vice presidents. These two were instructed to call a meeting of their respective directors to discuss their assignments. The meeting at Endicott also instructed Follmer to have an audit made of the association's books and to publish a financial statement. A statement of operation covering the period of 1945 through 1948 was published in the January 1949 journal. It showed a net worth of \$1823.63.

American Association of Hospital Accountants

Charles F. Mehler (Association Leader)

Charles F. Mehler, although technically not a founding member of the American Association of Hospital Accountants, made essential contributions to the association during its early development. He was the controller at Hamot Hospital in Erie, Pennsylvania.



In December 1945 William G. Follmer wrote a letter to more than 240 hospital accounting professionals who he thought could contribute to the AAHA as members. Mehler was one of those who responded with tremendous enthusiasm.

Mehler joined the AAHA in 1945 as a member of the Organizing Committee that developed the association's constitution, bylaws, charter, and membership qualification profile. He was unanimously elected in 1946 to serve as the director of the Middle Atlantic States region and in 1949 was elected by the Nominating Committee to the presidency of the AAHA. During his term as president, the association grew in size from 300 to more than 500 members and from one to six local chapters.

One of Mehler's many contributions to the AAHA was his decision to take over as editor in chief of *Hospital Accounting*, the AAHA's journal. In April 1949 the second issue of *Hospital Accounting* (Volume III, Number 4), was released 22 months after Volume I, Number 1, in 1947. The journal continued to print regularly thereafter 10 times a year. Mehler held this position until 1956.

In addition to his work for the AAHA, Mehler was involved in the organization of the Northwestern Pennsylvania Hospital Accountants and helped plan its 1947 hospital accounting institute at Allegheny College, at which William G. Follmer was a guest lecturer.

Mehler's great concern for the profession of hospital accounting did not go unrecognized by the AAHA. In 1956 he was honored by having named for him the Charles F. Mehler League, one of three leagues established under the Graham L. Davis Award system to group chapters by membership size for competition purposes.

Charles Frank Mehler died May 23, 1977, in Erie, Pennsylvania, at age 69.

Communication between President Mehler and Secretary-Treasurer Follmer percolated because of their mutual habitat in Pennsylvania and their attendance at statewide hospital meetings. But Follmer surprised everyone in February by explaining that his position with the Hospital Association of Pennsylvania would terminate on May 11, 1949, and that because of possible difficulties ahead, he would be forced to resign as secretary-treasurer. At the request of Charles Mehler,

American Association of Hospital Accountants

John M. Stagl (Association Leader)

John M. Stagl was business manager of Passavant Hospital in Chicago when he was elected to the board of directors of the American Association of Hospital Accountants in 1950. Known to Fred Muncie, Stagl was a speaker at the annual institute at Indiana University that same year.



Stagl, later with the title of assistant director at Passavant Hospital, was elected president of AAHA in 1952 and was reelected for the 1953 year. During his term of office, the Graham L. Davis Award for Chapter Achievement was initiated, a chapter formation manual was published, a complete analysis of the association membership composition was published, the first meeting of the board of directors with all elected directors in attendance was held, and a research project on the retention of hospital records was initiated.

In 1955 Stagl chaired the Committee on Structure and Program, composed of hospital-related officials in other organizations, which reviewed AAHA's accomplishments of its formative years and issued *The Second Decade Report*, which recommended the hiring of a salaried executive director, relocation of the AAHA office from Rochester to Chicago, and certain other actions that became part of the association's agenda.

Stagl became the director of Passavant Hospital, and after its merger with Wesley Hospital as McGaw Medical Center, Northwestern University, he was named executive vice president.

In 1976 Stagl was elected to the office of chairman of the American Hospital Association and served in the various chairs in the protocol of AHA.

Stagl received the Frederick C. Morgan Individual Achievement Award in 1960 and HFMA Life Membership in 1953. He has served as president of the Chicago Hospital Council; on the board of trustees of the Illinois Hospital Association; and is a Fellow, American College of Healthcare Executives.

On the occasion of the association's 25th anniversary, Stagl recalled that his presidential term "was the era when hospital accounting played very little part in the operation of the institution other than posting, billing, and collecting patient charges." He commented that the association's lack of funds precluded engaging in broad scope programs and acknowledged that "those years were the ones in which the solid foundation was laid on which the association built to become a professional group with leadership status in financial management."

American Association of Hospital Accountants

Sister Mary Gerald, CSC (Association Leader)

Sister Mary Gerald, CSC, was general treasurer, Sisters of the Holy Cross, Notre Dame, Indiana, when she was elected president of the American Association of Hospital Accountants in 1954 and reelected in 1955.

Sister was one of the Organizing Members of AAHA and was appointed as regional director of the North East Central States in 1947. She remained on the board of directors until her election as president.



Following her term as general treasurer of her order, Sister served as administrator at Holy Cross Hospital, San Fernando, California, and as administrator at Holy Cross Hospital, Salt Lake City. She has taught Asian and African sisters at Mater Ecclesiae Center in Tiberias, Israel; has served as field consultant for financial management, Catholic Hospital Association; and has consulted for bishops in dioceses throughout the world.

As president of AAHA, Sister published an article in *Hospital Progress* featuring AAHA that prompted an inpouring of membership applications of Catholic sisters. During her two-year tenure, the first correspondence course on hospital accounting was published by Indiana University; the first meeting of chapter presidents was held; the 2500th member was featured in the journal; the Committee on Structure and Program submitted its report; and she led the interview process that resulted in hiring William M. Pierce as executive secretary.

Sister Mary Gerald served as a committee member, under chairman Fred Muncie, to plan the program of the first Indiana University institute to be cosponsored by AAHA, and in ensuing years she was on the Program Planning Committee and invariably appeared on the platform at the annual national institute. She appeared on numerous chapter programs where, rather than a set topic, members were educated through a "picking her brains" process.

Sister Gerald served on the committee that wrote and scored the first Fellowship examination and, in 1958, became a Fellow. She was awarded the Frederick C. Morgan Individual Achievement Award in 1962 and was accorded Life Membership in 1953.

Helen Yerger agreed to accept this post, and Mehler agreed to become editor of the journal. All association records and property were transferred back to Rochester. Helen Yerger was nominated for a full-year term as secretary-treasurer, but in November 1949 she announced that she had been appointed administrator of a hospital in Albion, New York, and would have to resign her elected post.

Frederick C. Morgan had joined the staff of Genesee Hospital in Rochester in 1948, immediately joined AAHA, and attended local meetings of hospital accountants. He obviously made a good first impression, because when Yerger was

American Association of Hospital Accountants

Frederick C. Morgan (Association Leader)

Fred Morgan joined the association in 1948. From the start he worked tirelessly as an HFMA volunteer. In 1971, the silver anniversary year of HFMA, past-president Robert H. Reeves said of Morgan: "During his six-year tenure as volunteer secretary-treasurer (while holding the responsible position of controller and assistant director of Genesee Hospital, Rochester, New York), through his untiring efforts, and with some assistance from the succession of National officers, he saw the membership increase from 504 to 2655 and the local chapters from six to 42."



Morgan's achievements for the good of the association were a matter of proud record, Reeves pointed out. A native Rochesterian, Morgan was a graduate of the International Accountants Society and attended the Rochester Institute of Technology. He did not possess a college degree, but he taught in RIT's evening school for a number of years as an instructor in economics and later in office management and methods. He authored a textbook on the latter subject. He was engaged in industrial accounting and in systems and procedures work for 28 years before joining the staff of Genesee Hospital on July 19, 1948.

In 1957, the idea of an award to honor the outstanding hospital accountant of the year was presented. The Graham L. Davis Award for Chapter Achievement had been in place for several years, and it seemed appropriate to cite an individual for outstanding accomplishment. It was natural that the award be named for Frederick C. Morgan. Thus, the association's most prestigious award, the Frederick C. Morgan Individual Achievement Award, is given to encourage the spirit of service to the principles of the Association as fostered by Morgan himself.

Morgan retired from the hospital field in 1965 and died in Rochester, New York, on April 14, 1985, at age 82.

asked to suggest candidates for her replacement, she responded by nominating Morgan. Yerger was well aware of the workload required of the secretary-treasurer and commented that the position needed an individual "who has sufficient enthusiasm for AAHA and a background in accounting who can stimulate others to join." Pointing out that the individual must have time to devote to the job, she commented that the association was "growing to the point where the detail work is messy." Approached informally at Yerger's farewell dinner, Morgan, at Bob Reeves' invitation, agreed to attend a meeting of the 1950 elected officers on November 13. When he was extended a formal invitation to take over the secretary-treasurer reins, Morgan promptly accepted.

Helen Yerger's appraisal of Morgan's ability to fill the important position of secretary-treasurer proved accurate: Morgan worked hard during the following

six years of rapid growth of AAHA. He had been authorized to purchase Kardex equipment for the membership records, and, in 1953, he was authorized to rent office space in an old brownstone across the street from Genesee Hospital. Rent—which included 250 square feet of office, storage space, heat, light, and cleaning—was \$50 a month. AAHA's first official office was located at 245 Alexander Street, Rochester, New York. When Morgan turned the reins over to William Pierce in 1956 for the move to Chicago, the association had two clerical employees.

When Morgan took over the important secretary-treasurer task late in 1949, the association had achieved marked progress on several fronts. There were 504 members; the first AAHA chapter had been chartered in Illinois; the journal had been published monthly since April; AAHA had cosponsored the annual institute at Indiana University; some of the assignments given to directors-at-large had borne fruit; and a strong, positive spirit prevailed among the association leaders.

The Rochester years continued through 1955, when the report of the Committee on Structure and Program was implemented, the first salaried executive director hired, and the headquarters office moved to Chicago. The association flourished through the dedicated nourishment and tender loving care of Fred Morgan, buttressed by enthusiastic and hard-working elected officers and directors and appointed committees. Morgan had concentrated on the formation of chapters, and by November 1955, 42 chapters had been organized and there were 2620 members. The remaining chapters in this history incorporate the achievements and progress of the association on many fronts by many individuals who inherited the strong spirit of volunteerism characterized in the early years of AAHA's development.

TWO

The Association Structure



*... and did not fall, because it had been
founded on a rock.*

Matthew 7:25 RSV

Constitution and Bylaws

Constitution and bylaws are vital to any organization, and the American Association of Hospital Accountants was no exception. In an August 18, 1945, letter to the 16-member Organizing Committee, Bill Follmer outlined many of the provisions that would later be incorporated into the association's constitution and bylaws. After more than a year of deliberation, the association's Organizing Committee adopted its constitution and bylaws in 1946, and a summary of these documents was published in Volume I, Number 1, of *Hospital Accounting* in June 1947.

Changes naturally followed. The fiscal year soon changed, and in 1950, the bylaws were revamped to provide for a single, more equitable dues structure. Instead of requiring \$10 dues for senior members and \$5 dues for junior and associate members, the amended bylaws provided for annual dues of \$10 for all membership categories. A year later, more far-reaching bylaws changes expanded the number of officers by adding a third vice president and provided for the appointment of an editor-in-chief of *Hospital Accounting* who would also serve as an ex-officio, nonvoting member of the board. The association, which up to this point had not held regular board meetings, was authorized to hold an annual meeting of the board of directors each January for which it would provide notification the previous November.

New Categories of Membership

Changes continued to be made. One article authorized a fourth membership classification, *life member*, and provided strategies for the nomination and approval of candidates for life membership, noting that "such life membership carries exemption from all dues and assessments for life." Another change deleted the

standing committees and provided for a Nominating Committee composed of three senior members. Special committees were to be appointed "to serve such purposes as the Board of Directors may designate." Still another article noted that elective officers would appoint and prescribe the duties of regional directors.

A 1955 report from the Committee on Structure and Program (detailed later) led to major changes in membership categories and procedures. Senior and junior membership designations were deleted and new classifications of *nominee*, *member*, *Fellow*, *life member*, and *associate member* were established. Former senior members became members and junior members became nominees, whereas associates retained their status. The bylaws described a Fellow as someone "whose ability is certified by the passing of a written examination." The application fee remained unchanged, but the bylaws provided for a new dues structure.

Qualifications for the Board and Committees

Because of plans to hire an executive secretary as the association's first full-time administrator effective January 1, 1956, the bylaws provided for the annual election of a president, first vice president, second vice president, and treasurer. In addition, the bylaws noted that only members, Fellows, and life members could qualify for the board of directors.

The Second Decade Report also resulted in changes in committee structure. The Nominating Committee was expanded from three to five members, with the president authorized to appoint three committee members. The chairman was required to be a past president of the association. The remaining two members would be elected through a majority vote of chapter representatives who attended the annual chapter presidents' meeting, which was initiated in 1954. An Executive Committee that consisted of the four elected officers and the immediate past president, a Committee on Chapters, and a Committee on Education were also established. A joint committee of AAHA and the American Hospital Association (AHA) would "meet periodically to discuss program and to eliminate duplication of effort wherever possible."

Under the chairmanship of Frederick E. Krizman, an AAHA board member and attorney, the Constitution and Bylaws Committee continued to refine these important operating documents. A key change was the establishment of a new fiscal year that would begin on June 1, 1958, and provide "better organization and administration." The term of office of 1957 incumbents was extended to May 31, 1958, with this extension "not to be deemed as an additional term of office." During this period, the committee reviewed the constitutions and bylaws of AAHA chapters, recommended updates, approved the petition for charter for would-be chapters, drafted a ceremony for the installation of national officers and directors, and created a code of ethics.

More Membership Classifications

In recognition of an expanding market, the AAHA bylaws went through additional changes in the early 1960s. Associate membership was expanded to include personnel of nonprofit insurance companies other than Blue Cross as well as hospital consulting firms. Hospital credit managers and data processing supervisors and accountants in other healthcare facilities were specified as eligible for membership

by title. Two new categories of membership were introduced: *retired member* and *chapter life membership*. In addition, specific amounts for fees and dues were eliminated by the bylaws and replaced by a mail ballot and the requirement of majority approval of the voting membership for dues increases. Fellow was deleted as a membership classification and established as an earned title, with a provision for retention of the title after membership ceased. In 1964 the office of president-elect was authorized and the office of vice president was deleted.

Changes executed in 1982 provided that individuals employed by healthcare insurance organizations and consulting firms be included within the definition of associate membership. The student membership category was also broadened to include interns, residents, and cooperative students who participated in recognized educational programs. Any member who was currently serving as an elected national officer or director was prohibited from being accorded national life membership. Finally, several bylaws were amended to "provide for general classification and improvement of existing language and for increased consistency of provisions." A name change became effective on June 1, 1982, and the newly revised documents were published in full in the July 1982 issue of the journal.

Changing the Association's Name

In 1968 the Committee on Scope of Association Activities recommended sweeping changes in the bylaws, including a change in the association's name from the American Association of Hospital Accountants (AAHA) to the Hospital Financial Management Association (HFMA). The changes provided for an expansion of HFMA's scope through four additional objectives and a delineation of its membership structure.

At the April 1982 annual meeting the membership approved bylaws changes of major proportion. A change in the corporation's name had been discussed for several years. When it was finally announced, the meeting call explained that "careful study and evaluation of the healthcare industry's direction and the ongoing needs of our association by our association's leadership have prompted HFMA's board of directors to recommend that the association's name be changed to the Healthcare Financial Management Association." To effect this change, it was necessary to amend the articles of incorporation and make appropriate changes in the constitution and bylaws. The single word *healthcare* was coined so that the well-known association acronym of HFMA would remain the same.

Matrix Organization

The classification of nominee was eliminated and the classification of advanced member was added. In 1969 the board of directors was expanded from 7 to 10 members, and in the early 1970s, the association formalized a regional structure that brought about numerous changes in subsequent years. Through a matrix organization created in 1968, members within each of the association's 11 regions elected a colleague to serve as a member of the national matrix. Eventually, the national Nominating Committee would nominate only those members with prior national experience to the board of directors. The designation of Certified Manager of Patient Accounts (CMPA) was added and the date of the annual meeting was moved up to allow for earlier identification of national officers and regional representatives.

Significant changes in the organizational structure of HFMA went into effect on June 1, 1978. The chief elected officer, formerly known as president, became chairman of the board, and the chief salaried executive became known as president.

Because Illinois law prohibited someone with the title of president from serving as corporate secretary, the association appointed another salaried executive to serve as secretary. Later, when the position of secretary became an elected office, the appointed staff member became the assistant secretary and managed use of the corporate seal and other routine matters.

At the March 1983 meeting of the board of directors, the report of the association evaluation and assessment task force motivated other bylaws changes, which were presented to the membership for approval at the March 1984 annual meeting. Among the four proposals was one that provided for change in the way HFMA was structured and governed, including the combination of the associate and regular membership categories, which gave 4000 associate members the opportunity to vote and hold national office. Advanced membership eligibility requirements were also expanded, and composition of the national board of directors was altered to allow for the election of noninstitutionally based individuals to a maximum of 3 of the 15 positions on the board. This merger of membership categories also broadened eligibility for service on the Executive, Matrix, and Nominating Committees.

Proposal two changed the name and scope of the Audit Committee, which would subsequently be known as the Audit and Finance Committee and would counsel the board of directors on management of financial resources. The elected treasurer would serve as chairman. Proposal three established an advisory council of past elected presidents and chairmen as a standing committee so that HFMA could benefit from the contributions of its past leaders. Finally, proposal four provided additional clarification of bylaws language.

Members were given the opportunity to approve additional bylaws amendments at the April 1986 annual meeting. In the continuing compression of membership categories, affiliate members became regular members. The growing number of national members motivated an expansion of the national board of directors from 15 to 16 members. Although the ex-officio position of immediate past chairman was eliminated, the immediate past chairman would continue to occupy important official positions. Eligibility requirements for advanced membership were removed from the bylaws in favor of board policy, and eligibility requirements for national committee, council, and matrix memberships were revised. In addition, the composition of the Executive Committee was increased to six members with two second-year directors elected by the board, whereas the composition of the Nominating Committee was increased to six members with one member elected by chapter liaison representatives and two members elected by chapter presidents, as had previously been the case. Improvements in the article on professional certification specified that maintaining certified status would conform with guidelines and requirements set by the board of directors.

Recent Changes in Membership Status and Board Qualifications

In the continuing liberalization of membership requirements and eligibility for official positions, the HFMA membership was called on to approve bylaws changes in April 1988. The retired membership category was amended to enable members who attained age 70 to apply for this status—whether they were retired from employment or not.

Another amendment made possible the election to the board of directors of up to seven members employed by organizations other than healthcare providers. To comply with liberalization of Illinois regulations covering not-for-profit corporations, another amendment allowed for the appointment of the president as chief salaried executive to the board of directors and to an ex-officio voting position on the Executive Committee. Further changes were made in compliance with the Illinois General Not-for-Profit Corporations Act.

The March 1990 annual membership meeting witnessed the approval of several other amendments to the bylaws. The advisory council of past elected presidents and chairmen was designed to include only three immediate past chairmen but allowed for an annual meeting to which all former elected national chairmen and presidents would be invited. A second change provided that all members of the national Nominating Committee be certified members of HFMA.

Incorporation and Ethics

Incorporation and Relocation in 1956

Although the association received its tax exemption certificate in the early 1950s, the incorporation was executed only after the association moved its headquarters to Chicago in 1956. On February 16, 1956, the American Association of Hospital Accountants was officially incorporated in the state of Illinois. Incorporators were Robert H. Reeves, Rochester, New York; C. Henry Hottum, Jr., Memphis, Tennessee; and Robert M. Shelton, Trenton, New Jersey.

Development of a Code of Ethics

In the mid-1940s, Major Floyd Freeman of the Salvation Army provided Bill Follmer with initial arguments in favor of a code of ethics. Confidence, according to Freeman, was the foundation of all professional relationships, and confidence was rooted in integrity, fair dealings, efficient service, and mutual benefits. Freeman argued that everyone—members of the public, clients, and colleagues—deserved equitable treatment and continuity of services and that “as members of a profession serving the public in a confidential manner, we must strive first to observe these principles and [to] seek no success that is not founded on the highest justice to all.” In 1958 the Constitution and Bylaws Committee submitted a first draft of a code of ethics to the board of directors, which adopted the code one year later. When the association designed and disseminated its next round of membership applications in September 1960, it asked members to sign a statement obliging them to subscribe to the constitution and bylaws and to the code of ethics. Since that time, the association has made the code of ethics a feature of every recruitment brochure.

Despite its desire to achieve widespread recognition for its new code of ethics, the association believed it could not apply the code to associate members such as employees of certified public accounting firms. It was reasoned that they had no direct involvement with patient care and were covered by other professional codes. When *sustaining membership*, later known as *affiliate membership*, was introduced in 1970, the application form requested members to sign the following statement: "If accepted, I hereby agree to abide by accepted standards of conduct and to always properly use my membership affiliation with HFMA."

The Constitution and Bylaws Committee also recommended the development of a Grievance Committee "to police the membership in accordance with the code of ethics." When the association revised its bylaws in late 1959, it noted that an Ethics and Grievance Committee might be appointed. When formally introduced one year later, the committee acted on a case of member expulsion that had been referred by the board of directors. Following the ruling on that case, the board decided to handle all such cases, and the Ethics and Grievance Committee disappeared from the bylaws.

Over the years, several violations of the code of ethics were brought before the board of directors and quickly dealt with, because the courts had already ruled that the individual was guilty of a crime. But in cases that were less clear-cut, the member charged with a violation of the code insisted on a hearing. For its own protection and in fairness to the accused, the board of directors adopted a fair hearing policy and procedure in October 1984. Later, in April 1986, the Ethics and Bylaws Committee recommended a revised code of ethics that was approved by the board in August.

Membership Classifications

During its earliest years, the association was relatively open in its attitude toward recruitment and the qualifications for membership. "The nucleus of the association is in its registrants," wrote Bill Follmer in some early correspondence to Fred Muncie, "and to start off we cannot be too particular as to qualification." Follmer's letters to registrants of the Indiana University institutes brought numerous inquiries from potential members, including a Catholic sister who acknowledged that many sisters would apply for membership despite their status as part-time accountants.

Eligibility for membership was under constant discussion. As a member of the association's Organizing Committee, Percy Riggs asked, "Is the idea of the three classes of membership to grade men according to standards of ability and experience?" He cautioned association leaders not to "let poorly qualified accountants participate and yet keep the organization active enough and small enough to complete the real work we want to do." Hospital leaders such as Charles Roswell never joined the association because, according to one board member, "he would never join an outfit and be classed with a bookkeeper in a 15-bed hospital."

The meetings of chapter presidents that began in 1954 reiterated a widespread concern for qualifications that were "too liberal and did not exclude undesirable members." Chapter leaders also declared that membership should be withheld from professionals who were unwilling to make a contribution to the association

and its chapters. Although the presidents disapproved membership to salespeople, they agreed to embrace Blue Cross representatives and certified public accountants.

The debate on qualifications for membership continued during the ensuing board session. Sister Mary Gerald advocated admission of anyone who could benefit from membership, because no standards existed for membership by ability. William Markey, in contrast, suggested that the organization change its focus and title to the American Association of Hospital Business Office Employees and introduce entrance requirements.

Robert Reeves counseled members not to create a perception among hospital administrators that the association had become little more than a labor union. He also supported the ability of chapters to veto the admission of new chapter members within 10 days of application. After extensive debate on membership qualifications, board members voted unanimously "to not permit membership in the association to representatives of companies engaged in the sale of equipment and supplies to hospitals."

But the changes were far from over. At the next meeting of the board, members voted to discontinue the membership classifications of senior, junior, and associate. Following the model created by the American College of Hospital Administrators, the board created new classifications of nominee, member, associate, and Fellow. Sales representatives who had joined prior to 1956 were grandfathered and allowed to maintain their membership.

Debate About Affiliate Members

To address ongoing concerns about membership eligibility, the association's Executive Committee appointed an Ad Hoc Committee on Membership Eligibility in 1968 to interpret the requirements of various categories. Eventually, that committee recommended the category of affiliate member for a professional "interested in financial management in the healthcare field and who has business connections with the field." But conflict remained. Some chapters refused to accept affiliate members; others placed a quota on affiliate members. For example, one chapter refused to grant affiliate status to an associate member who had moved from a CPA firm to a commercial hospital-related consulting firm.

A special report to the board prepared in consultation with the association's attorney reaffirmed that the association had a national membership and bylaws that had established member classifications and qualifications. According to the report, specimen chapter bylaws provided that "membership in the chapter shall be synonymous with membership in HFMA," and that membership committees of chapters solicit members based on membership quotas set by the national office and forward applications to the board with a recommendation for approval or decline. In addition, the report suggested that chapters could control affiliate membership by monitoring active recruitment of these members and by introducing a procedure to minimize legal action by disgruntled applicants for affiliate membership. Although board members approved the concepts within the report, they also recommended that chapter liaison representatives explore the implications of these ideas in chapter operations workshops.

The debates on membership qualifications that took place among chapter presidents and members of the board of directors caused the association's leadership to reflect on its core mission, vision, and values. Through its use of the word *accountant* in the association's title, members of the Organizing Committee had not intended to create an organization composed exclusively of hospital accountants. The association screened applicants not according to their position but according to their employer and involvement in supervision. Because the membership application repeatedly used such terms as *accounting* and *accounting officer*, some association leaders assumed that professionals in positions such as credit manager were ineligible for membership positions.

Adding Credit Management Under the Membership Umbrella

After meetings with several hospital credit manager groups in the early 1960s, the association decided that the responsibilities of accountants and credit managers were closely related and that the association should include credit and collections issues in its programs. In addition, the association decided that because credit managers perform an accounting function, they were qualified for membership. Credit and collections was also receiving broad attention at the chapter level, and the association briefly entertained the idea of eliminating the word *accountants* from its title. Although the association never developed a separate department or division to address the concerns of credit managers, it continued to relate its programs and services to their needs.

At the same time, the board appointed an ad hoc committee to study the possibility of considering data processing professionals for association membership. Chaired by Don D. Hamachek, a board member associated with Baptist Hospital in Memphis, the committee recognized the association's responsibility to train data processing personnel in hospital accounting theory and practice and to foster a dialogue among administrators, accountants, and data processing professionals. In addition, the ad hoc group committee suggested a standing committee to promote automation of hospital financial management.

Retired, Advanced, and Student Member Categories

In 1963 the association created the category of *retired member*, which allowed members who had already retired from their positions to retain voting rights and privileges of the membership classification held at the time of retirement by paying annual dues of \$10. Subject to approval by the national board of directors, a chapter could also award a retiring member chapter life membership for outstanding chapter accomplishments and assume payment of that member's dues for a five-year period, after which time the dues were waived.

Concurrent with the association's name change from the American Association of Hospital Accountants to the Hospital Financial Management Association in 1968, the association introduced the category of *advanced member*, which duplicated requirements for the fellowship exam. Members who had already achieved fellowship were immediately transferred to advanced membership. Other applicants for advanced member status had to be members for at least three years and earn points for education, experience, and/or authorship. Several years later, the board of directors ruled that advanced members would not lose status because of changes in employment.

Other membership changes included the development of a membership category for students with modest annual dues of \$10. Although the association seriously considered institutional membership, the board of directors declared that the association was, above all, an organization of individual professionals who had come together to further the aims of healthcare financial management. Still, organizations continued to have a critical role in the association's success. Of the checks received for dues payments in 1990, more than 90 percent were written by hospitals or other employers.

Membership Development

In addition to debating membership qualifications and categories, the association has always focused on member recruitment. Although the association sent out the first issue of *Hospital Accounting* to 7000 hospitals in the United States and Canada in 1947 as an introductory and recruitment vehicle, the effort was hardly an overwhelming success. A direct mail recruitment campaign held shortly after Fred Morgan became secretary in 1948 resulted in 43 new members to bolster the association's total membership of 500. But it was the designation of second vice president Charles Warfield as director of recruitment that turned the tide. Warfield drafted personal letters to hospital administrators in states that had not yet been approached about membership, persuaded the board to approve the purchase of 10,000 membership brochures, and introduced the concept of "every member get a member." At the end of 1952, the secretary reported a total of 1178 members and 17 chapters.

By 1953 the focus shifted to chapter formation and for good reason: Organized groups at the local level offered potential members an instant return on their dues dollars. In the early years of the decade, chapter formation mushroomed, and in 1959 the association boasted 58 chapters and more than 3200 members. Grass roots organizers received an extra boost of encouragement to expand chapters through the implementation of the Graham L. Davis Award for Chapter Achievement. Ultimately, the association decided to establish chapters in every state of the nation, an objective that was realized in 1972.

But none of this growth would have been possible without the extraordinary faith and confidence displayed by the association's earliest members. When Martha Crumpton Wood, business manager of Houston Hospital, Houston, Mississippi, returned her application to Bill Follmer in 1946 and become the association's first official member, he commented with some surprise, "It is rather hard to adequately express one's feelings at such a display of confidence in an organization which to all appearances is not completely organized." Only a few years later, the application of a member from South Dakota put the association over the top with members from every state in the union. The association's abiding faith in its members eventually led it to acknowledge "milestone members"—those members whose application helped the association hit a new milestone in membership.

Effects of Bylaws Changes

Many of the more recent bylaws changes have affected membership classifications. In the days when recruiting new members was difficult, proper classification based on the applicant's work environment was a major issue, and transfers between

classifications were made when a member changed employers. At one time an immediate past president left his hospital to join a Blue Cross firm and the board of directors insisted that according to the bylaws, he was disqualified from continuing on the board. He was forced to resign his office.

Bylaws changes made in March 1984 permitted associate members to become regular members, and in April 1986, affiliate members were merged into regular membership status. These changes gave individuals connected with CPA firms, consulting firms, and even commercial firms the power to vote in national elections and to hold office—although there were still some restrictions concerning composition of elected bodies. Thus, with the exception of student members, applicants for membership were classified as regular members. Other membership classifications such as advanced member, national life member, retired member, and chapter life member remained earned categories.

Chapter-Level Recruitment

With the growing sophistication of computerized records and the association's increased desire to respond to members' needs, membership procedures continued to change over the years. Because the incentive program for HFMA chapters (the Graham L. Davis Award) required that chapters meet an annual quota of new members, membership recruitment never warranted a program operated through the national office. Instead, recruitment programs were designed for and targeted toward chapters that almost always found a strong, enthusiastic audience for chapter educational programs and HFMA membership benefits.

Over the years, the recruitment appeals and concepts that were communicated to chapters also grew more sophisticated. In the early 1990s membership materials focused on the slogan: "You Need to Know."

Board of Directors

Throughout its history the board of directors has given the association vision, power, and momentum. The association, in turn, has asked board members to assume specific roles and responsibilities and to address changing needs. For example, in the late 1940s, Sister Mary Gerald served as director of manuscripts and spearheaded the effort to secure new manuscripts for the association's starving journal. At the same time, Charles Warfield concentrated on membership recruitment. Because of financial constraints, the board met only once a year at the national institute at Indiana University. Directors typically received speaking assignments or other work, and institute revenues covered their transportation and housing costs.

Frequency of Meetings

In 1954 board members discussed the merit of more frequent meetings. Although they regularly received information on member and chapter statistics, they had little communication on such issues as planning for the annual institute due to the absence of a full-time executive secretary. As a result, board members were at a disadvantaged position when critical association issues came to the table for discussion. The officers decided to invite newly elected board members for the first time to their 1954 meeting to help plan the year ahead.

Debates About the Size of the Board

Citing the need to maintain fair representation of the growing number of association members, several chapters recommended expansion of the number of members on the board of directors in early 1981. This recommendation was referred to a task force on association evaluation and assessment, which had been created to fill the vacancy in the position of president. The task force subsequently developed a detailed position description for the president as well as a white paper on shared leadership responsibilities of the president, chairman of the board, and board of directors. However, it chose to defer the issue of board size.

Despite the recommendation on board expansion, bylaws changes adopted in March 1983 reduced the number of board members through elimination of the governance of the immediate past chairman, who was, in turn, named to chair the newly created advisory council of past presidents and chairmen and the Nominating Committee. This action relieved the immediate past chairman of the burdens of governorship and the time-consuming responsibilities of serving on the matrix or board or as an officer for a period of four to six years.

Conscious of its responsibility to adhere to federal and state laws and to comply with the ethics of its elected position, the board passed a March 1984 resolution on conflict of interest that stated "full disclosure . . . in the case of a duality or conflict of interest must be an established standard of conduct. . . ." Each incoming member of the board is required to sign this resolution. With continuing growth in the association's membership, the issue of board expansion once again came under discussion. Bylaws changes in 1986 called for the election of 12 directors—for two-year staggered terms of six years each—and 4 officers. The board currently stands at 16 persons.

Committees and Task Forces

Member involvement through committees is critical to the success of any association. Through its 1946 bylaws, the American Association of Hospital Accountants created three standing committees: Membership, Program, and Nominating. The bylaws also stipulated that with the exception of the Program Committee, the association's president would appoint each committee chairman and would retain the power to appoint special committees to serve the needs of the board.

Committee Assignments

In 1946 President Fred Muncie made two critical appointments: Bob Reeves as permanent chairman of the Nominating Committee and William Voboril as chairman of the Membership Committee. At the ad hoc meeting held later that year at Indiana University, officers and directors empowered the president to appoint an Executive Committee to chart the association's new course. Although the committee never met formally, members previewed the premiere issue of *Hospital Accounting* and approved Muncie's decision to order reprinting of the issue.

In 1949 President Charles F. Mehler assigned duties to people serving in the newly elected directors-at-large positions and, with Fred Muncie, appointed a special committee to plan an institute on elementary accounting at Indiana University in 1949. This event marked the first AAHA-cosponsored annual national

institute at Indiana University, an educational tradition that continued through 1962. Institute planning was further enhanced when the association appointed a Committee on Education and an Annual Institute Subcommittee.

In her 1955 term as president, Sister Mary Gerald appointed a Correspondence Course Committee, a Journal Committee, a Financial Report Committee to investigate administrators' needs for timely financial data, a Research Committee to further develop a record retention manual, and a Chapter Manual Development Committee. Her action signaled the beginning of an era of structured committees that had the freedom to meet and carry out their responsibilities.

After almost 10 years of operation, the association began to focus on the appointment of a full-time executive director who could support committee programs. To fulfill this new objective, Past-President John Stagl developed a proposal that led to the creation of a Committee on Structure and Program that he chaired. In 1956 the association hired William M. Pierce, and President Robert H. Reeves implemented the directives of *The Second Decade Report* by naming relevant committees: a Committee on Education, a Committee on Chapters, a board of examiners, a Research Committee, a Committee on Revision of Bylaws, a Finance Committee, and a joint committee with the American Hospital Association. Bylaws amendments passed in 1956 authorized these committees, and they continued to actively function until 1968, when the association changed its name and the matrix organization was created. The Nominating Committee, the Executive Committee, and the joint committee continued to function as structured committees outside of the matrix.

From time to time, some of the association's presidents also appointed special committees. In 1957, for example, Henry Hottum named a Committee on Research to work on the development of a record retention manual, a national Publicity Committee to develop a fact sheet on careers in hospital accounting, and a Committee on Grants to investigate new funding sources. In addition, Hottum appointed two special-level committees: a Journal Advisory Committee and an Accounting Reference Committee that featured association fellows who answered technical questions from members. In 1959 President Ray Everett also designated a Committee on History.

In the early 1960s, one member complained to association headquarters that only 32 people occupied the 52 available committee positions and that it would be disappointing to discover that an "inner circle" governed association affairs. Unfortunately, budgetary constraints—not favoritism—dictated multiple appointments. Board members who chaired key committees also served as members of other committees.

As the association grew, the board of directors began to meet semiannually. During a four-year period beginning in 1958, the Executive Committee met no fewer than 10 times and saved the board considerable time and expense through analysis of budgets and financial statements.

When I became president in 1958, I appointed two chapter presidents to supplement the board-based Committee on Chapters. At the same time, the national Nominating Committee featured three past presidents and two individuals elected by chapter presidents at their annual meeting. The result was to bring the

membership closer to national policy making. By the mid-1960s a new bylaws provision offered chapter presidents the option of electing a board member to the Executive Committee.

Committee Responsibilities

President Jeff Steinert appointed an Association Office Committee in 1968 to review office procedures and organization, staff salaries and fringe benefits, and office space requirements. During its four years of existence, this committee formulated staff personnel policies, developed capital budgets, member group insurance programs and membership pins, and clarified membership eligibility problems.

In the same way, the Committee on Chapters worked for more than a decade to develop some of the association's most respected programs, including the Graham L. Davis Award for Chapter Achievement and a chapter officers' newsletter, "Notes from National," designed to encourage chapter activity and discuss association issues. Most significantly, the committee spearheaded the movement toward "professionalism" by recommending that "programs, achievements, all chapter activities, etc., should be geared to recognize hospital accounting as a profession." To achieve this objective and to address the lull in activity within some chapters, the committee authorized the development and distribution of a chapter program manual and a chapter institute manual.

In 1959 members of the Committee on Chapters attended the first regional institute in Philadelphia. The executive director was asked to draft a modus operandi so that chapters that served as sponsors would be clear on their responsibilities and duties. In addition, details of a chapter merit award plan were discussed, leading eventually to establishment of the William G. Follmer Merit Award. A few years later, the committee outlined the first annual chapter newsletter contest and developed a program whereby chapters would develop technical exhibits for display at the ANI.

Making an equally strong contribution to the usefulness and worth of the association was the Committee on Education, which helped to plan the annual Indiana University institutes and assisted in developing the university's three correspondence courses in the early 1960s. The committee also worked closely with L. Vann Seawell to publish two textbooks used in the correspondence courses. Published by Physicians Record Co. of Berwyn, Illinois, the books became the association's first textbooks. When an education director was hired in 1964, the committee worked to bring sharper direction and focus to educational activities.

Board of Examiners

Also critical to the association's sense of professionalism, and in compliance with a recommendation of *The Second Decade Report*, was the board of examiners, which met frequently to develop the first fellowship examination in 1956 and eligibility requirements and processes. Although the board of examiners constructed the examination, supervised grading, and certified candidates, a Credentials Committee reviewed applications and approved candidates who met eligibility requirements. Once eligibility was defined more tightly, the Credentials Committee was terminated and eligibility was determined by the executive director.

Task Forces

The term *task force* was infrequently used within HFMA circles to identify a group appointed to carry out a specific mission. In 1973 the HFMA Washington office was established, and President Ida Milanese requested each chapter to appoint a "standby task force in order to broaden the base of responses and to get involvement from chapters." Earlier that year, President Ron Kovener had appointed a special task force on accounting principles to compare the *Hospital Audit Guide* published by AICPA with the American Hospital Association's *Chart of Accounts for Hospitals* and other publications to report on discrepancies and to recommend appropriate positions for HFMA.

With the advent of a new association structure, board Chairman Herman Guenther appointed 10 administrative task forces to address long-range planning issues. Among them were a matrix effectiveness task force designed to study recommendations made by a special Matrix Effectiveness Committee the previous year and an International Involvement Committee designed to pursue the development of educational programs and chapters in other countries. Also included among the task forces were association bylaws, recertification, specialty care, awards and recognition, education, management achievement, and cost effectiveness. A tenth task force, financial advisory, considered additional sources of funding, dues income ratio, chapter treasury balances, chapter rebate programs, and registration fees.

The task forces that evolved within the first three years of the HFMA's new corporate structure were geared to internal issues confronted by the new structure. The task forces demanded careful study of where the association had been and where it should be headed. These administrative task forces were complemented by task forces that scrutinized other healthcare organizations and explored how the association could better serve them. A third category of task forces grappled with the ever-changing technical issues on which the association was expected to assume a leadership role.

As a result of experience on the board of directors and as a practicing healthcare executive, every incoming chairman of the board was aware of critical needs within the field. For this reason, the task force evolved into the preferred strategy for pursuing a given subject or project. The chairman knew that HFMA activities would be handled appropriately by the matrix organization, which remained loosely structured even though each chairman had the opportunity to revamp the matrix to fit current circumstances or address task force recommendations.

In 1983 the chairman appointed several task forces, each of which was assigned an administrative subject area. These task forces included assessment and evaluation, information systems, pricing policies, and funding guidelines. The first of these task forces reinforced the notion that the association was member driven and that frequent assessment and evaluation of its mission was essential. Pricing policies, in contrast, were a subject that staff had continually confronted for years in an attempt to find a formula for pricing the association's published textbooks.

In 1985 a task force on organization and structure continued to look within the association to ensure that it was moving in the proper direction. A technical

task force on uncompensated care also pinpointed problems related to this troublesome social issue. One of the prime advantages of a task force is that it can remain in operation until it fulfills its charge and issues a report. Both the task forces on organization and structure and uncompensated care remained in session during the following chairman's tenure and were supplemented by two additional technical task forces: the long-term care special advisory task force and the 2552 task force.

Technical issues also demanded attention in 1986 and were addressed by the appointment of two task forces on future Medicare alternatives and health policy. The Graham L. Davis Award for Chapter Achievement was a strong motivational force within HFMA chapters and was regularly updated to fulfill its incentive role. In 1987 the association reviewed the award's scoring system by appointing a special task force. Other technical issues prompted the appointment of an additional two task forces—one on tax-exempt status of institutional providers and another on ambulatory services.

The Matrix Organization

When the association considered changing its name to the Hospital Financial Management Association in 1968, President Jeff Steinert outlined plans for a matrix organization that would include four councils designed to carry out the association's objectives: education and research, publications, principles and policies, and professional excellence.

In addition, Steinert envisioned six technical committees—Management Accounting, General Finance, Receivables Management, Reimbursement and Third Party Relations, Systems and Data Processing, and Office Management—that would represent various functions of hospital accounting and provide support and resources to the councils. Members appointed to one of the four councils would also serve on one of the six committees, thereby contributing to active communication.

Problems and Progress of the Revised Structure

Although the matrix concept offered the association numerous benefits, several flaws emerged. Absenteeism short-circuited communication between councils and committees, because alternate members were sometimes appointed to each of the technical advisory committees. During its first year, the General Finance Committee had little to do and recommended that its responsibilities be transferred to the Management Accounting Committee. Eventually, this committee evolved into the Management Accounting and Finance Committee. In 1969 President Sister Mary Bertrand integrated the Committee on Chapters into the matrix as a council.

Although the association adopted its original matrix structure in 1968, it waited until 1974 to articulate the structure within the bylaws. In the intervening years, many changes in title, function, and scope evolved within various committees and councils. To help members stay informed about the national matrix structure and its achievements, *Hospital Accounting* carried an annual report of its accomplishments and outlined goals and objectives for the upcoming year. In

addition, following one of three matrix meetings held each year, matrix and board members received a summary of activities and board actions. In their role as chapter liaison representatives, board members communicated with their assigned chapters.

In 1970 President Charles Anderson assigned the association's president-elect, treasurer, and immediate past-president to serve as liaisons between his office and various councils by attending assigned meetings. To provide for better communication, Anderson introduced the concept of a general session for council and committee members during matrix meetings.

In addition, the matrix reached stability through extended terms of office. Board members who received first-year appointments as committee chairmen occupied council chairmanships during their second year of office. In addition, new matrix members received a customized matrix handbook that described the relationship between the board and committees, outlined their roles and responsibilities, and offered tips on how to handle communications and policy.

Restructuring in 1979

Although the matrix structure won kudos from the membership, President Joseph McCue appointed a special committee to study its effectiveness in 1977. The committee urged continuation of the matrix structure. But in view of the ever-changing healthcare environment, the committee also offered more far-reaching recommendations, including having the chairman-elect make annual program recommendations for councils and committees (in effect an annual cursory re-evaluation of the matrix), and an in-depth evaluation every three years. When the matrix was restructured to meet new industry challenges in 1979, long-standing technical committees were renamed advisory committees. Each was charged to review and provide advice on various areas of the healthcare field or on the association's position.

At the same time, matrix structures were drafted to reflect contemporary concerns. In 1982 and 1983, for example, advisory committees were made responsible for professional specialties, image promotion, healthcare financing, systems, support resources, and delivery systems and localities. In subsequent years, committees carried such titles and responsibilities as Association Services, Media and Communications, PPS Technical Issues, Long-Term Care, Alternate Delivery Systems, Multi-unit Healthcare Providers, New Products and Services, Regional Liaison, the Changing Role of the CFO, Competition, Eldercare, Specialty Hospitals, and Ambulatory Care. A Committee on Patient Accounting was resurrected to meet the growing demands for information on this technical subject. Because councils related to the association's mission, their titles have remained largely unchanged, although responsibilities change annually to meet the needs of the times.

Dues Structure

The original bylaws of 1946 stipulated that dues for senior members be \$10 and those for associate and junior members be \$5. Although dues revenue increased over the years, the association continually faced the challenge of budgeting expenses to conform to anticipated income. In the early 1950s, the cost of each copy

of *Hospital Accounting* was calculated at 52 cents, which translated to 52 percent of annual dues for 10 issues. In addition, the association rebated approximately 30 percent of dues paid by chapter members to individual chapters. By that time, members affiliated with chapters had grown from almost 29 percent of the total membership to slightly more than 62 percent. With the implementation of recommendations of *The Second Decade Report* in 1956, annual dues were increased for each of the new membership classifications:

Nominees	\$12.50
Members	\$17.50
Associates	\$15.00
Fellows	\$25.00

In response to complaints from the field, the board agreed that *Fellow* should be an earned title and not a membership classification. In 1961, dues were billed at \$17.50.

Change in the Dues-Setting Procedure

The board was aware of the problems of stipulating specific rates for dues within the bylaws, and so the bylaws were amended to provide for setting dues increases by the board with approval by a majority of the membership through a mail ballot. When the association changed its name and expanded its function and scope in 1968, the board chose not to request a simultaneous dues increase. Shortly thereafter, however, the board cited growing recognition and demand for association programs and the increased influence of financial management as arguments for an adjustment to \$30 in annual dues. In a special statement, the board listed the activities and contributions that would be financed through the dues increase. Expenses included \$54,500 for expansion of educational offerings and \$44,400 for development of a technical assistance program.

After reviewing anticipated deficits in the early 1970s, the board chose to once again approve a dues increase as an alternative to curtailing services. In a carefully crafted statement that referred to the needs of members and allied groups, the board disseminated a proposal to increase dues to \$40. Using these funds, the board planned to strengthen technical assistance to members, fortify relationships with other groups, and expand the journal and its special "Update" insert.

In 1973 the board expanded technical and information services by opening an office in Washington, D.C. But continuing demands for service and the runaway inflation rates of the 1970s severely eroded the association's equity. In 1975 the board approved a dues increase of \$12, setting total annual dues at \$52, and just two years later, another dues increase, from \$52 to \$60. Although some members argued for an automatic annual increase to cover inflation, others advocated that the association cap inflation through sound fiscal management. The debate continued until the early 1980s, when the association once again increased dues to \$75 in 1980 and to \$95 in 1981. Renewal rates in recent years remained high at some 89 percent.

Conscious of the time interval between the membership voting process for dues approval and the effect of a dues increase on association finances, the board

of directors noted in 1974 that the three-to-two approval margin of the most recent increase and the nine-to-one approval margin at dues-paying time was inconsistent. The board then presented a bylaws change that gave it authority to increase dues without submitting the action to the membership for approval. For many years, the dues year coincided with the calendar year, and dues invoices were mailed early in December, with a 90-day grace period to March 31.

The Association's Dues Year Matched to the Fiscal Year

In 1979 the dues year was changed to coincide with the association's fiscal year of June 1 through May 31, and dues invoices were subsequently mailed in March. With the association's growth and increased demands for services, the dues stipulation increased incrementally throughout the 1980s. Although membership had grown and other sources of revenue had been generated, membership dues continue to serve as the association's lifeblood. In the early 1980s, dues accounted for some 45 percent of total revenue.

The Second Decade Report

With only a handful of members in the early years, the association's progress was slow. Services to the membership were minimal, and a monthly publication and an annual accounting institute were the AAHA's only contributions to the hospital accounting field. Restricted by the association's financial resources, projects could be initiated and completed only if association officers and board members sacrificed their time and effort. But the soundness of the association's objectives; the benefits derived by members who attended chapter meetings; and the self-evaluation of procedures, methods, and theories contributed to the steady increases in new members. With the additional revenue that accrued through membership increases, the monthly publication's appearance became more dignified and mature. At the same time, chapter formation increased steadily, bringing the total number of chapters to 41 by early 1955. With the membership at more than 2400, the AAHA had truly come of age.

But with this steadily growing membership came a new responsibility that could not be ignored and that rested heavily on the shoulders of new officers and board members. No longer could the association limit the benefits of its membership to a monthly periodical and annual institute. No longer could it confine its activities to membership recruitment and chapter formation. Instead it had to accept its obligation to serve its membership and the entire hospital field.

Formation of the Committee on Structure and Program

The foregoing paragraphs paraphrase the opening statements of the report of the Committee on Structure and Program, which was created by the board of directors in November 1954.

To obtain an objective perspective, the committee chaired by Past-President John Stagl included several administrators as well as representatives of the American Hospital Association, the Catholic Hospital Association, the American Medical Librarians Association, the editor of *The Modern Hospital*, Graham L. Davis, C. Rufus Rorem, and Charles G. Roswell. After deliberating for more than a year,

the committee recommended moderate changes in the association's objectives and major ones in membership and services.

Aware of the benefits that members derived from exchanging ideas at the chapter level, the committee suggested that a Committee on Chapters be formed to suggest program topics, encourage local participation in accounting projects, and promote the Graham L. Davis Award as a means of increasing chapter activities. Formation of a Committee on Education was also recommended to create correspondence courses and encourage chapters to promote accounting institutes through preparation manuals. The identification of a membership classification of *Fellow* signaled the creation of a board of examiners that would develop and conduct the fellowship examination. The committee report also stressed the need to employ a full-time executive secretary to oversee the association's activities and its recommendations.

Publication of the Report

Finally, the committee recommended that *Hospital Accounting* continue its policy of offering readers a combination of technical articles and news and that the association form a joint committee with the American Hospital Association "to meet periodically to discuss programs and to eliminate duplication of effort wherever possible." As approved and published by the board, the committee's recommendations were disseminated under the title, *The Second Decade Report*. The board established a target date of January 1, 1956, for implementation.

Relocation from Rochester to Chicago

The serious search for an executive secretary began in 1955, and interviews were held with professionals in the hospital field—some of whom were close to the association—and with professionals outside the field. Eventually, the association retained William M. Pierce as executive secretary. Pierce held a bachelor's degree in accounting and had a year's experience in public accounting and over five years of experience as an accountant with Jewish Hospital, Louisville. He had been active in the Kentuckiana Chapter of AAHA since its formation and served as its president in 1955. Elected as a national director in 1955, he was on intimate terms with the work of the Committee on Structure and Program and with the ambitious programs that the committee had advocated in its report.

Plans called for Pierce to remain in Rochester for about two months beginning in November and December 1955 and then move to Chicago where the association would have to wait several years before moving into space in the American Hospital Association building at 840 North Lake Shore Drive, then under construction. In January 1956 Pierce set up shop at 530 East 31st Street in the campus of Michael Reese Hospital. The association's new headquarters was 13 by 18 feet, and the \$35 monthly rent included electricity, air conditioning, housecleaning, and local phone service. After spending part of his tenure at a hallway desk, Pierce moved to larger interim headquarters at 2630 East 75th Street. Pierce selected Northwestern Printing House and published the first Chicago-based issue of *Hospital Accounting* in 1956. A new chapter officer's newsletter, known as "Notes from National," was also launched.

Leadership Changes

After two and a half years of service and extensive travel to chapters, Pierce resigned in 1958. Hugh N. Brown became Pierce's replacement. With a background in education and public relations, Brown was employed as assistant administrator in a hospital in Xenia, Ohio. In 1955 he was invited to transform the report of the Committee on Structure and Program into a more readable, public relations-oriented document—*The Second Decade Report*.

On June 1, 1958, I assumed the elected presidency of AAHA and chaired the activities of the national institute at Indiana University. During the institute Brown engineered plans to hold a meeting of chapter presidents in Philadelphia in August. This meeting was attended by officers of all 12 invited chapters that extended from New England southward through Virginia. At the meeting I announced my desire to hold a regional educational institute that would fulfill the 1956 agreement with the American Hospital Association that AAHA conduct educational programs on general hospital accounting topics. The Philadelphia chapter agreed to sponsor this institute in October 1959 and plans were launched.

Hugh Brown's expertise in public relations and communications created notable changes in the layout, illustrations, and articles within *Hospital Accounting*. But Brown knew that public relations was no match for a background in technical accounting when the affairs of a national association were at stake; he resigned in December, effective February 28, 1959. A contract was negotiated so he could serve as editor of the journal, a position he continued to hold until mid-1964.

In December the Executive Committee met in Chicago, and I was offered the position of executive director. It was agreed that I would complete my term as president and, in the interim, run the office through several trips from Trenton to Chicago and communication by telephone. On June 1, 1959, the day following the end of my term as association president, I moved to the executive director's chair at the association's headquarters, which since January 1959 had been located in Suite 500 of the American Hospital Association building.

Meeting New Challenges in the Healthcare Field

By the mid-1960s, the association had achieved many of its objectives and had much in which it could take pride. In the 10 years from 1955 to 1965 membership swelled from 2500 to 3600 and chapters mushroomed from 42 to 61. Among the myriad achievements was the first fellowship examination, a chapter officer's manual, a marketed records retention manual, the Frederick C. Morgan Individual Achievement Award and the William C. Follmer Merit Award for chapter service, several correspondence courses, a series of regional institutes, and closer relationships with the American Hospital Association and the Catholic Hospital Association.

The challenges posed by the introduction of Medicare coverage were barely distinguishable specks on the horizon. As the demands increased for more sophistication in hospital accounting, the association also continued to grow. Medicare would soon awaken the entire healthcare field to the need for stronger management and change forever the nature of health care.

In response to this paradigm shift, President Harold Hinderer appointed a special Committee on Scope of Association Activities in 1966. The committee,

which consisted of five past presidents, suggested changes in membership classifications to provide for vertical expansion by category and identification of other categories: member, advanced member, and associate. The committee recommended bylaws changes that would expand the association's objectives from five to nine and extend its appeal to other healthcare organizations, such as extended care facilities, rehabilitation centers, and home healthcare agencies. Most important, however, the committee recommended that the association change its name from the American Association of Hospital Accountants to the Association of Hospital Financial Management.

Changing the Association's Name to Reflect Its Role

After rejecting the suggested name change, the board referred the issue back to the special committee that had spent an entire day discussing names and variations of names. Their final recommendation was "Financial Management Association for Health Facilities," but no action was taken. Several years later, the Executive Committee again considered names and recommended two: "Association of Hospital Financial Managers" or "Hospital Financial Managers Association." When the new name was presented to the membership for approval, the word *managers* had been changed to *management*. In the summer of 1968, the association's membership newsletter proclaimed, "We have a new name." Hospital Financial Management Association won approval by a 20-to-1 margin. At the time, the hospital was the focal point of patient care. But as early as 1974, another name change was already under consideration.

Committee on Association Activities

In the mid-1970s, the association's leadership recognized the association's potential stature and impact in the healthcare industry and encouraged discussion of public policy issues. The board and staff had reaffirmed the association's future as a policy-making body, but it also recognized the American Hospital Association's position as the prime policy-making body for the hospital industry. The association chose to continue its limited policy-making function while it investigated a restructuring of HFMA in the corporate format, including the appointment of a salaried president who could bring credibility and presence to negotiations with other groups and agencies. And at that time, I had indicated my desire to retire within the next few years.

To validate its decision, the board appointed a special Committee on Association Activities to develop a job description and qualifications for the position of president and to recommend the changes within the association. Although the committee initially recommended that the president reside in Washington, D.C., both AAHA Past-President John Stagl, then chairman of the American Hospital Association, and I stated that Washington's role was to provide "eyes and ears" for the "brains" in Chicago. Working through an appointed search committee and a healthcare executive search firm, the association hired James T. Whitman, FHFMA, CPA, as its first full-time salaried president, based in Chicago. Whitman, who was then serving as the association's treasurer, assumed the mantle of president on June 1, 1978.

Long-Range Planning

On July 23, 1963, as executive director, I addressed a memo to the board of directors on the subject of planning. I recapped the recommendations of *The Second Decade Report*, commented on the implementation of each item, and suggested that a special advisory committee be formed to review major issues then on the horizon. Among the items cited were integrating hospital credit managers, data processing supervisors, and accountants from nursing homes into AAHA membership; a change in AAHA's name; possible dues increases; and plans for the early acquisition of an education director. Eventually, the board took up these items. In December 1964 Rodney S. Brutlag was hired as the first executive staff assistant.

After several years, the board requested that Brutlag and I brainstorm ideas on the association's future. In response, we created a report entitled *Prospectus for Planning*, which recommended that the association hire a technical services director, expand the association's lending and reference libraries and hire a librarian, purchase briefcases for chapter presidents, publish compilations of journal articles, and develop packaged educational programs. Although board members sighed and smiled when they heard additional recommendations, many ideas took root, including the development of a Washington office, automation of membership records, implementation of Fellows' seminars, and publication of books and newsletters.

But most important, this creative and somewhat whimsical exercise resulted in an important innovation: the inauguration of a formal long-range planning program and the adoption of a policy that dictated how the association would develop, promote, and deliver its educational programs. According to the policy, the association would assist "outside individuals and organizations, including commercial enterprises, who have the demonstrated resources to help meet these [educational] needs better than other available individuals or organizations." As a result, the association suggested that chapter and state CPA societies work together—evidence of the growing importance of CPA firms within the association. In 1970 the executive staff got involved in long-range planning as part of the annual budgeting process, and in 1973, the board put aside its prepared agenda to take part in a brainstorming exercise. The Executive Committee and the executive staff joined forces to become the association's first Long-Range Planning Committee early in 1976.

Over the next several years, the long-range planning process focused on the potential and the effect of the evolving structure of hospitals with satellite facilities, on new healthcare delivery mechanisms such as HMOs, staffing needs within finance, and the impact of HFMA on healthcare issues. By that time, membership records had been computerized, giving committees access to helpful statistics such as the number of members employed in various hospitals state by state. The exercise of long-range planning accelerated the introduction and implementation of projects and ideas that might otherwise have been overlooked or unappreciated. By 1978 the association had prepared and accepted its first five-year outlook, including projections of space needs, personnel requirements, capital equipment

needs, and other expenses to meet the needs of a burgeoning healthcare marketplace.

When Jim Whitman became president in 1978, he was charged with developing a reliable and meaningful long-range planning process as a document to serve as an indispensable management tool. A short-range plan, excerpted from the five-year forecast, is budgeted along with a departmental plan of action and quarterly management reports to the board.

As HFMA created more policy statements in the early 1980s, long-range planning shifted to strategic corporate planning. A "cornerstone of organizational direction," the strategic plan incorporated these policy statements and their implications for regulations. According to association policy, "programs and services will be updated and revised continually to accommodate changing membership needs." After the advisory council of past presidents and chairmen was introduced in 1984, it reviewed draft copy of the strategic plan and provided commentary. Updated annually, the association's strategic plan provides a concise, specific, and measurable blueprint for HFMA's future. Apart from establishing goals and objectives, it provides the motivation for national headquarters and chapters to achieve ongoing professionalism and excellence.

Public Relations

In 1982 the Image Promotion Advisory Committee recommended—and the board of directors approved—that staff develop a public relations program that would include analysis of the current situation, definition of problem areas and opportunities, identification of relevant publics, specific objectives, implementation strategies, and a means to qualitatively and quantitatively evaluate the program.

Prior to 1982 public relations had been an incidental by-product of the association's journal, its educational program, and other accomplishments. Late in 1983 the position of director of public affairs—later called corporate relations—was filled for the first time. The position's responsibilities included a corporate identity program, media relations, and public relations. In August 1987 the board of directors adopted "guidelines for advocacy" to define its role in development of public policy. These guidelines recognized the association as an organization composed of "professionals who are contributing to the debate" and who could, in turn, serve as a source for "technical input on the real-world effect of proposals on the fiscal viability and operational efficiency of healthcare providers." They then addressed the association's responsibility to "seek equitable treatment of the industry," to "enhance the image of healthcare professionals," to "preserve the opportunity for individuality," to "seek policies and procedures that are practical to implement," and, finally, to "ensure that decisions are based on data."

International Involvement

Involvement in international healthcare affairs dates back to the beginning of the American Association of Hospital Accountants, when financially oriented individuals in Canada were recruited as members. The roster of charter members included 20 Canadians. In the association's first year, President Fred Muncie was

supported by Second Vice President Percy Ward of the British Columbia Hospital Association and by Director-at-Large James C. Brady of Ottawa. The first life membership was conferred on Percy Ward in 1948, and Brady was accorded life membership in 1950. Sister Marie Florida, F.C.S.P., of Montreal, earned her fellowship designation in 1959. Until 1960, there was at least one Canadian on the board of directors.

Early Efforts Toward Internationalism

The Northern New York International Chapter was chartered in 1963 and included an area of eastern Ontario equivalent to districts 9 and 10 of the Ontario Hospital Association. Arthur Fry of the Hotel Dieu, Cornwall, Ontario, was elected vice president the first year and served as chapter president the following year. The chapter flourished for several years until Medicare changed the focus of U.S. health care, and interests formerly held in common declined. The chapter was dissolved in 1974, and the New York area was absorbed by two existing chapters.

A highlight of the annual national institute in 1964 was the presence of Reginald Stacey of Sheffield, England, an immediate past chairman of the Association of Chief Financial Officers in Hospital Services in England and Wales, who delivered a paper entitled "The Financial Administration of the British Hospital Service." In the early 1970s, Eric "Tony" Hall, an English district chief financial officer, visited and spent a few days at the national office.

By 1978 HFMA members and journal subscribers were spread across the globe, and three published HFMA texts had been translated into Portuguese for accounting instruction in Brazil. At the invitation of the Puerto Rico Chapter, Ron Kovener of HFMA's Washington office appeared on the program of the Hemispheric Hospital Federation Congress in San Juan, Puerto Rico. Foreign visitors at national institutes included several from Israel.

Conscious of the growing interest in HFMA from professionals in foreign countries, an international involvement task force was named in 1978 with Joseph A. Levi, long-time advocate of international relationships through the International Hospital Federation, serving as chairman. Attention of the task force immediately turned to the IHF congress scheduled for Oslo, Norway, in June 1979 where Levi was scheduled to appear as a panelist. The board approved a recommendation that HFMA be officially represented. Chairman Herman Guenther and President Jim Whitman attended, the latter as chairman of three sessions on cost containment and quality control. The task force completed its assignment by issuing a strategic plan for international activities.

Formalizing the International Involvement

In October 1981 the board of directors approved a modus operandi for international involvement, which focused on professional development, membership and chapter services, professional affairs, and editorial services. The plan included the admonition that involvement complement long- and short-range plans and budgetary limits. The paper read, "Necessarily, activities will be specifically considered and evaluated as to their applicability to the particular country being served."

The first in an annual series of seminars that involved American healthcare executives and the United Kingdom's Association of Health Service Treasurers

was held in London in July 1981. The meeting identified differences and similarities between the two healthcare systems and "was of substantial benefit to all in attendance."

A second U.S./UK seminar and visitation was hosted by HFMA in Boston in 1982 and there was a return trip to London the following year. The fourth event in the series was held in Philadelphia in July 1984, with a program that focused on interests of the English contingent, including case-mix management, diagnosis-related groups (DRGs), and computer applications. A highlight was a tour of Pennsylvania Hospital, the oldest hospital in the United States, and its historic Benjamin Franklin library. In 1985 London and Warwick provided the site for the seminar, and in 1986, the program was centered in Denver, Colorado. In 1986, the UK Association of Health Systems Treasurers formally changed its name to Healthcare Financial Management Association (UK).

One session noted the difference in capital spending between the two systems: the United States spending too much on equipment and facilities and the UK spending too little. The distinction, it was thought, was rooted in national priorities with the British "guaranteeing equal access to health care at the cost of convenience, while the U.S. decided convenience was the highest priority and equal access was secondary."

The 1987 meeting, now known as the USA/UK Exchange and Seminar, was held in Bath, England, and in Washington, D.C., in 1988. In 1989 the program was situated in the old Roman walled city of Chester, England, and in 1990, the tenth annual seminar was held in Chicago with the theme, "A Decade of Sharing—an Exchange for the Future."

Interest in renewing communication with Canadian healthcare executives was revived in 1980 when, during the American Hospital Association convention in Montreal, HFMA officials met with Canadian counterparts. A year later, a joint meeting was held in Quebec City.

The first formal exchange between HFMA and Canadian counterparts, the Financial Executives and Managers Association, was conducted the week of August 5, 1990, in Banff, Alberta, Canada. The program, patterned after the HFMA US/UK International Exchange, paired five U.S. participants with five Canadian participants. U.S. attendees arrived at the home site of their Canadian partner and spent two to three days at their partner's home and office location before assembling at the central location for a two-day group session. The Banff program included a presentation of hospital funding and proposed changes as well as discussions on similarities, differences, and futures of each system.

In May 1985 Chairman Paul Long and President Michael Doodly attended the International Hospital Federation meeting in Puerto Rico. Then, in 1986, a group of Japanese businessmen who represented banks that had opened branches in the United States visited the HFMA offices with questions on tax-exempt revenue financing, leasing arrangements, and other capital financing schemes. Internationalism remains an interest of the association, and opportunities are pursued as options and differing health systems permit.



The original logomark of AAHA as designed by Helen Yerger in 1947. Symbols of the United States (American eagle) and Canada (maple leaves) are superimposed on the caduceus (symbol of the medical profession). The Red Cross is the universal symbol for mercy and succor, and the quill symbolizes the concentrated effort of hospital accountants.



The symbol of the association was changed in 1968 when the name was changed to Hospital Financial Management Association.



In 1982 the Association changed its name from "Hospital" to "Healthcare" Financial Management Association. The new name recognized the significant changes occurring in the healthcare industry with regard to corporate structure, multisystem developments, and diversification in the delivery of health care. The new name accurately described who association members are and the arena in which they work.



The current logomark of the association was designed in 1984 and is a combination of the stylized Swiss cross and the letters HFMA. The logomark is the only graphic design that can be used in conjunction with the name of the association, its chapters, its affiliates, and products or services.



In 1978, HFMA adopted the corporate form of organization with James T. Whitman (second from right) as CEO with the title of president. Also shown (from left to right), are Raymond Cisneros, chairman elect, Lee Kaiser of the University of Colorado, and Park H. Haussler, chairman of the board (1982).



Indiana Chapter (later the Indiana-Pressler Chapter) recognizing Stanley Pressler with a plaque in April 1977.

ANI 1964 at University of Chicago
(Ernest Laetz and Sister Mary Assunta,
S.C.).



Northeastern Pennsylvania Chapter, 1967. Seated, left to right, Robert
M. Meyers (Director, Bureau of State-Aided Institutions), Chapter
President James L. Kinney, and Sister Mary Venard, RSM.

Standing left to right, Joan R. Mican, Orion Beckerman, Paul
Dougherty, and Gerald F. Malloy.



The California Chapter received its charter in 1953. It later became the Northern California Chapter. Frances B. Ducey, member of the Board of AAHA, at left, presenting the charter to Lucy Gorton, Charles W. Cullen, Elmer O. Messmann, Gardner E. Burke, and Alfred E. Maffley, chapter president.



Wilbur Stevens, a member of the AICPA board of directors, receives the HFMA Board of Directors Award, 1974.

National AAHA officers and directors, 1951. Top row, from left: Marguerite Humes, Frederick C. Morgan, John M. Stagl, David H. Spanier, George H. Long, Jr. Front row, from left: Robert H. Reeves, Sister Mary Gerald, Charles F. Mehler.





Past presidents of the AAHA met at the 1962 ANI. They include from left to right: Sister Mary Gerald, Bob Shelton (executive director), Harry O. Humbert, Ernest C. Laetz, Sister Loretta Marie, C. Henry Hottum, Charles Mehler, Ray Everett, and Robert M. Reeves.

The 1982-1983 board, seated from left to right, Steve Wesby, John Patillo, Jr., Park W. Haussler, James Whitman (president), Raymond J. Cisneros, Paul M. Long. Standing, left to right, Mary A. Sloboda, Thomas H. Kohl, Steven Reed, Herschel Timmons, Jr., Eileen Oldenburg, Stanley Abramowski, Kenneth Hews, Robert Newton, Janet Ott, Thomas Boyd.



1965-1966 Board of Directors. Seated from left to right: Jeff Steinert, FAAHA, Sr. Mary Assunta, SC, Past President Harold Hinderer, FAAHA, President-elect Robert L. Schultze, President Joseph D. Clancy, Sister Mary Bertrand, CSC, FAAHA.

Standing (left to right): Rodney S. Brutlag (Director, AAHA Educational Foundation), Ellen A. Forin, Howard J. Seminzson, Charles H. Anderson, Walter E. Joeschke, and Robert M. Shelton, FAAHA (Executive Director of AAHA).

Not pictured: Henry F. Conrad.



Indiana Chapter Meeting of
March 17, 1954.



Fourth Annual
Institute on Hospital
Accounting, Indiana
University, 1945, when
and where the
association began. In
the front row are
founders Robert
Reeves (fourth from
left), Stanley Pressler
(fifth from left),
Charles Roswell
(seventh from left),
and Fred Muncie
(eighth from left). In
the third row is Sister
Mary Gerald (fourth
from right), and in the
top row center is
William G. Follmer.





Special recognition is given in 1967 to member Joseph D. Clancy (left), a national past president, by the Massachusetts Chapter, while future national President Joseph McCue officiates.



In 1968, Executive Director Robert Shelton (second from right) attended a Hawaii Chapter meeting on Aloha Day. Greeting him are (from left to right) Richard S. Okouchi, Richard L. Wood, and Elliott T. Ozu.



Puerto Rico Chapter meeting on February 26, 1975. Seated from left to right, Enrique Baquero, Domingo Velez (president-elect), Manual Mendez, president, Juan Aponte (chairman of the Commission for Universal Health Insurance), Jose V. deJesus, and Rafael Garcia.



In 1959 the first recipient of the Frederick C. Morgan Individual Achievement Award, Charles G. Roswell (left), receives a plaque and congratulatory handshake from President Ray Everett. Frederick C. Morgan, for whom award was named, witnesses the presentation.



1962 President Harry Humbert confers Morgan Award on Sister Mary Gerald as Frederick C. Morgan (center) expresses congratulations.



President Ronald Kovener (left) presents the Board of Directors Award in 1972 to C. Rufus Rorem, Ph.D.

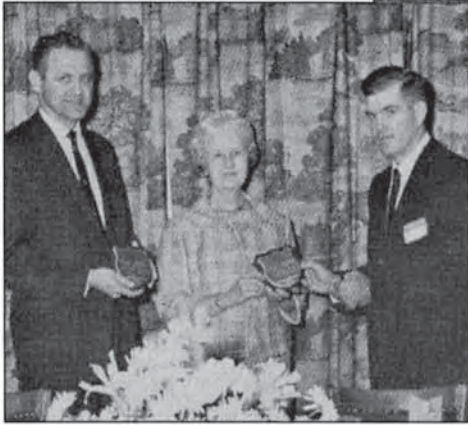


Faculty members of the 10th ANI at Indiana University, including (left to right) Howard Wassenaar, Charles Warfield, L. P. Allaire, Frederick C. Morgan, Robert H. Reeves, Bernard Felton, John Stagl, and David Spanier.

Appalachia Chapter officers, 1965-1966. Seated: Sr. M. Walburgis, president, and Paul R. Whitney, past president. Standing, left to right, Carlton Flores, Robert G. Garves, Arthur S. Wayndt.



New Jersey Chapter (shown at right) Follmer Merit Award winners of 1968 (left to right): James Hannah, Andrew T. Suppa, Martin Ulan (President of the New Jersey Hospital Association who presented the awards), William T. Gill, Emil Horak, and William K. Hogan.



Arkansas Chapter (shown at left) President Howard Johnson on the right presented 1968 Follmer Merit Awards to N. Terry Lynn and Delphine Sutton.



Montana Chapter officers, 1965-1966 (left to right) were Sister Mary Josephine, Ray Bradley, Charlotte Rominger, James Adams, William Martin (president), and Ronald Purdom (outgoing president).



New Mexico Chapter members at La Fonda Hotel, Santa Fe, New Mexico. October 4, 1954.



Long Island Chapter organizational meeting, 1955 (later became Metropolitan New York). Left to right: Helen McMillan, James A. Beach, Raymond F. Mack, and Joseph R. Bradley, president.

Ethel and Bob Shelton at the unveiling of the Shelton Award in 1979.



THREE

Growth Through Chapters and Awards



All your strength is in your union.

Henry Wadsworth Longfellow
The Song of Hiawatha

From the beginning William G. Follmer believed that a national association of hospital accountants would include chapters. In an August 1945 letter outlining the organization's founding principles, he requested "that the association encourage the formation of state or local chapters for advancement within that territory of the association."

Although the AAHA's first constitution and bylaws failed to provide for chapters, the documents delineated 12 regions that incorporated the United States and Canada and allowed for the appointment of regional directors. These regions were intended to decentralize new member recruitment by giving regional directors the responsibility to identify professionals within each state or metropolitan district who would then serve as membership "sponsors" by recruiting other hospital accountants. Association leaders hoped that this regionally based recruitment initiative would ultimately motivate members to form chapters and to associate on the local level. Delays in recruiting members on the national level, the tardy publication of the first issue of the journal, and the wide geographic dispersion of members throughout the nation slowed the formation of chapters, although local groups begin to meet in southern California, northwest Pennsylvania, northeastern Pennsylvania, Pittsburgh, and Philadelphia.

Launching the First Chapter

A major breakthrough in chapter formation occurred in November 1948. In a letter to Bill Follmer, national President Fred Muncie reported on the formation of the first AAHA chapter incorporating the state of Illinois. Elected as president was Charles Warfield, chief accountant, Alexian Brothers Hospital, Chicago; as vice president, Lela Wright, business manager, Evanston Hospital in Evanston,

Illinois; and as secretary-treasurer, Bertha Judson, chief accountant, Woodlawn Hospital, Chicago.

Fred Muncie was enthusiastic about the new chapter and its bond to the AAHA:

While a formal article of organization was not drawn up, it was agreed by acclamation that the charter and bylaws of the AAHA would govern the actions of the chapter, and membership in AAHA would be a prerequisite for membership in the chapter.

Encouraging Formation of New Chapters

At the first formal meeting of national association officers held in Philadelphia in December 1948, Muncie led a discussion on the formation of chapters. Director-at-Large David Spanier was named director of chapter organization. The January 1949 issue of Bill Follmer's news bulletin reported on recent developments in a column entitled "Formation of Chapters." To promote chapter formation, association officers agreed that any group of 10 or more persons could form a chapter of the national association.

New chapters would be given quarterly financial payments that amounted to 30 percent of the dues collected during the first year of the chapter. In subsequent years, rebates would be made based on five factors:

- Not less than four meetings per year
- Submission of meeting reports to the chapter director
- Advance notice of chapter meetings for listing in the national news bulletin
- Financial aid based on average attendance for the previous year according to the following guidelines: 30 percent refund of dues for 50 percent attendance; 25 percent for 40 percent attendance; and 20 percent for 30 percent attendance
- Refunds to chapters of 30 percent of application fees collected

Fortunately, Follmer had allies in his effort to facilitate chapter formation. Helen Yerger and Robert Reeves lived several hundred miles from Follmer's new headquarters in Harrisburg, Pennsylvania, but they were able to form the Rochester (New York) Regional Chapter with 10 members. Among other early chapters chartered in accordance with national requirements were those in Wisconsin, northeastern Pennsylvania, eastern Michigan, Mississippi, and northwestern Pennsylvania.

The aggressive pursuit of chapter formation yielded strong results. In his report to the board of directors prior to the January 1952 board meeting, Secretary-Treasurer Fred Morgan reported that national membership had reached 862 and that chapter charters had recently been issued to the seven existing chapters. The board authorized the association's president to clear visits made by national officers to chapters or prospective chapters. The secretary-treasurer would turn over requests for chapter formation to chapter director David Spanier, who would then approve the chapter's petitions for charter, its constitution, and its bylaws, and maintain ongoing communication with chapter presidents.

Bylaws revisions approved in March 1952 provided a section on chapters for the first time that read:

Chapters of the Association may be established by charter wherever the Board of Directors may approve, subject to such regulations as to membership, organization, procedures, and financial relationship with the Association as the Board of Directors may prescribe.

Charters for the operation of chapters may be revoked at any time in such manner and after such investigation as the Board of Directors may deem necessary. Upon the revocation of a chapter charter, all funds in the chapter treasury and all chapter records shall be returned to the National Secretary.

Association policies on chapter formation and operations occupied a major portion of board meetings for years to come. By July 1952, 11 chapters had been organized and the board opted to focus on county lines rather than state lines in making decisions about chapters that were formed on the basis of a metropolitan area or in areas within a state.

Start of the Graham L. Davis Award Program

Launching the Point System

Robert Reeves expressed his dissatisfaction with the technical quality of the journal and its poor representation from membership among article authors. This, in turn, led to a discussion on the development of a quota or point system for chapters that submitted articles for publication. At a subsequent board meeting in November 1952, Reeves and Mehler outlined a program to award points to chapters in three areas: attendance at four chapter meetings, growth in membership strength, and submission of acceptable articles to the journal. Board members also agreed to present a special trophy to the chapter that had earned the greatest number of points within a calendar year and turn this chapter achievement award into a tribute to the life and work of Graham L. Davis.

From 1952 to 1955 the association continued to use chapters as a vehicle for membership growth. At the same time, the pace and level of chapter growth continued to increase. By December 1953 total chapter strength was brought to 25 and the total AAHA membership to 1866 members. With the bulk of administrative work handled by Fred Morgan and a paid secretary, national directors began to focus on new chapter formation.

Supporting Chapters Financially

At about the same time, incoming President Sister Mary Gerald directed that all correspondence from the national office relating to chapter formation be sent to appropriate directors (geographically) for follow-up. Directors were authorized to bill the national office for postage costs and obtain advance approval for special travel. In 1954 Sister Gerald called for the first meeting of chapter presidents at Indiana University. By that time 30 chapters had been formed and 3 others were in the process of organizing. When Fred Morgan turned over the association's reins to Bill Pierce at the end of 1955, membership strength totaled 2620 with 42 organized chapters.

Bill Follmer envisioned chapters as the association's backbone and a guarantee of its future success. But he also recognized the need for a plan that would provide

ongoing financial support to the decentralized structure. To this end, he outlined a framework that supported the decision to rebate a percentage of dues and application fees collected from members.

To encourage attendance by members at the four regional chapter meetings, the national office authorized a step-down refund based on a percentage of average attendance at meetings. Although noble in its intent, this program produced mixed results. In her 1949 farewell report as treasurer, Helen Yerger reported that only the Illinois chapter had received a refund. Although several other chapters were due refunds, she claimed that "calculating and figuring the refunds for the individual chapters requires plenty of time and accounting" and recommended that incoming officers develop a new procedure for refunding chapters.

In November 1949 the board added another complication to the formula for chapter reimbursement by voting a 3 percent bonus to chapters that could maintain or increase their membership during the year and a 2 percent bonus to chapters "having four meetings a year with minutes of the chapter meeting submitted to the national secretary on forms to be sent to the chapters."

At about the same time that the association approved the development of the Graham L. Davis Award for Chapter Achievement, it also abandoned the policy of tying chapter refunds to chapter performance. Effective January 1, 1953, the association planned to pay chapters flat rebates of 30 percent of total dues paid. Through this action, the association effectively transferred the motivating power of its refund policy to the new chapter trophy award.

But the level and quality of activity within chapters continued to be an issue. In December 1953 board members voted to withhold refunds from chapters that failed to comply with the requirement to hold at least four meetings a year. However, the reduction or discontinuation of refunds was vetoed. The association realized that some seemingly dormant chapters periodically held meetings and encouraged chapter presidents to file meeting reports so the association could adequately compute and distribute refund dues to chapters.

In 1956 the newly formed Committee on Chapters began to administer the association's chapter rebate policy. One of its first actions was to authorize the executive secretary to withhold the quarterly rebate to more than 20 chapters that had failed to report holding at least one meeting during the quarter. When chapters eventually submitted their reports, they received their rebate checks.

The debate on rebates continued for several years. Surprisingly, chapter presidents sometimes favored the elimination of rebates in lieu of instituting an increase in dues. Because chapters frequently collected fees for educational programs, they sometimes earned enough income to meet their operational costs. Although smaller chapters were less able to generate enough revenue to meet their costs, the national board continued to support the chapter rebate program largely because of its psychological value and its role in precluding chapter assessments.

The formation of chapters and the strengthening of existing chapters continued throughout the 1960s. Chapter relations were high on the agenda of the Committee on Chapters and a top priority for the executive director and national staff. The Graham L. Davis Award successfully fulfilled its mission to help chapters

plan programs and carry out chapter activities. In addition, the award motivated the national office to monitor chapter activities and provided the necessary push to develop chapters where none existed.

Association Structure

To serve all hospital accountants within its chartered boundaries, the association decided to allow chapters to form geographic council areas or regions, or to spin off into separate chapters.

Council Areas

As the most informal of decentralized chapter organizations, geographic council areas were usually established to coincide with council areas or districts defined by state hospital associations.

Pioneered by the Mississippi chapter, these geographic councils usually required a chairman, secretary, and sometimes a program chairman. The council chairman was responsible to the chapter president and its secretary to the chapter secretary. Evening council meetings in connection with Dutch-treat suppers were held regularly at local hotels or restaurants, and programs were targeted to the needs of hospitals in the area. Where chapters held quarterly chapter-wide meetings, the councils met in the intervening months.

There was no need for bylaws changes to establish geographic councils. The only requirement was that a local group of hospital personnel had the desire to meet. Working with such a group, the chapter's board of directors defined the geographic area, appointed or officially recognized a chairman and secretary, and allowed the council group to develop program content and direction. The national office provided a special reporting form that enabled council secretaries to report meetings to the chapter secretary, who, in turn, consolidated all council meetings held within a given time period on the chapter reporting form and submitted it to the national office.

An excellent example of the value of geographic councils was demonstrated by the Alabama chapter. When the Alabama Hospital Association introduced a uniform accounting manual in the early 1960s, it formed five chapter council areas that could meet as frequently as they wished, set their own pace for learning, and gradually adopt the provisions within the manual.

Regions

The regional organization provided a more formal way to decentralize the chapter, and instituting this type of structure required bylaws provisions. Operating almost like a separate chapter, each region pursued its own meeting program and was usually headed by a chapter vice president. Apart from the advantage of shorter travel distances and the ability of each region to set its own program, the regional approach fostered healthy competition among regions and strengthened chapter relations. A seven-time winner of the Graham L. Davis Award, the Tennessee Chapter was the leading advocate of the regional chapter organization. Today, the regional organization continues to flourish in Florida as well as Tennessee.

Chapters

Chapters already in operation served as a crucible for new chapters in the 1950s and 1960s. Chapters formed through older, more established chapters included

- Southern Illinois (1954) from the Illinois Chapter, which subsequently changed its name to the First Illinois Chapter
- McMahan-Illini (1963) from the Illinois Chapter
- Central Michigan (1959) from the Eastern Michigan Chapter
- San Diego Imperial Chapter (1968) from the Southern California Chapter
- North Central Michigan Chapter (1969) from the Western Michigan Chapter

In addition, three Kentucky chapters formed in the 1950s combined to form one Kentucky chapter in 1966. And in 1955 the Metropolitan New York Chapter developed as a result of a merger between the Long Island Chapter and a new chapter organized within the city of New York.

Coordinating Conferences

For states that had more than one chapter, the national office recommended the formation of a statewide coordinating conference of chapters. The association reasoned that these conferences could coordinate educational chapter activities within the state and facilitate communication with state hospital associations. Although these relatively informal conferences had no constitution or bylaws, they eventually operated according to guidelines developed by the chapters that were involved.

Like geographic councils, special interest councils provided a way to extend the scope of chapters and lend more depth to chapter programs. For example, the southwestern Pennsylvania chapter agreed to meet the needs of admitting officers by forming a special interest council. In the same way, the Indiana Chapter established a special interest council to assist county hospitals to comply with state legislation. These state laws required county institutions to conform more closely to general not-for-profit hospitals. Despite the growth of specialty positions within the field of healthcare financial management, the concept of special interest groups never developed a strong following within the chapters. Nevertheless, chapters established technical committees that offered input into planning general and specialty programs.

In 1982 the association passed an important milestone: the achievement of its 20,000th member. As financial specialists continued to enter the mainstream of hospital financial operations, the association used the March journal to announce a program to acquire information about each member. An enclosure in the 1981–1982 dues invoices provided a list of 25 professional designations from which members were asked to select a primary and secondary designation that best fit their employment function. Although the categories were broad, they were also specific enough to enable the association to accurately identify the functional responsibilities of members and to respond with communication tools, specialized publications, and educational and technical resources for each membership classification. As they looked toward the future, association leaders continued to seek

the best solution for decentralizing the chapter organization so that local activities would support the many and varied needs of financial management specialists.

Over the years the council of membership and chapter services has overseen all elements of chapter operations. In the May 1988 issue of the journal, President Richard Clarke wrote that because members enjoyed dual membership in national HFMA and local chapters, "national-chapter membership" was "at the root of HFMA's success." Because HFMA is membership driven, it views chapters as a critical channel of communication and offers them regular support through the national office.

Impact of Minimum Activity Standards

The Graham L. Davis Award had a long track record of success as a chapter incentive program. But aware that some chapters failed to meet the minimum standards of the award, the board of directors in 1987 set forth minimum criteria for chapter activities. Failure to meet these standards would precipitate a national review and possible loss of the chapter's charter. In addition, the board hoped that the criteria would provide guidelines for the formation of new chapters.

The partnership theory is also supported by HFMA's provision of insurance coverage to chapters under two separate policies: host liquor liability and general liability. In 1984 the national office added travel insurance to provide coverage for members traveling to and from national events and programs. And three years later errors and omissions coverage for chapter officers, directors, and committee members was secured. Fidelity bond coverage remains an option that each chapter can purchase.

The board of directors still may withdraw a chapter's charter for valid reasons. For example, the western area of Texas had poor member participation for several years due to the vast distances between members. In 1983 the board withdrew the charter of the west Texas chapter but reinstated it in 1987 when new leadership emerged. Two years later, the west Texas and El Paso chapters merged with the central Texas chapter to form the new Lone Star Chapter. Faced with a somewhat disinterested membership, the Northwestern Pennsylvania Chapter chose to merge with the Southwestern Pennsylvania Chapter to form the Western Pennsylvania Chapter in 1984. In the state of Washington, chapters had long accepted members from Alaska who traveled to Washington for meetings and institutes. The chapter was rechartered as the Washington-Alaska Chapter in 1987.

In 1991, the Northern Great Lakes Chapter and the North Central Michigan Chapter surrendered their charters and merged with the Central Michigan Chapter. The new and expanded chapter was renamed the Great Lakes Chapter. The consolidated chapter operates on the regional concept, thus enabling the former chapters to continue to meet in their own areas. Total chapter strength at one time reached 75; now consolidation has reduced the total to 70, but with the entire country still covered by active chapters.

HFMA Publications for Chapters

First issued in 1956, the chapter officer manual advised that

Each chapter must decide its manner of operation as outlined in its constitution and bylaws, but it is hoped that the suggestions contained in this manual and taken from the experiences of other chapters will be helpful.

Divided into five sections, the manual included a membership section that explained applications, transfers between classifications, reinstatements, and membership and voting classifications. Also included was a section on meetings that outlined the requirement to hold at least four meetings a year and endorsed sectional meetings (geographical councils) as a strategy to bring educational sessions to a larger group of members. The finance section set forth the association's schedule of application fees, dues and rebates to chapters, restrictions on chapter dues assessments, and suggestions on how to allocate chapter funds. A final section on local relationships promoted dialogue between chapters and state hospital associations and called for involvement by chapter presidents in the annual meeting held at the annual national institutes.

In 1958 and 1960 the chapter officer manual was significantly expanded. A separate chapter program manual appeared in early 1963. The chapter activity manual was designed to provide each of the chapter's four major officers with the information they needed to carry out the duties of their office and effectively administer the chapter. It was based on the premise that all chapter operations emanate from the chapter's charter, the national and chapter constitutions and bylaws, the Graham L. David Award for Chapter Achievement, and the HFMA Code of Ethics.

Realizing that it was essential for a newly elected chapter secretary to begin performing promptly, the association issued in 1961 a chapter secretary's handbook that described the duties and responsibilities of the secretary's office. After the association launched chapter workshops in 1967, it also developed handbooks for chapter presidents, treasurers, and program chairmen.

The large influx of new members into the association through local chapters made it obvious that new members knew little of the association's national activities and that the information they had was limited to what they read in the journal and the new member's kit. The members' image of the national association was also shaped by their perception of local chapter activities and educational programs. The national office created a new member's orientation manual in 1977, supplemented by an extensive slide/tape program that was made available to chapters on loan. The national office also recommended that chapters conduct an orientation program for new members at least once annually and appoint an orientation officer to fulfill this function.

In 1991 each incoming chapter officer received a chapter officer manual, which could be retained. Sections included About Your Association, Chapter Administration, Planning Chapter Education Programs, Chapter Financial Management, Planning for Excellence, Public Relations Media Kit, Reference Materials, and a Chapter Self-Assessment Guide. Although chapters are still encouraged to provide new member programs, communication technology has improved significantly. Each chapter now has its own videotape patterned after a previously developed slide program.

Chapter Presidents' Meeting

The idea of holding a meeting of chapter presidents during the annual national institute was first mentioned in the early 1950s, and Sister Mary Gerald implemented the concept when she became the president in 1954. This highly valued

tradition has continued annually, serving as a showcase for the association's achievements at national and chapter levels. Ideas are presented by the association's matrix and staff, and reactions from chapter representatives are requested. For the first few years, only chapter presidents or duly authorized representatives were invited to attend. But as time passed, invitations were extended in each chapter to the immediate past president, under whose tenure a chapter is honored for achievements; the current president; and president-elect. The continuity and camaraderie generated by bringing together all involved parties has strengthened the association's commitment to function as a membership-driven organization.

With the theme, "How Are We Accomplishing the Objectives of AAHA?" the first meeting concentrated on the Graham L. Davis Award. Chaired by Henry Hottum, the 1955 meeting used a formal agenda that focused on *The Second Decade Report* as well as plans to implement the report and hire a new executive secretary. At the third meeting in 1956, new Executive Secretary William Pierce reported on the state of the association. I chaired the meeting as AAHA's second vice president and chairman of the Committee on Chapters. I reprised my role at the 1957 session. Meetings held through 1960 were chaired by the chairman of the Committee on Chapters. But beginning in 1961, the current national president served as presiding officer or, after 1977, the chairman of the board.

As president in 1958 I introduced the Frederick C. Morgan Individual Achievement Award. For the first time, a reception for chapter representatives was held prior to the meeting and featured a display of chapter achievement reports. One year later, in 1960, the code of ethics and the William G. Follmer Merit Award were unveiled. Over the years, meetings have featured announcements of chapter awards, including the winner of the coveted Graham L. Davis Award for Chapter Achievement and various special awards that had been implemented as the association expanded its programs and as members recognized the value of these honors. A typical agenda included explanation of proposed bylaws changes; promotion of communication, membership recruitment, and professional examinations; and an explanation of the annual theme.

Evolution and Innovation

Regionalization of chapters was first discussed at the chapter presidents' meeting in 1964, followed by a discussion of possible changes in the association's name in 1965. Plans for the introduction of chapter operations workshops—later called leadership training conferences—and announcement of the Robert H. Reeves Merit Award were features of the 1967 agenda. The 1969 meetings disclosed details on the third stage of the founders' merit award series named for Frederick T. Muncie, the association's first president.

Chapter innovations took place in the following areas:

1. Plans for regionalization were announced in 1971.
2. Fall meetings of chapter presidents were initiated following a successful pilot program.
3. The First Illinois Chapter was honored on its 25th anniversary, and membership records were converted to computer.
4. In the following year (1974), the concept of a principles and practices board was discussed.

5. In 1975, a \$670,000 grant from the W. K. Kellogg Foundation was received.
6. League awards were announced for the first time in 1976.
7. In the next year, plans were disclosed for achieving changes in the national structure.
8. In 1989, the development of a new league that would incorporate the largest chapters was announced, and C. Henry Hottum—for whom the league was named—addressed the group.

The concept of a dinner meeting following a reception had begun in 1963. For several years, during the meeting's tenure in Boulder, chapter presidents met on two successive days with dinner and award announcements made on Tuesday and a luncheon and business meeting held on Wednesday. The annual meeting also served as the scene for chapter representatives' annual election of members to the national Nominating Committee and of a sitting national director to the Executive Committee. One item on the agenda gave chapter officers the opportunity to voice concerns and offer recommendations. The national board of directors subsequently discussed their comments and criticisms at their next meeting.

I attended my first chapter president's meeting in 1955 as president of the New Jersey chapter, and from 1956 through 1981, as a national official. In my role as executive director, the annual meeting became one of the most enjoyable responsibilities of my position, primarily because the annual meeting represented the culmination of national and chapter activities that had taken place over the course of a year. In 1980 the Robert M. Shelton Award for Sustained Chapter Excellence was presented for the first time.

National Regionalization

The concept of decentralizing the North American continent into geographic regions was rooted in Bill Follmer's early vision for the American Association of Hospital Accountants. The original bylaws adopted in June 1946 provided for 12 regions—9 within the United States and 3 within Canada. Later, a thirteenth region was identified to cover all foreign areas from which the association might receive membership applications. One regional director for each of the 12 regions was appointed in 1947 and held office through 1948, but no regional directors were named in 1949 or in the years thereafter. Robert Reeves later commented that the idea of apportioning regional directors "just didn't work out."

By 1958 there was growing interest in having regional meetings of chapters. During the 1958 institute at Indiana University, executive director Hugh Brown met with chapter presidents or delegates from chapters within the northeastern corridor to investigate how to pursue better relations between chapters and the national office. Chapter representatives argued that membership strength within chapters could be increased through improved recruiting and cited the urgent need for better programs, workshops, and communications. They concluded that a meeting should be held during the late summer to develop these concepts. The Philadelphia chapter agreed to host this meeting August 15 to 26, and Paul Bourquin offered the facilities of Lankenau Hospital for a cost of just \$2 per room per night.

The First Regional Chapter Meeting

Twelve chapters—from New Hampshire/Vermont to Virginia and West Virginia—were represented at the meeting along with Brown, Mary S. Corbett, chairman of the national Committee on Chapters, and me. As national president I expressed my desire to develop and conduct a regional institute on hospital accounting as a goal of my presidency. Three chapters—Philadelphia, Appalachian, and New Jersey—agreed to cooperate in hosting a program in October 1959.

At the start of this meeting, I commented on the historical significance of the impressive turnout and observed that it would be a precursor of other successful gatherings. I further predicted that the session would generate ideas that had not yet been anticipated when the agenda was prepared and that could eventually be adapted and enhanced by other chapters and the national office. Because the proceedings of the meeting were taped, the verbatim transcript provided valuable feedback to the national office that ultimately influenced current practice and long-term policy decisions.

Chapter Liaison Representatives

In the 1960s the association created a system that allowed national officers and directors to serve as liaisons to their home chapters and to several other area chapters. Scheduling meetings with chapter officers during regional hospital association meetings occurred for several years. A national exhibit booth was created, and chapters were invited to arrange to participate in booth setup and staffing. Usually involved in conducting a session with chapter officers during the convention, national officers and the executive director also staffed the booth. This offered an opportunity to meet chapter members and hospital administrators and to promote the association.

In 1966 national officers and directors received the official title of *chapter liaison representatives (CLRs)* and were assigned to specific chapters, using a guideline booklet to promote uniform action by all representatives. The introduction of regional and national chapter operations workshops in 1967 further encouraged the formalization of regional boundaries.

In 1971 the council on chapters began to consider the regional concept. After one year of study, staff submitted a report on a chapter regional organization that set forth several versions of geographical divisions based on census bureau regions, hospital convention areas, and the American Hospital Association's regional advisory board areas. The council on chapters presented its resolution to the board of directors in October and precipitated a lengthy discussion. The board voted that the proposal, which outlined a formal method for members to select leaders, be presented to chapter officers during meetings with CLRs in their region.

Armed with chapter presidents' overwhelming support of the new plan, and later approval from the board, in 1973 voting members received a description that described the proposed regional structure and its implications. Members were advised that "in April 1974, you will be asked to vote to approve pertinent bylaws changes as well as to participate in the first regional election to the national matrix."

Ron Lochbaum, national director and chairman of the council on chapters, was convinced of the importance of annual regional meetings of chapter presidents

and turned his 1972 meeting of chapter presidents into a full-scale training event. Originally conceived as a pilot program, the meeting evolved into a follow-up to the chapter operations workshop (COW), which was the annual spring training session to help chapter officers develop program plans for submission to the national office. Scheduled in the fall, the second session allowed chapter presidents to exchange concrete ideas and to sharpen their focus. Because of the progress made through these meetings, annual fall meetings consisted of chapter presidents and presidents-elect and were chaired by the CLR.

Whenever a member was elected to the national matrix within each of the 11 regions, that person was also designated an associate chapter liaison representative who would support the member of the board of directors assigned to a particular region. But because not all board members resided in their assigned regions, it soon became obvious that the regional matrix representative should also be designated as the principal chapter liaison representative. Since 1987 chapter presidents-elect during the fall regional meetings elect the chapter liaison representative for the ensuing year. The CLR also serves on the national matrix.

HFMA's regional structure has provided a strong foundation for the association and its chapters. The defined regional boundaries permit chapters to work together closely and to plan for the future as a unit. Moreover, annual regionally sponsored institutes are now commonplace in most of the 11 regions. Finally, the procedure for regional nomination of matrix members and the bylaws restriction that candidates to the national board of directors have matrix experience provides for a highly democratic organization.

Chapter Operations Workshops

Aware that the association's founding fathers had patterned some of their plans after activities of the National Association of Accountants (formerly the National Association of Cost Accountants), I met with Walter Kasunic, NAA's director of membership and chapter relations, at NAA's New York City office in the early 1960s. Kasunic freely shared his success with chapter operations workshops for incoming chapter officers. I then recommended that the board authorize a pilot chapter operations workshop. With the support of Past President Ernest Laetz and national Director Sister Mary Bertrand, staff conducted a highly successful workshop in Ann Arbor in May 1967, where 11 of the 12 chapters within the invitational area were represented by presidents and/or secretaries. Impressed with the training workshop, the board of directors authorized a series of seven regional chapter operations workshops in spring 1968.

When several chapters indicated they couldn't afford to send representatives to the chapter operations workshops, the board considered ways to provide financial assistance. Ultimately, however, they decided to redouble their efforts to promote the value of the training sessions. As the years passed, attitudes became more positive and the workshops developed a loyal following. It became obvious that high-performing chapters that earned the maximum 90 points in the Graham L. Davis Award scoring system learned many of their success secrets at chapter operations workshops.

In 1979 chapter operations workshops came to be known as *leadership training conferences (LTCs)*. More recently, LTCs were merged and offered at fewer sites,

thereby giving more chapters and regions the opportunity to communicate face-to-face. Since that time, chapter officer conferences and instructional programs have become an integral part of HFMA and chapter operations. In 1987 more than 70 chapters were represented at the conferences. In 1991, 290 incoming chapter officers representing all chapters attended the conferences.

HFMA recognized the inherent value of written communication within HFMA chapters and initiated a seminar for incoming chapter newsletter editors in 1985. This innovation supplemented the long-standing annual chapter newsletter contest and the regular newsletter release to chapters called "PumPrimer," originally created to aid chapter newsletter editors who had minimal journalistic skill. The seminar was promoted as offering instruction in the basics of newsletter production: writing, editing, organizing, scheduling, and production. Twenty-six editors attended the first seminar, which became an annual event with ever-increasing attendance.

The success of this seminar led to the 1988 introduction of an instructional seminar for incoming chapter membership chairmen. These seminars had two goals: help in designing and conducting recruitment and retention programs and explanation of the support services available from HFMA.

Awards Programs

National Life Membership

Bylaws revisions approved in March 1952 authorized the conferral of life memberships for national meritorious service, a designation that allows exemption from dues for life. At that time, life memberships had already been given to Percy Ward and James C. Brady, two Canadians who were retiring from the hospital field and who had served in the positions of second vice president and director-at-large, respectively, with Fred Muncie. In 1950 Charles F. Mehler, Frederick T. Muncie, and Stanley A. Pressler were accorded life memberships. In 1951 life memberships were conferred on Robert H. Reeves, Frederick C. Morgan, and William G. Follmer. This rather incongruous action was taken posthumously for Follmer following his tragic death in December 1950, but no other means existed then to honor one of the association's most prominent pioneers.

In the early years, the association's pioneering leaders were accorded life membership. Moreover, numerous individuals who had served as officers or directors were recognized for meritorious service in those years. Leaders successfully completed assignments that would normally have been undertaken by staff or external consultants and agencies. In subsequent years, some members were granted life membership because of their extraordinary contributions to the association. In 1978 chairman Herman Guenther appointed an awards and recognition task force that studied the life membership program and evaluated the award principles and selection process but made no significant changes.

The Graham L. Davis Award

The Graham L. Davis Award for Chapter Achievement grew out of the need for an incentive program that would encourage the submission of articles to the association's struggling journal. Designed with a point system for tracking attendance quotas and membership growth goals as well as article submissions, the

award was named for Graham L. Davis. A former executive at the American Hospital Association, Davis had arranged for the AHA to co-sponsor the first several years of the annual institute at Indiana University and had supported the fledgling AAHA through the AHA hierarchy. The first Graham L. Davis Award was presented to the Tennessee chapter in 1953.

Throughout the 1950s and 1960s, chapter presidents discussed the scoring system at their annual meeting and offered criticism as well as recommendations for improvement. Published in the journal for the first time in 1956, chapter point totals encouraged members to recognize the award. At each meeting, the national Committee on Chapters considered the award's motivational power, reviewed and added new criteria, and periodically made revisions. As scoring of points became more routine, these criteria were eliminated and new incentives were added. For example, as the backlog of articles expanded at the national office, the number of papers required for submission annually was reduced from 10 to 5. When liaison with state hospital associations and uniformity in the use of the chart of accounts in hospitals became customary, these categories were eliminated.

The point system topped out at 90 points. In 1957 the "90-point club" was created to recognize chapters that had provided their members with maximum benefits as established by the award's scoring system. In the early 1960s, flexibility was built into the system through the introduction of "extra effort combinations," which allowed chapters to exceed the stated maximum in several categories and still attain the maximum 90 points. Competition for the Davis trophy continued, but satisfaction came primarily from attaining the objective of 90 points. Every year, the national office tried to bring more chapters into the 90-point club circle. As the number of qualifying chapters increased, the association became more confident in its strength and recognition. When 90 points no longer was regarded as the top score, chapters worked to attain the ultimate recognition through membership in the "GLD Club."

Special awards to chapters for notable improvement, professional programming, outstanding projects, and other extraordinary efforts were introduced in 1960. In recent years, chapters' annual membership service plans—a requirement for the Graham L. Davis Award—have been judged separately, with the best plans receiving certificates. All plans are critiqued and feedback is reported to chapter presidents-elect who use it to plan for the coming year.

The Graham L. Davis Award scoring system was viewed as a device to measure quantity, whereas the competition factor inherent in judging the award was viewed as a quality measurement. Because of the inherent difficulty in this level of measurement, chapters were required to submit an annual chapter achievement report. The chapter was permitted to use "its imagination, ingenuity, and originality" in highlighting the quality of its total program.

When the association changed its name in 1968, the Graham L. Davis Award was thoroughly examined to ensure that it was still viable in the new environment. After chapter officers enthusiastically endorsed a new scoring system, it became operational on May 1, 1969. The required 90-point maximum was described in terms of "45 essential points with 45 additional points achieved within the limitations of each of the five major categories," one of which stressed "educational

programming" as the chapter's major function. Three-part forms were introduced to permit the national office to return a feedback copy showing the total number of points accumulated in each area to the chapter president.

Expanded recognition of chapter standing within the GLD competition was introduced in 1969, with honorable mention awards presented to four chapters placing in the top five. In 1972 the top nine chapters were cited. By 1976 chapters had been divided into three leagues based on chapter membership size, and awards were given to outstanding chapters in each league. Today, the top chapter in each league is presented with the award of excellence, with the first and second runner-up chapters also recognized.

Because of the vast differences among chapters in membership strength and geographical area, the concept of three divisions of the 75 chapters was implemented. With each division encompassing 25 chapters, divisions were termed "leagues" and named for three past presidents. The Charles F. Mehler League embraced the group of small chapters; the John M. Stagl League was designed for medium-size chapter groups; and the Sister Mary Gerald League identified the large chapter groups. Because this latter group included chapters with a wide membership differential, a new division called the C. Henry Hottum League was formed in 1989.

Chapters are assigned to leagues every three years based on membership count. Chapters of 160 or fewer members are assigned to the Charles F. Mehler League; from 161 to 300 to the John M. Stagl League; from 301 to 550 to the Sister Mary Gerald League; and those exceeding 550 to the C. Henry Hottum League. The current scoring system recognizes the ability of chapters to earn points, with each league identifying its own maximum as a requirement to earn the chapter achievement award.

The annual chapter achievement report, used in the early years to judge the quality of a chapter's program, became unwieldy because it cataloged a chapter's entire program. For this reason, an annual highlight report was introduced in 1975. A form called for the chapter president or an appointed delegate to describe each of the four best educational programs of the year, the membership recruitment plan, the two most beneficial projects, commentary on several other requirements, and finally, a summary observation of the chapter's year in terms of its quality and value to the membership. The highlight report enabled the judging committee to zero in on outstanding chapter activities and then refer to the achievement report for details. Although the chapter achievement report was eliminated as a requirement in 1986, the annual highlight report is still required, because it allows the judging committee to view the chapter's year in perspective and note special successes.

The preamble to the Graham L. Davis Award scoring system explains that "earning an award is secondary to the chapter's main purpose. The ultimate reward for chapter effort is the growth and development of the individual member." Today, its basic purpose remains unchanged.

Frederick C. Morgan Individual Achievement Award

With a chapter achievement award program firmly in place, it seemed appropriate to cite an individual for outstanding contributions to the field of hospital accounting. Developed by the Committee on Chapters in 1957, the award was

introduced to the membership in 1958. The first Frederick C. Morgan Individual Achievement Award was presented in 1959 to Charles G. Roswell at the annual national institute banquet. This award, the highest personal award presented by the association, is the highlight of the annual banquet.

It was natural that an award for individual achievement be named for Frederick C. Morgan. His six-year tenure as secretary-treasurer of AAHA had ended in 1956, and his substantial service to the association was a matter of record. A native of Rochester, New York, Morgan graduated from the International Accountants Society, a correspondence school based in Chicago, and he later attended the Rochester Institute of Technology. Although he had no college degree, Morgan taught economics and office management at the Rochester institute and later authored a textbook on the subject. Before he became controller of the Genesee Hospital, Rochester, in 1946, Morgan was involved in industrial accounting and systems for more than 28 years. When the individual achievement award was developed, the association's leadership enthusiastically endorsed the idea of making it a tribute to the life and work of Fred Morgan.

A special nominating petition was devised and disseminated that allowed nominators to cite a nominee's accomplishments on the local, state, and national levels; personal character; community activities; articles published; and lectures given, along with references. Because the individual achievement award was designed to gain increased national visibility for the association, press releases were distributed to announce award winners.

In the judging process, nominating petitions are numbered, and references to the name of the individual are deleted. In 1972 judges could not conscientiously break a point tie in their review of the scoring and selected cowinners: Joseph D. Clancy and Jeff H. Steinert. And consider the odds of a husband and wife being selected as recipients of the individual achievement award. Nevertheless, it happened: Allen G. Herkimer was the honored recipient in 1975 followed by the honoring of Fay Page Herkimer in 1979.

The Founder's Merit Award Series

Launched in 1960 with the William G. Follmer Merit Award (now the Follmer Bronze), the Founder's Merit Award Series was created to recognize individual association members for meritorious service at the chapter level. During the next nine years, the Robert H. Reeves and Frederick T. Muncie Merit Awards—now called the Reeves Silver and Muncie Gold—were developed to recognize higher levels of chapter service. In 1986 a fourth award, the Founder's Medal of Honor, was added along with categories of points for national service to HFMA. Through this series HFMA members are rewarded for their contributions of time and effort to chapter growth and success.

The concept of an individual merit award for chapter service was the brain-child of Robert H. Reeves and was rooted in his knowledge of a merit award plan already in use by the National Office Management Association (NOMA), now the Administrative Management Society. Reeves reasoned that such an award would not only encourage members to work for the good of their chapter but also would complement the objectives of the Graham L. Davis Award. He suggested that the award be named for William G. Follmer, whom he credited with

the creation of the American Association of Hospital Accountants. Reeves once had written: "Perhaps others could have done it before Bill took the initiative, but the simple fact is that Bill did it."

The Committee on Chapters met in Philadelphia in October 1959 and devoted a major portion of its agenda to consideration of the chapter merit award plan. With the assistance of a staff director from NOMA, award details were fine-tuned, a recording form developed, and instructions written on the chapter's responsibility to record and maintain historical records. A carefully crafted point system was created with the added requirement that four to five years be invested to gain the award. (Later, it was calculated that the average length of time that a member needed to gain an award was seven years.) A total of 100 points was required to receive the William G. Follmer Merit Award, and this total was extended by 100 points for each of the two following awards. The initial award became effective June 1, 1960, with a provision that allowed points for association membership from the time of chapter chartering and for chapter officerships and directorships held before the effective date. A year after the William G. Follmer Merit Award was announced, seven members qualified to receive the plaque. Raymond F. Mach of Mineola, New York, was the first recipient.

Chapters that embraced the merit program found it to be a definitive membership incentive. Some even began to hold award banquets or ceremonies to honor recipients. But because of the difficulty of recordkeeping, not all chapters adopted the program. Eventually, a new program was developed to facilitate the updating process. Unfortunately, the effort suffered from gaps in retrievable records. When the national association began to plan for computerization of its membership records in 1971, the computerization of Founder's Merit Award Series records was accepted as part of the long-range automation plan.

At present, points are accumulated and accounted for annually, and an appointed chapter leader is given the responsibility to monitor and report member activity. A "point entry form" provided by the national office is used by each chapter to enter the points earned by members during the previous year and is then sent to the national office. Staff records the data, identifies members who are eligible for awards, and coordinates distribution of plaques to chapter presidents for presentation.

The Founder's Medal of Honor, an award added in 1986, is not based on a point system but is conferred through nomination by the chapter's board of directors. To be eligible, a member must have a minimum of three years of service since earning the Muncie Gold award, must have provided significant service at the chapter and/or national levels for at least two of these years, and must be a member in good standing.

Robert M. Shelton Award for Sustained Chapter Excellence

In 1978 a special award and recognition task force reviewed new ways to recognize service to the association. Based on recommendations of the task force, the board established the Robert M. Shelton Award for Sustained Chapter Excellence "on the occasion of Shelton's 20th anniversary of service with the association [and] in recognition of his unique and exemplary service and meritorious contribution to HFMA, its chapters, and members." Judging criteria gave chapters of all sizes

the opportunity to be rewarded for an ability to deliver high levels of service to members over a five-year period.

Among the areas in which chapters could demonstrate service excellence were quality and variety of educational programs; high performance in registrant hour quotas, steady growth in membership, attractive and useful publications, and the level of interaction and cooperation with state hospital associations and other chapters. The award trophy was first presented in 1980 to the Massachusetts Chapter. The five chapter presidents under whose leadership the award is won are presented with individual plaques.

Chapter Life Membership

The *chapter life membership* designation was created by the national board of directors in 1964 along with the introduction of the classification of retired member. A chapter can confer chapter life membership on a retired member in recognition of that member's contributions to the chapter over a period of years. Because national life membership already existed, chapters made numerous inquiries about honoring retiring chapter presidents or other prominent members with life membership. The New Hampshire-Vermont chapter reported to the Committee on Chapters that Sybil Chaney, a veteran member and chapter past president, had retired and that the chapter wanted to pay her association dues for the balance of her life. Regulations governing conferral of chapter life membership were developed and announced, and in February 1965 the national board approved this honor for Chaney.

All chapter life membership nominations require specific action by the national board. A nominating letter forwarded by the chapter must detail the accomplishments of the individual to whom it wants to pay its respects. Through its actions, the chapter assumes the responsibility of paying the retired member's dues for a five-year period. Thereafter, payment of dues is waived and is assumed by the national office. In this way, chapter life membership is awarded to individuals who have exhibited leadership and dedication to a chapter during their membership tenure.

Board of Directors' Award

I recommended to the board of directors in 1964 that a recognition award be developed to honor individuals who had contributed to hospital accounting but who would probably not be eligible for the Frederick C. Morgan Award. The names of several deserving individuals were mentioned. Although the concept did not progress beyond those early discussions, it remained in place and could be acted on if warranted.

When the special committee to plan the association's 25th anniversary celebration met in 1970, the recognition award was explained. The committee then recommended the creation of the Board of Directors Award, which was presented to Stanley A. Pressler of Indiana University at the 1971 annual national institute banquet in Columbus, Ohio. The award was in the form of a custom designed and framed painting entitled, "This Is Your Still Life," illustrating key mementos of the recipient's life. It was later changed to an inscribed plaque.

Fortunately, the award regulations permit the honor to be bestowed on organizations as well as on individuals. In 1974 the award was presented in the

form of a plaque to the American Institute of Certified Public Accountants in recognition of its contributions to the hospital industry during the years of economic controls.

In 1978 the awards and recognition task force recommended that specific criteria for this award be shunned in favor of the recognition of unique, individualized contributions to the field. The regulations noted that the contribution should be significant enough that 75 percent of members of the board of directors would vote to bestow the award. The board in 1984 adopted an award protocol that outlined criteria.

Other Recognition

Several awards emanated from the Graham L. Davis Award system. For example, special awards were given for extraordinary chapter activity such as notable improvement, submissions of articles in excess of the stated requirements, an outstanding array of projects, and specific projects with area-wide benefits. The board of directors recognized the importance of chapter-level projects in bringing recognition to local chapters. The board therefore decided to emphasize projects within the Graham L. Davis Award scoring system and through special awards. Today, the national office continues to state that "one of the most significant activities in which a chapter can be involved is the planning and implementation of projects," and that "this kind of activity is fundamental to a successful chapter organization." Each year the association bestows special awards for outstanding project activity.

Chapter formation anniversaries have been recognized through the presentation of certificates on a chapter's 10th anniversary, testifying to a decade of service to the hospital financial management profession. On a chapter's 25th anniversary, the association presents a certificate in a silver (chrome) frame. At present, chapters celebrate anniversaries with a special program or with a series of programs throughout the year, as the First Illinois Chapter did in 1988 on the occasion of its 40th year. Speakers with national reputations are often invited to participate.

Chapter newsletters were also included in the scoring system of the Graham L. Davis Award, although scoring is based exclusively on the quantity of newsletter issues. To recognize the quality of chapter newsletters, the association inaugurated an annual contest of newsletters in 1961. Participating chapters must submit a specific number of newsletters based on the requirements of the league in which the chapter is located. The best newsletters in each league are selected and recognized through the presentation of a certificate at the annual chapter presidents' meeting.

On the occasion of the association's 25th anniversary in 1971, a special committee announced the creation of an annual award to commemorate the 25th anniversary. The author of an article published in the journal the previous year is awarded a cash prize of \$250 and an engraved plaque. The first award was presented during the 25th anniversary banquet in Columbus, Ohio, to Tor Dahl. His article, "A Health Care Reimbursement Concept That Will Work," was published in the January 1971 issue of the journal.

In 1978 the awards and recognition task force recommended a change in the name of the 25th Anniversary Article Award to the HFMA Journal Article Award and that the award presentation be made at a meeting of the author's local chapter or at an appropriate place.

Two awards were authorized in 1984—one for the best article written by an association member, and one for the best article written by a nonmember. Motivated by the role that Helen M. Yerger filled in the early days of the association, the association named the award for the member-written article for her. Yerger wrote the lead technical article in Volume I, Number 1, of *Hospital Accounting* in 1947 and subsequently contributed to many issues in striving to maintain its technical quality and usefulness. The second award was named for L. Vann Seawell, DBA, professor of accounting at Indiana University and author of textbooks and literature in healthcare finance. Because the growth of membership has attracted persons in many disciplines, a single best article award, known as the Yerger-Seawell Award, is now given along with second- and third-place selections. These two awards recognize the critical role of the printed page as a communications vehicle and an educational tool for the HFMA membership.

In addition to the chapter and individual achievement award programs that are coordinated or administered by the national HFMA, chapters have developed a number of achievement awards. Some interchapter awards are given for membership solicitation and submission of manuscripts; others are given for more general meritorious achievement. Most awards are named after chapter presidents who served in significant roles. Among the chapter awards given over the years are the Donna Anderson Scholarship by the Northern California Chapter; the Dale Reed Award by the Northeast Ohio Chapter; the Benjamin Franklin Award by the Philadelphia Chapter; the Henry Hottum Award by the Tennessee Chapter; the Robert C. McMahon Award by the McMahon-Illini Chapter; and the Alice V. Runyan Award by the First Illinois Chapter.

The board of directors believes that chapter recognition is just as important—if not more important—than national recognition. The reason is simple: This recognition gives the association the opportunity to reward individual leadership and outstanding achievement before a member's colleagues and peers. This recognition, in turn, helps to activate greater involvement in chapter activities and allows chapters to promote outstanding examples of selfless volunteerism and professionalism. To ensure adequacy and appropriateness, chapters are urged to periodically review their total award program.

FOUR

Education as the Fountainhead



*Tis education forms the common mind;
Just as the twig is bent, the tree's inclined.*

Alexander Pope
Moral Essays

Although the word *education* never appeared in William Follmer's 1945 letter outlining the need for a national organization of hospital accountants, in his view education was a key to fulfill the needs of this new, emerging profession. Education wasn't mentioned in any of the five objectives of the association's first constitution, but the bylaws stated that the organization would help members "to increase their knowledge of hospital accounting" and "encourage and assist in the holding of meetings and conferences on hospital accounting." Eventually, the association could reduce its five original objectives to three words: education, communication, and service.

The Annual National Institute

Although Bill Follmer at first had little interest in developing a hospital accounting institute other than the Annual National Institute (ANI) at Indiana University (IU) in Bloomington, Fred Muncie committed the association to cosponsor a program on punch card accounting at IBM's facility at Endicott, New York, in August 1948. The brochure for the Institute on Hospital Financial Control at Endicott was sent to the association's 400 members with the advice that all expenses except for travel would be covered by IBM. Supported by Helen Yerger, Muncie saw this as an opportunity for HFMA leaders to meet and, with travel expenses paid by each employer, make concrete plans for the association's future.

Subsequently, Fred Muncie spoke with Stanley Pressler about the possibility of cosponsoring the 1949 institute in Bloomington, Indiana. Follmer knew of IU's successful track record and urged Muncie to "get a committee busy on the plans right away—we can almost rest assured that our members will support the program." In addition, he advanced the case for two types of institutes. Fundamentals of Accounting, designed for "glorified bookkeepers and accountants who do not

even know what a debit and credit is," would include basic books, ledgers, trial balance, work sheets, financial reports, and simple cost apportionment. Designed for more qualified accountants, the second program would focus on advanced costs and shortcuts in procedures. Muncie urged Follmer to inform members that the proposed institute "would be designed particularly to help the bookkeepers and accountants from the small and middle class hospitals, and advanced enough that all can benefit from it."

Early Institutes

Scheduled for August 1949, the Hospital Accounting Clinic and Workshop at IU was promoted in the association's journal. So pleased was Muncie with the five-star promotion effort that he wrote to Charles Mehler, the journal's editor: "If we don't get our quota of 75 to 90 applicants before June 1st, then I shall be ready to admit that administrators are not interested in the improvement of the accounting situation in their respective hospitals." Fortunately, the heavy promotion paid off. The clinic and workshop attracted 75 registrants from 13 states and everyone involved evaluated the program as worthwhile. Robert Reeves wrote to Fred Muncie: "You and your committee deserve more thanks and appreciation than you are likely to receive."

Innovations continued. Charles Mehler and Robert Reeves served as co-chairmen of the 1950 IU institute, the association's first dual-track program. In addition to the basic study program directed by Reeves, registrants pursued a program that featured accounting statements, internal control methods and procedures, work simplification, graphic presentation of budget reports, depreciation, appraisals, and insurance, cost analysis, inventory control, credit and collections, mechanical accounting, and disbursements for payroll and accounts payable. Faculty included such hospital administrators as Fred Muncie, John Stagl, Robert Penn, David Spanier, Ray Kneifel, Charles Mehler, Fred Morgan, and Charles Clifford. Also involved was W. Y. Armstrong of American Appraisal Co. Dr. Louis Block, associated with the U.S. Public Health Service, Washington, D.C., became the general chairman of the 1951 institute and set a new goal of 125 registrants.

By 1952 the annual IU Institute had evolved into a nationally recognized program. Because of its growing importance, the association's president began to serve as chair of the institute's Planning Committee. The institute adopted its first official theme for the 1952 program: Better Administration Through Better Accounting. As a result of some changes in promotion, 170 registrants, who represented 32 states and four Canadian provinces, attended the 1952 institute.

Programming improved throughout the 1950s. The 1953 institute theme was Improving Financial Management Through Better Accounting. By the mid-1950s, the association offered three week-long courses, including General Hospital Accounting, Controllership in Larger Hospitals, and Workshops in Bookkeeping Principles and Basic Procedures. Faculty included such nationally respected personalities as Ray E. Brown; Robert M. Cunningham, Jr.; Anthony J. J. Rourke, M.D.; and Glenn B. Sanberg of the American Collectors Association.

The annual institute continued to grow. In 1956 L. Vann Seawell, who was then a teaching associate at IU, began teaching the basic bookkeeping course. In 1957 a fourth course, Study Group in Cost Analysis, was added under the direction

of Leon Hay, an assistant professor of accounting at Indiana University. In subsequent years, Hay expanded this course to include budgeting, advanced cost analysis, and special sessions with hospital practitioners. The institutes increasingly offered nationally respected keynoters and assembly speakers who rounded out a full week of high-level educational programming.

On the anniversary of the 18th annual institute in 1960, a new format was introduced that included 12 courses. Course A, Basic Accounting, was offered for the full week; Courses B, C, and D comprised two full days of intensive study on principles of cost analysis, advanced cost analysis, and budgeting. Course E, Credit and Collections, was offered in two sections based on bed size. Course F, Control of Insurance Costs, was presented in two sections of identical one-day courses.

Classes G through L, all of which were a half-day in length, were selected by registrants to fill vacant periods. Duplicated in a variety of time slots for the convenience of registrants, these courses focused on cost control in the areas of nursing services, food services, laundry, personnel, and purchasing as well as reimbursable cost contracts. Section M offered a problem-solving clinic in which registrants discussed healthcare finance problems. During a general session held in the first hour of each day, speakers featured in various courses presented overviews of their topics and, in the process, exposed registrants to such diverse issues as credit and collections, interpretation of financial and statistical reports, and cost control versus cost computations. In the early 1960s, the institute began to offer a special evening session for chapter officers on how to run a chapter. This was a forerunner of the annual chapter operations workshops, which were later renamed leadership training conferences.

The Final IU Annual Institute in 1962

The 20th annual institute held at Indiana University in 1962 was the last institute sponsored with the association. Only five courses were offered, including one optional course composed of a variety of optional sessions, basic hospital accounting, principles of cost finding and budgeting, accounts receivable control and credit and collections, and a high-level management course.

Despite the anniversary celebration, the atmosphere at the final 1962 institute was far from friendly. Strong-willed and opinionated, Stan Pressler and Association President Harry Humbert each hurled their share of barbs and innuendoes. Registrants recognized that something was wrong, but only members of the association's inner circle knew the true meaning of their remarks. The reality was that the verbal jousting masked more profound problems between the association and IU—not the least of which were financial arrangements.

Although the university maintained a trust fund to underwrite the annual hospital educational venture, the association was never able to accurately determine the size of that fund or win the university's approval to underwrite such projects as a record retention manual. And although the university approved the use of trust funds for such projects as the development of correspondence courses, the first hospital accounting career brochure, and the first Fellowship study guide, the university declined funding for other association proposed ventures. Even though the fund boasted a balance of \$9000 by 1961, the university declined to

underwrite interassociation programming and to validate the association's two-year track record of regional educational institutes.

Political pressures were an additional deterrent to joint programming. The Indiana Hotel Association launched a newspaper publicity campaign advocating that hotel sites—not tax-supported school facilities—be used for business meetings conducted by external groups. Although IU's Graduate School of Business was never named in the allegations, the university adopted a policy that restricted institutes held on campus by external organizations.

Stan Pressler shared the university's new policies with the association's leadership in 1962. The first regulation required at least 50 percent of the presenters at a conference to be university faculty; a second regulation stipulated that a mutually agreed on budget be submitted prior to a conference. Other regulations specified that the conference's committee be named by two people selected by the association and two selected by the university's institute director, the association's institute chairman, and the association's executive director. This committee would then choose a chairman, who was not required to be an association member. In addition, it was hinted that such activities as the chapter presidents' meeting might be excluded from the printed educational program and be held off-campus or at a downtown hotel.

The Switch to Chicago

After reviewing these stipulations, the association's board voted by a nine to one margin not to cosponsor another institute at Indiana University but to appoint a special committee to choose another institute site. Among the many sites available was the new Center for Continuing Education at the University of Chicago, where the board decided to hold the institute on June 9 through 14, 1963.

Although it appeared that the association had come of age and had successfully untied its apron strings, other association leaders had reservations. Sister Mary Gerald believed that if faculty made "joint appearances" at Indiana's institute and at the association's institute, it might "confuse the membership." She expressed confidence that most healthcare financial management professionals "will do anything humanly possible to prevent a split within our own ranks." She also credited Indiana University for its ongoing contributions to the field. "Indiana University sponsored our association when no one else sponsored us," she said, and offered special praise for Mr. Pressler's and the university's support of the Fellowship examination, correspondence courses, and implementation of the recommendations of the Committee on Structure and Program.

Other association leaders disagreed. "The association must accept its responsibility for leadership in the field of hospital finance," said past president John Stagl. "It cannot allow its program content to be determined by any group other than its own representatives." The association thus untied the apron strings of its annual institute; however, past presidents and other association leaders continued to work with Indiana University and its institute program. The association also sustained its relationship with the university through its correspondence courses and through the work of such leaders as professors L. Vann Seawell, Leon Hay, and Samuel Frumer.

The University of Chicago's Center for Continuing Education opened in January 1963, making the association the first client to use the entire facility. Although logistical problems abounded, the association developed an ambitious five-course program for the 1963 institute that included basic hospital accounting, cost finding and rate setting, accounts receivable control and credit and collections, 13 optional selections, and executive financial management. Final attendance included 386 registrants from 45 states, the District of Columbia, Canada, and the Virgin Islands.

Following a long tradition at Indiana University, proceedings from the 1963 institute were mailed free to all participants and offered to other AAHA members at \$1.50 per copy. Unfortunately, sales failed to meet expectations and a large overstock of proceedings books was eventually discarded. A year later the board voted to replace special proceedings books with a special institute section in the journal.

Meeting the 1963 institute goal of attracting a record number of registrants generated serious logistical problems. As a result, the 1964 Institute Planning Committee set a limit of 350 registrants, 35 of whom would be part-time enrollees in Course D. The committee limited enrollment for all courses to guard against overcrowded classrooms and to ensure that faculty could meet their teaching objectives. The 1964 institute achieved its goal of 350 participants and showcased an international presentation by Reginald Stacey, immediate past chairman of the Chief Financial Officers in the Hospital Service in England and Wales. General assemblies were reduced from five to three, which lengthened classroom hours in all courses. Opening ceremonies included installation of AAHA officers and directors and a welcome from Madison B. Brown, M.D., director of the American Hospital Association. The association introduced daily bulletins by publishing four daily issues. To promote and sell AAHA and AHA publications and reprints of journal articles, the association launched the first AAHA book mart. Finally, the 1964 institute marked the first annual breakfast meeting of AAHA Fellows.

Beginning in 1965 the association conducted its annual institute under the auspices of the American Association of Hospital Accountants Educational Foundation. Its five-course program covered admitting, receivables and collections, data processing and systems, general finance, managerial accounting, executive financial management, and office management. Each course ran Monday through Thursday with no optional course offerings. In addition, the institute featured a variety of innovations, including Wednesday morning field trips to eight Chicago firms and institutions such as the Federal Reserve Bank. Registrants totaled 363 from 42 states, Canada, the Virgin Islands, and Puerto Rico.

Even before the conclusion of the 1965 institute, association leaders heard their share of complaints and rumblings about the site. Although the University of Chicago offered a convenient midwestern location, and new, air-conditioned facilities, many university professors seemed disinterested in the institute, and most institute programs lacked the academic point of view. In 1966 association leaders felt compelled to rent furniture for the spacious but spartan conference center lobby so that registrants could meet voluntarily in small discussion groups.

Because of these problems, association leaders investigated alternative sites based on criteria established by the board of directors. These included Southern

Illinois University, several universities in the St. Louis area, Northwestern University, the University of Michigan, Michigan State University, and finally, Ohio State University. After visiting Columbus, Ohio, home of Ohio State University (OSU), association leaders concluded that university facilities met the criteria and recommended that the 1967 institute be held there.

The annual institute held in Chicago in 1966 marked the 20th anniversary of the American Association of Hospital Accountants with a special banquet attended by past presidents. A record attendance of 428 registrants was noted.

The Move to Ohio State University

Advertised as "A New Look in 1967," an expanded program for the OSU site offered 12 concurrent sessions, with programs aimed at various levels of the profession of hospital accounting. An all-star faculty from health care, business, government, and higher education attracted a record 479 registrants. Fourteen courses featuring 77 faculty members appeared on the 1968 annual institute schedule and helped to showcase the installation of the first cabinet of officers and directors of the newly named Hospital Financial Management Association.

The 1969 institute centered around the theme, "Focus on Planning," and offered 13 courses, several of which were new offerings. However, several courses were dropped from the program for lack of attendance, including the curriculum for hospital administrators and the course for extended care financial management.

One attraction of OSU for the association was the school's intention to develop a facility dedicated to continuing education. But when the university finally completed the facility, it was much smaller than association leaders had anticipated and lacked the capacity to accommodate the complete educational program.

Alternating the Location

In addition, members in western states bemoaned the high cost of travel and time to Columbus, which led the association to consider a second site at the University of Colorado, Boulder. Although the board initially approved two annual institutes, it later reconsidered its decision, because only one site could accommodate annual events. The association then decided to alternate sites. In June 1970 the institute was held in Boulder with 10 courses followed by a more limited program of 3 courses and a seminar in Columbus in July. The Boulder institute site was an immediate hit with the 350 registrants and their families.

In 1971, the association's 25th anniversary, the roles of the two universities were reversed. A major program of five courses and a seminar was offered in Boulder in June, and OSU played host to the association's national institute in July. Stan Pressler was honored as the first recipient of the Board of Directors' Award, and I was the 13th recipient of the Frederick C. Morgan Individual Achievement Award. By 1972 the annual institute was permanently booked at the University of Colorado and OSU evolved into a significant but secondary site for institute programs.

Faced with the reality that the institute's University of Colorado location presented problems with housing and that attendance had reached a plateau at 600, the board of directors developed criteria for institute site selection in 1981 for discussion at the fall presidents' meetings. However, because of the need to

book sites several years in advance, the board also approved a resolution that designated the University of Colorado as a permanent site for the Annual National Institute.

By 1983 the problems with housing accommodations at Boulder became increasingly obvious, and chapter presidents recommended that the annual program be moved. In the October 1983 issue of the journal, President Michael F. Doody advised the membership that HFMA was reviewing site criteria and inspecting other locations.

Recent Site Changes and Introduction of Exhibitors

The final ANI was held in Boulder in 1984 and moved to a large Philadelphia hotel one year later. The board responded to complaints about the move by reiterating two criteria for site selection: placing ANIs close to large pockets of members and finding facilities and attractions that would attract the families of registrants.

The board recognized that having sites close to large concentrations of members offered registrants the opportunity to commute and attend courses that were less than a week in duration. For this reason, the board approved minicourses similar to those that were offered at the University of Chicago in the 1960s.

In 1985 the board also approved the introduction of exhibitors into the ANI, and 30 firms participated in the 1986 program, which offered registrants time on the exhibit floor during meal and cocktail hours. The "idea exchange," as it came to be known, proved popular with both exhibitors and registrants. By 1991 more than 100 exhibitors sought the opportunity to meet and confer with registrants.

Following the successful venture in Philadelphia, the association held subsequent ANIs in Chicago, where it commemorated the association's 40th anniversary, as well as in Anaheim, Washington, D.C., New Orleans, San Diego, and Orlando. By 1988 the annual program still retained the ANI identification but was being broadened and referred to as the "National Convention." The board also approved some changes in site criteria in 1989, emphasizing the importance of alternating sites between eastern, western, and central U.S. cities.

March 1982 marked the passing of Joseph A. Levi, who had been a long-time HFMA leader and registrant at the ANI. Committed to honoring Levi's memory, the Metropolitan New York Chapter suggested that a fund be developed to underwrite the costs of obtaining a prominent speaker for the opening assembly. The board of directors set a minimum fund balance of \$25,000 and the Joseph Levi Memorial Address was launched in 1983.

Correspondence Courses

As the association's leadership began to develop new educational opportunities for its members, the concept of correspondence courses immediately came to mind. In the early 1950s most hospital accountants had little more than a high school education, and as Bill Follmer stated, "don't know a debit from a credit." Bill Follmer and Charles Mehler began to study correspondence course models such as the one sponsored by the Texas Association of Hospital Accountants and offered through the University of Houston.

Codevelopment with IU

In 1953 the association launched the development of a three-tier correspondence program with Indiana University that consisted of principles of hospital accounting, intermediate hospital accounting, and hospital cost analysis and budgeting. The Physician Record Company in Chicago published books for the first two courses. The basic course, Principles of Hospital Accounting, was introduced in late 1955 through a nationwide mailing of a promotional brochure. By December, 281 professionals had enrolled in the course, with the majority of registrants being bookkeepers or administrators.

In the meantime, the American Hospital Association (AHA) created its own correspondence course in hospital accounting with the University of Chicago and made it available in 1956. Within a few years, the AHA voted to discontinue support of the course and to "endorse and actively support" the "excellent correspondence courses in hospital accounting which are offered by Indiana University in conjunction with your organization." Encouraged by the AHA's endorsement, the association's board charged the Committee on Education to review the three courses according to feedback from a participants' questionnaire. Ultimately, a revised edition of the Seawall text became the first official textbook publication of the Hospital Financial Management Association.

Almost 2500 students had enrolled in the association's correspondence courses by 1966—a tribute to the AAHA chapters that had set up study groups to help enrollees handle course content. In most cases, small groups of financial management professionals gathered regularly to discuss an assignment with a tutor and other group members before turning in the assignment to the university faculty member for grading. Through this method, while course enrollees developed a clearer understanding of the material they also got the encouragement they needed to finish the course. In some hospitals controllers led groups composed of several employees. Some chapters used the text as a focal point for discussion groups but did not require formal enrollment in the correspondence course. The national office promoted the correspondence course program as an adjunct to the basic hospital accounting packaged workshops for individuals who wished to expand their knowledge of basic accounting.

Launching a Revised Package

In 1970 the association's board endorsed a Basic Systems Course for Hospitals developed by Systemation, Inc., Colorado Springs, Colorado, with the proviso that the course would eventually be restructured and offered as a packaged program to members. Ultimately, this course evolved into a full 25-week curriculum that featured 17 subjects and focused on practical problems of hospital management. Programmed learning techniques also helped to tie participants' learning experiences to on-the-job results.

Regional and Special Institutes

A joint committee of the AAHA and the American Hospital Association decided in 1956 that AAHA would conduct institutes on general accounting matters and that the AHA would conduct programs on more specialized accounting issues.

Because the AAHA had made no effort to conduct an educational institute other than the annual program at IU, one of my presidential goals was to launch AAHA's first regional institute in compliance with the AHA agreement. After articulating this objective at the August 1958 ad hoc regional meeting in Philadelphia, the Philadelphia, Appalachian, and New Jersey chapters agreed to sponsor the program. Registration for the October 1959 meeting totaled 171 professionals, including several hospital administrators, from 14 states. Evaluations indicated that 80 percent of those who attended rated the institute as "very good" or "excellent."

In most cases the national association selected a site where a regional conference was needed and then approached local chapters for assistance or accepted invitations from local chapters. The national office planned to select two-thirds of the conference's programming while allowing local chapters to select one-third. The plan was to conduct two regional conferences annually—one in the spring and the other in the fall. The national office would receive all income from the conferences, and chapters would have the opportunity to earn income from the sale of exhibit space or program advertising space.

Evolution of Regional Programs

The concept of the regional institute immediately caught the attention of chapters, and they flooded the national office with requests to become sponsors. Charles Aenchbacher, who represented the Georgia Chapter, attended the Philadelphia program to learn the mechanics of institute management, and in September 1960 helped to spearhead a regional program at the University of Georgia. Because the association had billed the Philadelphia conference as its Eastern Regional Institute, it also made plans to develop a two-and-a-half-day Western Regional Institute in June 1960 at the University of Washington in Seattle. The two-track program attracted 107 registrants and consisted of a session on basic hospital accounting complemented by a general program that focused on systems and procedures, credit and collections, internal control, cost finding procedures, and rate setting.

As the association developed more experience in conducting regional conferences, it instituted a variety of changes. For example, after investigating the use of hotels and colleges as conference sites, the board concluded that the association should consider both types of sites before deciding on a final location. Shortly thereafter, the Committee on Chapters recommended to the board that the executive director "be given sole responsibility for planning regional institutes, utilizing every resource available for its [sic] success." Through 1964 the association sponsored two regional institutes annually in accordance with the guidelines it had outlined.

In almost every case, national staff and the officers of sponsoring chapters came together beforehand to select program content and then customize that content to meet the needs of hospitals within the immediate area. In addition, the association continually sought out nationally recognized speakers, including the association's president, to address regional institutes. The basic accounting workshop was often offered as a second track to the main program, which usually included a keynote address, a banquet speaker, and a closing luncheon speaker.

As regional institutes evolved, a rich variety of experiences offered many important lessons. In 1960 the University of Georgia Institute was almost canceled

because of low enrollment, and the national office changed the banquet appetizer from fruit cup to tomato juice to save an additional 25 cents per person. When the Athens, Georgia, site failed to attract an adequate number of registrants, the association recognized that the shopping and entertainment offered by Atlanta and other major metropolitan centers were important lures for registrants and their families.

The association thought it had a potential winner with its 1962 World's Fair Institute and made arrangements with the University of Washington for registrants to stay in residence halls and fraternity houses during and after the institute. Although the program attracted people from surrounding states, and as far away as Massachusetts and Alabama, final registration figures were far below expectations.

Unfortunately, the local committee overlooked cancellation of its reservations at the university's fraternity houses, and the association received thousands of dollars in bills for unused room reservations. Although the association successfully extricated itself from this financial predicament, it learned a valuable lesson: The national office had to participate in the total planning and management of regional conferences. Overall, regional institute programs helped many chapters gain practical experience in program planning and conference management.

New Institutes in the 1960s

Other innovations continued. With the agreement of the American Hospital Association, the association broke its pattern of regional institutes in 1964 with an institute on credit and collections in Atlanta. Because there was no set curriculum for such an institute, the program was developed with representatives of the Georgia chapter and Georgia Hospital Association. With slight modifications to fit the time and situation, the pioneering Atlanta program attracted 144 registrants and became the standard for credit and collections programming for years to come. Late in 1963 the association hosted a program on paperwork simplification in the hospital under the auspices of the Standard Register Company. Critiqued by AAHA and AHA representatives, the program was improved and endorsed for chapter presentation through the chapter program manual.

The format of regional institutes began to change slowly after the association hired a director of education and secretary-registrar. When the institutes no longer depended on local chapters to coordinate the facilities, program planning became more simplified. By 1965 the association had developed several programs for presentation at the national institute and found it easy to adapt abbreviated versions of these programs for other two-to-three-day programs.

It was now possible for the association to conduct more than two regional institutes annually, and in 1965-1966 the association scheduled five institutes. Although it scheduled five more institutes in 1966-1967, the AAHA no longer identified these programs as regional institutes and started to introduce other themes. A 20th anniversary program, held appropriately in Rochester, New York, was entitled "Institute on Managerial Accounting." It focused on managerial accounting and hospital accounting techniques, principles of hospital pricing, and interpretation and analysis of financial statements. Registration for the program, which had been budgeted for 100 participants, grew to 137.

With the advent of Medicare in 1967, the association returned to the format of customizing program content to meet the needs of local hospital accountants. One such program was an Institute on Hospital Financial Management at the Disneyland Hotel, Anaheim, California.

Interspersed with these regional-oriented, nationally conducted institutes were two newly developed three-day programs: an Institute for Independent Auditors, which was first presented at the University of Chicago's Center for Continuing Education in 1966; and an Institute on Hospital Accounting for Qualified Accountants New to the Field, which was first presented in 1967. The facilities at the University of Chicago enabled the association to continue its pleasant relationship with the conveniently located Chicago site after terminating use of the site for the Annual National Institute in 1966.

Medicare Programs with the Big Eight

In 1964, as executive director, I hosted a dinner meeting for associates of major accounting firms to discuss how AAHA could serve the needs of independent auditors within hospitals. Associate membership had grown significantly, and small CPA firms expressed a need for information on hospital auditing. Representatives of the Big Eight accounting firms agreed to participate in a special association-sponsored program. With the introduction of Medicare, their need for information became even more acute and broadened the market for registrants. Working with representatives of several CPA firms and the American Hospital Association, AAHA developed a program that consisted of sessions on the hospital environment, concepts in hospital management accounting, principles of hospital accounting, cost finding, rate setting, capital finance, investments, property and casualty insurance, tax-exempt problems, auditing, and certificate problems and principles of reimbursement.

Despite a national airline strike, 173 registrants appeared at the initial program, 30 percent of whom were from the expanding Big Eight firms. On the first day, faculty realized that many registrants had already gone far beyond the course content, and faculty worked into the night in an attempt to upgrade their presentations for registrants who had seemingly more significant needs than those of small independent auditors. In 1967 the curriculum was restricted and offered in two separate sections.

When the association relocated its annual national institute to the University of Colorado from OSU, the HFMA also transferred the Institute for Medicare Intermediary Auditors and the Institute for Experienced Accountants New to the Field from Chicago to the Columbus, Ohio, site. The Institute for Experienced Accountants returned to Chicago in 1971, but the program for intermediary auditors was dropped from the curriculum and replaced several years later by a Medicare program developed with the American Institute of Certified Public Accountants. Under a slightly retitled name, the Institute for Experienced Accountants New to the Field continues to flourish as one of the association's most successful and respected offerings.

Healthcare Accounting Orientation Programs

Prior to Medicare, the association was able to work through its chapters and its national institutes to orient newly hired accountants to the healthcare field. But after the mid-1960s, at least 85 percent of professionals who entered the field of

hospital finance had undergraduate degrees, and many had already earned graduate degrees or were certified public accountants. To help these "qualified and experienced newcomers" understand the intricacies of hospital finance, and to help the hospital field catch up with contemporary accounting methods, the association developed a sophisticated program that included orientation to hospital development, the concept of public trust, the organization and control of the voluntary hospital, hospital fund accounting, plant and construction funds, endowments and temporary funds, the operating fund, management accounting concepts, cost finding and rate setting, hospital reimbursement, and internal control and auditing systems. Presenters from the American Hospital Association, the Blue Cross Association, CPA firms, and hospitals attracted more than 150 registrants to the initial conference.

When the Institute for Experienced Accountants New to the Field returned to Chicago in 1971, it met at the American Hospital Association's headquarters building where the HFMA also had its offices. This location made it easier for the association to work with the AHA in program presentation and to provide registrants with tours of the building and nearby hospitals. At the same time, the registrants enjoyed shopping in a jointly sponsored book mart.

As the association gained more experience in conducting institutes and surveyed registrants for reactions, deep philosophical insights into the hospital and healthcare industry were replaced by more pragmatic guidance. Because newcomers to the field of hospital accounting were generally better educated, the association eliminated such sessions as fund and plant accounting.

The growing popularity of the program and the continuing influx of experienced accountants into the healthcare field as well as escalating government regulation led the association to schedule two annual programs beginning in 1977. For several years, association chapters, especially those in metropolitan areas, also held programs for new accountants while the association continued to hold its program in the metropolitan Chicago area.

Reevaluation of Educational Objectives

In 1969 the association revised its long-standing educational approach. Reflecting an education policy that the board had adopted the previous year, the new approach called for the association and chapters to assume a more competitive attitude in the marketplace in developing and conducting its educational programs. In addition, the association was to conduct its ANI with at least 10 courses complemented by 4 to 5 courses that would be offered at other national institutes held at various locations. Also emphasized were small class enrollments, the inclusion of academic faculty, clearcut educational objectives, and a preference for college campus settings. Moreover, the association announced its intention to develop programs that would meet specialized needs, cooperate with other associations, investigate new educational media such as the publication of textbooks, and encourage college and community college programming in healthcare financial management. The association also pledged to strengthen chapter-sponsored educational programming by providing packaged programs, topic outlines for programs, and a session on program planning at the annual chapter operations workshops.

After Education Director Rod Brutlag resigned from the staff in 1969 and was replaced by Augie Podolinsky, the association reevaluated its educational commitments and decided to continue its two annual institutes but limit the number of regional institutes. Eventually, the association developed a Committee on Institute Planning that met annually and included the association's president elect, the chairman of the Council on Education and Research, a Fellow, an educator, and a representative of a CPA firm or Blue Cross. Over the next several years, committee members met annually to study evaluation reports of previous institutes to determine new and emerging trends. In addition, the committee reviewed staff recommendations for upcoming programming and recommended courses of study for the annual institutes. In April 1971, Podolinsky left the national staff and was replaced by Ralph R. Gayner, who had been hired several weeks before to manage a project funded by the new W. K. Kellogg Foundation.

Medicare and Cost Finding

Early in 1961 Richard L. Johnson, head of the Hospital Counseling Program at the American Hospital Association and currently president of the Tribrook Group, Oak Brook, Illinois, expressed disappointment at the lack of cost-finding strategies within hospitals. Despite the fact that the American Hospital Association's cost-finding manual had been introduced through a series of state-by-state workshops in 1959, he believed that less than 1 percent of hospitals were engaged in cost finding.

Working cooperatively with the AHA, the association launched a pilot study to identify the problems of cost finding and determine a strategy for implementing cost-finding practices in hospitals. Working with six selected chapters, the association learned that the hospital administrator was often indirectly responsible for the lack of motivation or interest in cost finding. Despite AHA publications such as "Guiding Principles for Hospital Charges," hospitals accustomed to using traditional methods for setting charges resisted change. The technical aspects of cost finding may have been "mere arithmetic," but there were major problems related to the inaccuracy, inconsistency, and paucity of statistics.

Workshops to Meet Training Requirements

Although hospitals were able to provide one factor in the equation—uniform dollar figures by department designation—statistical gathering techniques were usually inadequate or nonexistent. To overcome this barrier, cost-finding programs invested significant time in identification of needed statistics, statistics-gathering techniques such as the exchange of locally devised forms, and developing definitions of necessary statistics such as what constituted a meal. Although statistical definitions varied from state to state, the association believed that uniformity within certain jurisdictions was essential. Because decisions on statistical measurements were usually the prerogative of administration, chapters were advised to clear any definitions through their state hospital association.

With Medicare on the horizon, AAHA staff met with the staff of the American Hospital Association and the Catholic Hospital Association in December 1965 to discuss the mechanics of a reimbursement formula for Medicare beneficiaries.

Although no one had received word on the details of the formula, participants agreed to expose as many hospitals as possible to the stepdown method of cost finding. In response to a request made of the three participating associations to provide an outline of proposed courses, AAHA reported on the 1961 pilot workshop series and outlined a program developed by Ray Everett and Jeff Steinert, both of whom had been key figures in the South Carolina pilot program.

Through a special journal issue on Medicare published in June 1966, AAHA members learned of the plan to conduct a series of national cost-finding workshops. The AAHA announcement stated that as soon as final forms and instructions for the minimum requirements for cost finding were made available, the committee that represented AHA, CHA, and AAHA would develop a two-to-three-day workshop and train faculty members. Members were also advised that the journal would continue to provide articles on the financial and statistical data needed for cost finding.

The journal's announcement brought a telephone call from Susan S. Jenkins, who had recently joined the Bureau of Health Insurance of the Social Security Administration after having served for many years as executive director of the Kansas City Hospital Association. Through Jenkins' efforts, AAHA obtained a small grant of \$4255 to meet the cost of transporting 16 qualified accountants to Chicago for a training session.

In September a special issue of "Notes from National" provided full details to chapters on how to conduct cost finding for Medicare workshops. The workshops were promoted as having been developed by the American Association of Hospital Accountants Educational Foundation (AAHAEF), in coordination with the American Hospital Association, in cooperation with the Catholic Hospital Association, and in consultation with the Social Security Administration and the Blue Cross Association. The workshop materials were available only through AAHAEF, and the educational foundation office was responsible for assigning 1 of the 16 regular instructors or stand-by instructors to ensure equal distribution of their time. With the expectation that enrollment restrictions would keep attendance below 60 people, the two-day workshop was limited to 25 hospitals with a maximum of 3 enrollees per hospital. In addition, the association recommended that the chapter assign 2 assistants to the appointed instructor so they could later handle additional or follow-up workshops. Materials for follow-up workshops were also developed and made available through AAHAEF.

In a June 1967 journal article education director Rod Brutlag recounted the success story of these workshops. Three thousand enrollees from 1,800 hospitals attended one of these two-day programs. Programs were designed to supply the basic nuts-and-bolts information on how to meet the statistical and financial requirements for reimbursement under PL 89-97. This involved 27 chapters making arrangements to conduct 64 workshops from Maine to Washington and Florida to North Dakota. Random feedback indicates that those who participated had a considerable head start over their nonparticipating peers.

For several years, the American Institute of Certified Public Accountants had conducted a Medicare Auditing Workshop, primarily for public accounting firms and hospitals. In the early 1970s the association and AICPA joined forces to

present a series of two-day basic Medicare workshops and a basic Medicare program. Representatives of the Blue Cross Association and the American Hospital Association joined with association and AICPA representatives to develop a modus operandi, workshop objectives, and content. Eventually, more than 10 workshops drew more than 1300 people.

The AICPA/HFMA working party convened early in 1971 to evaluate the two-day program and develop an advanced workshop. HFMA served as course coordinator for all planning, printing of course materials and publicity brochures, faculty scheduling, site selection, and coordination of facilities. AICPA coordinated development of program content by one of the Big Eight firms, arranging staff representation at programs, and providing mailing labels and publicity. The basic program was the two-day Medicare Financial Workshop, followed by a one-day Medicare Financial Strategies Conference. With program content modified to address changing Medicare regulations, 60 workshops and conferences were held throughout the nation in the following three years with a total attendance of more than 3700.

Ongoing Training Required

The association expanded its Medicare workshops in 1979. This expansion responded to new regulations that required hospitals with less than 100 beds to file cost reports using the departmental method of cost finding. The association decided to present a half-day preliminary session prior to the two-day workshops for small hospitals interested in converting to the departmental method. The annual pattern of five workshops, three conferences, and three half-day programs continued into the late 1970s and early 1980s with enrollments exceeding 3300.

Throughout the 1980s, Medicare regulations offered grist for the educational mill. Institutes included topics such as Financial Management of Medicare, Diagnosis-Related Groups, Financial Management of Rural Hospitals, PPS: Impact on Capital, and Medicare Cost Reporting Under Prospective Rate Setting. Developed by HFMA Washington staff, the semiannual Institute on Current Financial Issues was held in Washington, D.C., and invariably highlighted current and anticipated Medicare regulations.

Special Topic Institutes

Several factors influenced the association's 1976 decision to terminate the nationally sponsored regional institutes. For years the association had encouraged its chapters to upgrade their programming. As a result, chapters held at least one annual institute or several workshops or seminars throughout the year. They found it relatively easy to emulate national programs and customize and adapt them to meet local needs. In addition, the national office had encouraged regional programs within the 11 official areas, which eventually grew popular and proliferated.

By 1975 the association's attention turned to the development and implementation of institutes on specific subjects presented by a faculty of experts. When the federal government initiated its Economic Stabilization Program in 1972, the Internal Revenue Service was responsible for program enforcement. IRS personnel

were immediately invited to appear on HFMA chapter programs to explain the new regulation and its implementation. At one program in Dallas, the IRS agent was unable to answer even the most rudimentary questions and left registrants disappointed and confused.

Cosponsorship with Accounting Firms

After the government terminated the IRS's role in enforcement, other government agencies gained control of prices and wages. Representatives of national CPA firms assumed the role of interpreting information for hospital clients. In cooperation with representatives of most of the Big Eight firms, HFMA launched a series of two-day Institutes on Hospital Economic Controls. Introduced in Washington, D.C., in early 1973, the first institute of this type attracted 137 registrants. With regular revisions to communicate program changes and interpretations, the program series attracted more than 1300 participants during 1972 and 1973 and more than 1400 participants the next year.

Because the financial return was substantial, the association was able to allocate \$50,000 in excess revenue to a research project to help develop a hospital unit of service and to subsidize registration fees at the annual national institute as costs increased. The ongoing, excellent support of many CPA firms for national and chapter programs prompted the association to present its 1974 Board of Directors' Award to the American Institute of Certified Public Accountants.

Shift to Chapter Sponsorship

When the Economic Stabilization Program terminated in mid-1974, the association considered other institute subjects, such as receivables management. The chapter program manual contained 11 self-contained lessons on collections and receivables management, but many had not been prepackaged or recently updated.

A packaged program on management of patient account services had already been developed through a grant from the W. K. Kellogg Foundation, and elements of all programs were reassembled into a two-day A-B-C workshop for admitting, business office, and collections. From 1975 to 1978, the association sponsored 40 workshops throughout the country that attracted more than 2500 registrants. The program was dropped from the HFMA calendar in 1979—in part because of chapter competition. Stanley Levin, the principal instructor for the program, was invited by numerous HFMA chapters to conduct the program locally. His services were in such demand that he left his hospital credit manager position and formed an organization devoted to conducting educational programs for health care. Levin conducted the programs for a per capita fee, and chapters could charge far less for programs than the national office could due to overhead costs. Recognizing that Levin could never be compelled to work for national HFMA exclusively, the board voted to terminate the relationship with him.

Development of New National Programs

Productivity in hospitals became a critical issue during the turbulent days of the Economic Stabilization Program. The association focused on creating educational programs that measured and controlled hospital productivity. In November 1975 the chapters of Region VII (Indiana, Wisconsin, and the three Illinois Chapters)

held a regional institute on productivity in Chicago. Net proceeds of \$5300 were donated by chapters to the HFMA Educational Foundation as a token of appreciation. HFMA also pursued the elusive subject of measuring productivity by underwriting a project designed to define a hospital resource unit (HRU). Several other programs on hospital productivity were also developed, including a 1977 program conducted by Tribrook Group that attracted 102 registrants.

As the 1980s began, the association sought ways to deliver its educational programs in accessible, convenient locations and at reasonable costs. In 1982, the development of key city clusters allowed HFMA/EF to schedule between five and nine concurrent institutes at selected cities. In addition, more than one person from a hospital could travel and room together while attending the course of their choice.

The broad array of special topic institutes created in the 1980s testified to the changing and growing needs of the healthcare industry and HFMA's ability to address these needs through educational offerings. HFMA realized that financial executives looked to the association for information on how to manage their areas of responsibility.

Other special courses were developed and implemented through joint efforts of the American College of Healthcare Executives (Financial Management for Healthcare Executives) and the American Hospital Association (Financial and Strategic Planning and Budgeting Procedures for Hospitals).

During the 1980s institute registration averaged more than 4200 annually. In an effort to keep pace with evolving technologies, HFMA initiated audio teleconferences in 1989. These widely audiocast programs focused on productivity, rural hospitals, federal issues, resizing, and tax-exempt issues.

The Organization of the Educational Foundation

In the early 1960s the association's board recognized the need to hire a full-time educational director and began to outline potential duties and funding strategies. When the association learned that it was legally unable to receive funds from private foundations, its new attorneys recommended the formation of a not-for-profit foundation. Initial funding came through excess income generated through regional institutes.

The American Association of Hospital Accountants Educational Foundation was incorporated in October 1963 to provide for "the instruction and training of individuals and groups by means of discussion groups, forums, panels, lectures, or similar programs," and to encourage research "for the purpose of improving the scope and content of such instruction and training, and the dissemination to the public generally of information and data." In December 1964 the foundation hired Rodney S. Brutlag of Minneapolis as its first director of education.

Transfer of Association Resources

Beginning in 1965 the foundation sponsored the annual national institute and all regional institutes and educational programs. Ultimately, however, the association concluded that programs such as the Medicare workshops should be sponsored by the association. Legal and financial issues forced the decision. To maintain its

status as a not-for-profit public foundation, the educational foundation had to receive most of its financial support from public sources, which included fees paid by registrants to national institutes. If the foundation received only grant support or support from its parent organization, it would be viewed legally as a private foundation, meaning that such funding bodies as the W. K. Kellogg Foundation would be enjoined from offering support.

Under the law the foundation could not transfer funds to the association, but the association was able to transfer or contribute funds to the foundation. The split also extended to the area of human resources. Although Rodney Brutlag and his assistant were originally employed by the foundation, they eventually became association employees and functioned under the auspices of the foundation.

Monitoring the Quality of Its Offerings

To monitor the quality of its educational programming, the foundation established an Educational Advisory Committee composed of individuals from other associations and from several universities. Early on the committee recommended foundation-sponsored workshops at the local level, accounting courses in community colleges, accounting curricula within adult education programs, and promotion of hospital accounting as a career. More generally, the committee recommended upgrading hospital accounting personnel by establishing minimum standards for hospital accountants.

To sustain its commitment to quality, the foundation later created an Institute Advisory Committee of HFMA members. Although the foundation was established to receive grants, it had made no attempt during its initial years to obtain funding through grant proposals. Instead, the foundation preferred to focus on improving the quality and geographical spread of its educational offerings. In 1969 the foundation submitted a grant proposal to the W. K. Kellogg Foundation for the creation of five packaged training programs modeled after the already successful workshops in basic bookkeeping and budgeting. Although Kellogg eventually approved the grant, the foundation had to provide "indisputable evidence" that it was not a "private foundation." On May 31, 1970, the association informed the W. K. Kellogg Foundation that it had engaged the services of Marilyn Lunghi as project director and that she would join the staff on June 1. On that date a check for \$37,223—the first year's budget for the project—was received from the W. K. Kellogg Foundation.

New Types of Contributions and Participation

With the death of Harold Hinderer in 1981 and the receipt of contributions in his memory by the foundation, its board of directors established a fund for contributions that would honor past leaders "with a fitting memorial." The resolution called for a permanent plaque to be displayed in the headquarters office for each honored leader and authorized the board of directors to use funds received "in ways which will bring honor to the leaders being recognized." In 1982 the name of Joseph Levi was added to the memorial plaque.

The educational foundation continued to sponsor the annual national institute. In addition, the foundation's name appeared as sponsor of other selected topic institutes to comply with regulations and ensure its status as a 501(c)3

organization. When requested by the Metropolitan New York Chapter to share the tax and mailing privileges enjoyed by educational entities, the association in 1990 amended its bylaws to establish a chapter of the foundation. Thus far, the Metropolitan New York Chapter alone has educational chapter status.

Packaged Training Programs

When it decided to drop basic hospital accounting from its annual institute agenda, the association realized that the material might find a new audience if it were presented in a different form. After working with Charles Anderson and the Georgia chapter, a two-day, 12-hour instructional package that consisted of workshop materials for 30 students and 2 instructors was piloted and sold for \$150. In addition, a planning manual inserted into the chapter program manual explained how to plan the course: selection of local instructors and materials, budget development, registration fee structure, agenda, and promotion. The first workshop was conducted in Rochester, New York, in 1968. The grant application to the Kellogg Foundation noted that these workshops had attracted some 800 participants.

Cosponsored Offerings

In 1961 the American Hospital Association published a manual on hospital budgeting procedures that led to discussions with AAHA on the value of a joint seminar. Both parties realized that do-it-yourself manuals could never contain all the answers, so AHA and AAHA began to work on a training workshop for hospital financial personnel. As a first step, AHA sponsored a series of management seminars on budgeting in eight different cities across the country in early 1964. Targeted for hospital administrators and administrative assistants, these seminars explained how principles within the AHA's new manual could improve management. Within months, the grass roots element of the educational plan went into effect as a budget workshop complete with a two-part case problem on creating a budget was made available to AAHA chapters.

In executing this workshop plan, AHA and AAHA took a new approach. The two groups developed an instructor's manual and brought 11 knowledgeable professionals to Chicago in May 1964 to receive training on how to conduct the two-day workshop. AAHA also prepared another manual that explained the mechanics of planning and conducting the workshop. From that point, however, AAHA arranged its own budgeting programs by using the manuals and case problems, with the instructors jointly trained by AHA and AAHA. More than 34 workshops were conducted using the original materials. After revisions were made in 1968, another 27 workshops attracted more than 650 registrants. These figures supplemented AAHA's proposal to the W. K. Kellogg Foundation.

Grant Projects

In February 1971 Ralph Gayner assumed the role of education project director following the untimely death of Marilyn Lunghi. He immediately developed a receivables management course, which ultimately became Management of Patient Account Services. A special committee was convened to develop a course that featured an audio script, slides, and exercises; the course eventually was packaged

as three two-day workshops: Strategy, Key Systems, and Key Issues. In the interim, Gayner moved to the position of director of education services and was replaced as educational project director by Robert Shirley.

The second grant proposal submitted to the W. K. Kellogg Foundation in 1972 was rooted in the success of the five packaged programs that had been developed with the foundation's original grant. As a result of the many participants who attended various workshops, the foundation received a two-year grant totaling more than \$100,000 and used it to develop eight additional packaged training guides, including materials about advanced budgeting and rate setting, hospital work simplification, hospital internal control and auditing, communications for hospital financial management, and business management of healthcare providers. In addition, the foundation created basic bookkeeping for long-term care facilities, but its plans for joint programming with the American Nursing Home Association never bore fruit. By January 1982 sales of student workbooks for the 10 packaged programs totaled 31,343 units, 60 percent of which were for the three-session Management of Patient Account Services course.

Based on evaluations from the field, most workshops were revised and updated to conform to current circumstances. In cooperation with the First Illinois Chapter, Basic Bookkeeping for Hospitals was revised in 1979, and through the efforts of the Georgia Chapter, the Budgeting Process Workshop was revised in 1981. Based on his acclaimed workshops at the annual national institute, Charles Ferderber of Evansville, Indiana, developed a new workshop entitled Hospital Work Simplification that was launched in 1978.

Executive Graduate Programming

Midway through the term of the second grant from the W. K. Kellogg Foundation, Ralph Gayner and I conferred with Robert DeVries, Kellogg's program director, on how the foundation could further its relationship with Kellogg. Although DeVries was impressed with the packaged workshop concept and its educational products, he had no interest in providing additional funds for workshop development. Instead, because of the unprecedented need for top-level management expertise in fiscal control, he encouraged the foundation to develop a grant that would address a broader educational challenge. Aware of the need for greater emphasis on healthcare financial management within higher education, the board authorized staff to develop and write a grant proposal.

Launching the Program

In March 1974, William Van Lopik (HFMA's past president), Gayner, and I visited the Kellogg Foundation's headquarters in Battle Creek, Michigan, to learn more about the foundation philosophy and how it might respond to the concept of a high-level, university-based educational program. A university working party was organized with representation from Tulane University, the University of Colorado, Ohio State University, and the University of South Carolina. Each university agreed to subscribe to curriculum quality guidelines and an instructional format acceptable to the grantor. In February 1975 the foundation received a three-year grant of \$680,000. The foundation would receive approximately \$163,000, and

the four participating universities would divide the balance of funds. In announcing this historic grant, Robert DeVries said,

If there is to be any concern for rational allocation of resources between the health field and other national priorities, if there is to be any notion of maximizing human welfare through quality health care, the rational development of competent financial managers is imperative.

Such an in-depth external educational program demanded extraordinary commitment from students. In its role as overseer, the foundation insisted on adhering to strict entrance requirements and close monitoring of off-campus study. During week-long sessions, students attended seminars by resident faculty and other participating universities and, on some occasions, even went to special evening and weekend classes during the year. Students were assessed through oral and written exams and, at some university sites, submitted papers on national health-care policy topics.

Typical applicants for these programs were less than 40 years old, had a college degree, and were already employed in a hospital in the 300- to 399-bed range as an administrator (25 percent), chief financial officer, controller (35 percent), or in another financial function (24 percent). In addition, most had about six years of healthcare field experience. In most cases, a student's employer paid for program costs and allowed the student time off with pay to attend the program.

Although the program attracted widespread attention, not all of the universities experienced success. Because it was a private institution and its fees were higher, Tulane University had difficulty attracting an adequate number of students during the second year and terminated its involvement in the program. To ensure that university faculty upheld educational standards, the foundation periodically conducted special symposia on such topics as the healthcare environment, accounting, finance, systems development and analysis, and organization and management.

During the course of the initial three-year grant, the University of South Carolina took a leadership role in developing a complete external master's degree program. The university's initial success encouraged the foundation to request an additional three-year grant in 1979 to support the work at South Carolina and to launch nonresident master's degree programs at the University of Colorado and Boston University.

The Kellogg Foundation's foresight led to the development of an executive graduate program network, which eventually consisted of the University of Colorado, Ohio State University, the University of South Carolina, Boston University, the University of Wisconsin-Madison, and Temple University—the latter two funded directly by Kellogg.

After five years, the foundation was able to summarize its secrets of success: short, concentrated instructional sessions coupled with extensive home study, attention to unique healthcare issues, broad content within the discipline of healthcare financial management, and a clear linkage between academic learning and management practice. Educators continued to uphold specialized education for practicing healthcare executives. One stated:

Healthcare's market is not primarily structured by supply and demand. Health services are not purchased primarily by users; cost structures are different; free markets are almost nonexistent. If a person plans a career in healthcare, he or she should learn the techniques of this industry, not the generalized program which has to be fitted into this unique industry.

Shift in Funding

The February 1981 issue of *Hospital Financial Management* included a detailed history of executive graduate programs at various schools within the network. A year later the journal published a photo of 15 graduates from the fifth graduating class at Ohio State University. Funds were no longer received through the Kellogg grant, and the cost of HFMEF's role as program monitor was budgeted within the foundation's operations.

A special activities fund grant of \$50,000 covering a three-year period was received from the foundation to finance innovative programs within the network based on recommendations from the national Steering Committee. One project consisted of a Financial Management and Regulation (FMR) Game developed by David B. Starkweather, of the University of California. Previously, the University of Colorado, a pioneering school within the network, had expanded its recruitment effort to California and formed the Western Network with the University of California. The game was exhibited at the 1981 Congress on Administration conducted by the American College of Hospital Administrators, and again at the 1981 Annual Institute conducted by HFMEF. The intent was to sell the FMR game to schools within the executive graduate program network.

By 1990, executive graduate programs remained at Ohio State University and the University of Wisconsin. Several grant proposals were developed in the 1980s, including one directed to the Hartford Foundation. In 1982 a proposal directed to the W. K. Kellogg Foundation to develop a self-assessment program was rejected, and in July of the same year staffing of the education foundation was discontinued.

Healthcare financial management's development as a specialized area of scholarship in the 1970s paralleled an era of rapid and complex changes in healthcare financial management. The Hospital Financial Management Association and the HFMEF played a profound role in influencing these changes.

Research in Financial Management

In addition to offering a wide variety of educational programs, the association continued to fulfill its ninth objective of research in areas of financial management. Projects ranged from simple membership surveys designed to validate the name, job title, type of hospital and bed capacity, to a compilation of daily reports prepared by hospital accountants for administrators, hospital operating income and expense, and accounts receivable. Throughout the years, the association cooperated with the American Hospital Association to conduct research into such issues as insurance, hospital rates, and model hospital reporting forms.

Formalizing HFMA Efforts

In 1970 the foundation began a formal pursuit of research. A newly formed Research Project Committee recommended that the board develop a research policy statement and make a long-term commitment to research by hiring a research director and seeking funds from external sources. In addition, the committee outlined the elements of a successful research plan, delineated four areas

of research activity (basic, applied, consulting, and communications), and recommended a fundraising matrix that implied a potential need of a million dollars over a five-year period. Ultimately, the foundation board adopted a research policy that supported projects that would

... identify the functions ... of the art and science of hospital and health care financial management and improve the execution of these functions; identify the activities ... of hospital and health care financial management ... and to improve the professional execution of these activities; develop educational methods, formats and settings...; and improve systems and methods in planning, forecasting, controlling, measuring, evaluating, and accounting. ...

As the ad hoc Research Project Committee was considering research projects under a \$50,000 grant from HFMA, the board received a written proposal in March 1975 from Michael Eberhard of the Southern California Hospital Council and Allen G. Herkimer, Jr., then associated with Laventhol & Horwath, Los Angeles, to develop a standard unit of measurement for hospital services, to be known as a hospital resource unit (HRU). The proposal was based on an article written by Herkimer for HFMA's journal, which stated that a single unit could be developed and applied to all hospital revenue-producing departments. This unit could then help evaluate productivity and cost-effectiveness as well as cost distribution and rate setting for all departments within a hospital or between like departments of other hospitals.

The project would be completed in three phases. Phase I would determine what had been done nationally on the subject; phase II would involve the development and testing of the hospital resource unit. Phase III, which would feature a national demonstration at test sites around the nation, would require funding from other sources. The project was accepted as an HFMEF project to be developed by Laventhol & Horwath under the auspices of the Southern California Hospital Council with input from other bodies, including a select committee of HFMA's Southern California Chapter. A sum of \$4500 was allocated to pursue phase I. If no other similar projects were in process, phase II would be funded by HFMEF up to a total of \$50,000. Meanwhile, the foundation would seek funding for the continuation of phase II and implementation of phase III.

Convinced that the framework of a unique management tool had been discovered, several other organizations became intensely involved in the research by late 1976. These organizations included the Rand Corporation, the California State Department of Education and Welfare, Comprehensive Care Corporation, the University of Southern California, the City University of New York, the University of Colorado, Hyatt Medical Enterprises, and the California Hospital Association.

To obtain a valid and objective evaluation of the project and to evaluate its potential, HFMEF sponsored a Fellows' seminar in Chicago in September 1976. The seminar was attended by a review committee, which met with staff afterward to develop its recommendations for the board. Discussion by HFMA Fellows at a session held the previous evening focused on the future direction of the project, staffing, and HFMEF's relationship to the project. Among the recommendations were that the project team should proceed with a restructured phase III; technical expertise should increase; and HFMEF should serve not as a prime contractor or

grantee but as a subcontractor. Finally, the committee recommended that a steering committee be established to supervise the technical aspects of the project.

Most efforts to obtain additional funding through nationally known foundations were unsuccessful. At one point the National Health Services Center had expressed interest and, for a time, the foundation expected to receive a request for proposal from the Department of Health, Education and Welfare. But status reports showed little progress through 1982 and the RFP was never received. Allen Herkimer claims that researchers did not present the HRU as the ultimate panacea, but insists that "the designer of the original wheel probably did not have a perfectly round wheel in the beginning."

The Wide Range of Research Projects

The majority of the task forces appointed by incoming board chairmen after 1978 were charged with investigating some aspect of association operations. From these studies and recommendations came a much stronger organization. But other task forces were charged with a mission that had a potential long-term impact on the healthcare industry. In 1987 the Task Force on Future Medicare Payment Alternatives released a report that discussed capitation-based payment, unit of service payments, and other aspects of financial management, data collection, incentives, quality, access, and organization.

In its 1987 report, the Task Force on HFMA's Role in National Health Policy concluded that articulation of a national policy was an improper role for HFMA—not only because of the resources needed for such an effort but also because HFMA could relate only to the financial dimensions of national health policy. However, the report argued that members should receive information on HFMA's advocacy process and its positions on various issues and that a list of policy issues be reviewed and updated on a regular basis.

In 1984 the board of directors approved a proposal to survey cost accounting practices in health care. The proposal recognized that no single approach to cost accounting existed and that the design of such a system would be fruitless. Nevertheless, the survey was intended to assess the state of the art, provide a checklist of possible refinements for a customized program, and identify planned changes and types of assistance. The study was conducted by Coopers & Lybrand, and the findings were published by HFMA.

In 1984 the board also considered a proposal submitted by the North Carolina and South Carolina chapters, which had designed a project in cooperation with the University of North Carolina to develop a profile of a successful healthcare financial management executive. Cosponsored by HFMA, the profile was eventually published in the journal. In the same year the association also formalized an agreement with Arthur Young & Co. to conduct a study, later published, of the impact of hospital marketing practices on financial management.

Voluntary Education Guidelines

The association's attitude and commitment toward education was epitomized in the educational policy statement approved in late 1973 and disseminated to the membership in early 1974 in the form of voluntary education guidelines. It acknowledged the association's desire to

... provide the medium for disseminating information, ... providing educational experiences that will maximize the skills and knowledge of health care and other personnel concerned with the discipline of financial management. ...

It also recognized the association's role in meeting "the full spectrum of needs from basic educational efforts to continuing educational needs of accomplished professional personnel."

The issue of voluntary versus compulsory education was hotly debated, but the HFMA invariably opted for a voluntary approach that expressed faith in the innate professionalism of the association's membership. To this end, the association encouraged members to experience 30 hours of continuing education annually by providing them with a special form for individual record keeping. From time to time, HFMA's educational offerings were also deemed eligible for continuing education credit from other organizations, such as those representing nursing homes. However, because states had varying requirements, individual registrants usually had to verify that a program would win acceptance by a state group. In 1980 the HFMA adopted the policy and procedure originally developed by the American Institute of Certified Public Accountants. As a result, most HFMA educational programs now conform with AICPA's requirements for development and implementation and for educational credit under its continuing professional education guidelines.

FIVE

The Journal and Publishing



*Good, the more
Communicated, more abundant grows.*

John Milton

The Journal

More than a year elapsed between the time that the association began planning for the first issue of a periodical and its initial publication. The road was a rocky one, as already chronicled in Chapter One. Because the printer of the first journal was unqualified to perform the job, the production quality of the issue was poor. Later, when the printer tried to ship the journals to Chicago for binding, they were inexplicably lost.

To compensate for these delays, committed leaders like Bill Follmer sorted and stuffed one issue of the journal by hand and later disseminated several mimeographed news bulletins and one mimeographed issue of the journal.

Despite these management and production problems, the association was proud of the result. The first issue of the journal was a 50-page, 8½-by-11-inch publication with a blue cover that featured a photograph of "Our President" Frederick T. Muncie, CPA. It was the beginning of what would become one of the association's most respected and useful membership benefits.

In 1948 the association's officers made a formal decision to publish the journal monthly, with the exception of July and August, that would contain "a message from the President, reports of the Vice President and directors-at-large, articles, etc." Although the association had no plan to sell subscriptions, it hoped to sell at least two advertisements per issue.

Despite these high hopes and idealistic goals, the first issues of the journal were modest in size and appearance. The seven issues published between April and December 1949 averaged less than 20 pages and used a simple yellow cover stock imprinted with the title *Hospital Accounting: Official Journal of the American Association of Hospital Accountants* and the association's seal. The president's message kicked off each issue and briefed members on association plans and programs.

Although most issues featured sporadic news about the association, it wasn't until September 1949 that the journal reported on chapter activities. The April 1949 issue featured heavy promotion of the annual national institute, and the September 1949 issue featured a three-page follow-up report on the event. The November journal published 1950 election results, along with notification of Helen Yerger's resignation and Fred Morgan's appointment as the new secretary-treasurer. At the conclusion of Mehler's one-year term as president, the board appointed him the journal's managing editor.

At the 1952 board meeting, association leaders recommended journal format changes that would produce additional space for articles. In addition, leaders reinforced the push to obtain more quality articles by pursuing chapter members, monitoring other publications and conferences, and even conducting a contest. Association leaders also suggested that chapters tape record presentations that the editorial staff could transcribe and convert into articles. Although the association subsidized the purchase of a tape recorder, the practice of recording chapter presentations never yielded significant results. As an alternative, the board developed a quota or point system that rewarded chapters for submitting articles for publication. This action represented the beginning of the Graham L. Davis (GLD) Award for Chapter Achievement.

As the journal continued to develop, the association's president, secretary, and editor participated in routine editorial decisions that ultimately evolved into a more concrete editorial policy. On one occasion, association leaders debated a highly controversial article and eventually decided to publish it with a disclaimer:

The statements and opinions appearing in articles and departments are those of the authors and not necessarily those of the AAHA. The editorial staff believes that the contents of the journal are interesting and thought-provoking, but the staff has no authority to speak for the officers or board of directors.

In addition, the association continued to reaffirm its decision not to compensate authors for articles. Throughout 1953 and 1954 the journal's appearance was easily recognizable and its contents and graphics remained virtually unchanged. Chapter coverage expanded as more and more chapters joined the ranks, and membership growth statistics appeared regularly. In accordance with its officially stated purpose, information and announcements about association activities were intermixed with a selection of three or four technical articles per issue. In 1954 the November issue was replaced by the distribution of the Proceedings of the Annual National Institute at Indiana University, and a volume of nine issues a year continued until 1960 when the November issue was reinstated.

In 1960 association members found relief from the traditional summer journal hiatus by receiving an expanded "Notes from National," a newsletter usually reserved for chapter officers. Shortly before that time, the association had introduced a 12-lesson professional development series. Authored by Vann Seawell, the series oriented "members who are new to the field and who are in need of indoctrination in hospital accounting" and "those members who are established in the field, but who, because they are so engrossed in the day-to-day practicalities of their work, tend to lose sight of good hospital accounting theory."

Fellowship Questions

Initially, the association published fellowship examination questions and answers in the journal, but then decided to provide questions and answers through a journal supplement. In 1965 the journal initiated the practice of publishing examination questions in one issue of the journal and following up in the next issue with the question's solution as well as another question. The concept grew out of the experience of a finance professional who decided to learn about the hospital field by studying examination questions from the previous year, developing answers, and then comparing the answers with those published. This series of questions and answers continued for five years and was discontinued in 1970.

The association in 1974 initiated its current practice of publishing examination questions and suggested solutions in each issue of the journal with the query and challenge: "If you had to, could you pass the FHFMA or CMPA exam today? Test yourself!" The editor published several questions and promised sample solutions in the next issue. With its educational value and track record clearly established, "Test Yourself" became a monthly feature that alternated questions from the Fellowship and CMPA examinations and presented sample solutions in the next issue.

The Editorship

As the new executive director in April 1958, Hugh Brown brought with him a solid professional background in journalism and public relations, and the journal immediately began to harvest his expertise.

Use of the inside back cover for announcements, advertisements, and slogans expanded the printed capability of the 24-page journal. Colored pages from time to time made special announcements or presented special features, such as "Chapter Chatter" and the annual index. Special typefaces were purchased to provide style and attractiveness to technical articles. The journal clearly took on a professional look, and compliments were heard from many sources.

Hugh Brown resigned as executive director on February 28, 1959, and I succeeded to the position on June 1. A contract was negotiated with Brown to serve as editor of the journal. The arrangement worked well. Brown, whose home was in Xenia, Ohio, arranged for the journal to be printed there where he was in a position to oversee its production. A once-a-month trip to Chicago for a day-long conference with me provided the necessary exchange of selected and edited manuscripts, and discussion concerning their handling and graphic elements. Customarily, I selected from among the always plentiful supply of manuscripts those that attracted particular attention due to subject matter or authorship, or that fit into albeit somewhat sketchy publication plans. However, thanks to chapter response to the requirements of the Graham L. Davis Award, we never had to scratch for an acceptable manuscript, and the inflow enabled us to plan ahead satisfactorily.

Hugh Brown's contract was renewed every year through fiscal 1964-1965, but late in 1964, he announced that he would no longer be able to fulfill his "moonlighting" contract.

January 1960 signaled the debut of the first special issue of the journal. Focusing on credit and collections and motivated by an unusually high number of

manuscript submissions on the topic, this issue was the first of many specially published journals. Theme issues also were introduced and the journal developed its May issue around the topic of personnel practices to tie in with National Hospital Week.

Reaching Its Potential

Despite the journal's initial success, the association realized that it had not yet fulfilled its potential. With Brown's resignation I recommended that the association expand the journal from 32 to 40 pages and transfer production facilities back to Chicago. Beginning in September 1965, every issue of the journal featured a unique custom-designed cover that either reflected the subject of the lead article or the projected theme. Although some covers have showed similarities in style and approach, no cover has ever been reused.

When the association changed its name in 1968, the journal also changed its name from *Hospital Accounting* to *Hospital Financial Management*. Readers learned of the change through the final issue of *Hospital Accounting* that appeared in September 1968 and pictured the October inaugural cover of its successor, *Hospital Financial Management*. Billed as a special "membership issue designed to publicize the name change," the association disseminated copies to administrators of all short-term general hospitals and to 2800 administrators of extended care facilities.

Every few years, the journal expanded in size to accommodate a steadily growing supply of professional and technical information. At the same time, commercial and technical advertising expanded, necessitating additional pages. Because there was a paucity of literature extant on hospital financial management, special issues and theme issues were popular. Theme issues included two or more complementary articles on a single topic in addition to the issue's more general subject matter. Topics included management, data processing, prospective reimbursement, fringe and personnel benefits, uniform accounting, inventory management, leasing, investments, accounts receivable management, planning, working capital, budgeting, and public relations.

Impact of Medicare

The months leading up to July 1, 1966—D-Day for the implementation of Medicare—were hectic ones for the hospital field.

The nature of AAHA's role remained obscure, because neither the American Hospital Association nor the Blue Cross Association was able to obtain definitive information concerning its own particular role. In anticipation of fulfilling an educational function, AAHA planned to present a course at the 1966 annual national institute on "Cost Reimbursement and Medicare," with Ray Everett as course developer and coordinator, and the Friday morning general assembly was planned to be devoted to Medicare.

When the executive committee met on April 29, 1966, definite information about Medicare implementational procedures was still lacking. (Not until May 2 did Commissioner Robert Ball of the Social Security Administration release the first public information about a program that was to be in place within 60 days. He did so in a speech given in Minneapolis before the Upper Midwest Hospital Association's annual meeting.)

The AAHA Executive Committee decided to move ahead with a special issue of the journal in June devoted to Medicare. It was agreed that assignments of specific subjects would be made to a number of qualified and informed people with the request that each write a concise, informative article within a two-week period. The Executive Committee also authorized a budget amount to cover the printing and distribution of extra copies of the June Medicare issue to administrators of all short-term general, voluntary, proprietary, and state and local government hospitals.

The demand for copies, sold for one dollar each, was so great that the journal went back on the press and 2500 additional copies were printed. Several hundred copies were purchased by the Social Security Administration and distributed to field personnel across the country. During the AHA convention that year, the AAHA display booth was busy handing out complimentary copies.

Introducing "Updata"

In addition to keeping members informed through the journal, the association wanted to keep finance professionals briefed on the association's involvement in a variety of regulatory, legislative, or research projects such as requests from government agencies to react to proposed regulations. Keeping the membership up-to-date and informed of these developments was the mission of "Updata," a four-page insert in the journal. Introduced in July 1971, the first edition included items on Medicare's 8.5 percent nursing salary differential, the AICPA Hospital Audit Guide, causes of bankruptcy, unemployment insurance, the application of law to hospitals, and status reports on relevant legislation. Although readers responded enthusiastically, limited funds prevented publication of "Updata" as a monthly feature until October 1972.

"Updata" was the first thing readers saw as they opened the journal's cover. Even when the association changed the journal's binding from a stapled to perfect-bound book, "Updata" continued to occupy its position of prominence at the front of the publication. When the association opened its Washington office in October 1973, "Updata" provided a convenient and respected vehicle to communicate news of the Washington scene.

Readership surveys confirmed what association leaders had known intuitively for years: "Updata" had the highest readership of any journal feature. One survey indicated that more than 93 percent of readers read a specific issue of "Updata."

In 1972 the board directed the editorial staff to prepare and publish articles in the journal relating to current issues rather than waiting for a pertinent article to come from other sources. To initiate this concept, Editor Patricia Weide (who had assumed this position in 1968) began interviewing prominent healthcare figures about issues in healthcare financial management. The first interview was with the controversial Herbert S. Dennenberg, Pennsylvania's insurance commissioner, and the interview itself stirred controversy within HFMA ranks. However, the draft had been read by two HFMA officers from Pennsylvania and they had agreed it was clearly an opinion piece.

Over the course of the next five years, the journal published interviews with such well-known personalities as Anne R. Somers, author, lecturer, and healthcare

economics consultant; Ray Everett Brown, long-time authority on hospital management issues; John Alexander McMahon, president of the American Hospital Association; Congressman Al Ullman of Oregon on his national health insurance bill; Canadian economist George McCracken; Louis A. Orsini, director of consumer and professional relations, Health Insurance Association of America; Harold Hinderer, former HFMA president and a member of the Provider Reimbursement Review Board; Walter McClure, Ph.D., associate director, Health Policy Group, Interstudy; and Walter J. McNerney, president, Blue Cross Association.

Articles that editor Patricia (Weide) Rummer, assistant editor Hellena Smejda, Washington office director Ronald Kovener, technical services department directors William Fill and William Oviatt, and I wrote dealt with diverse but temporarily important subjects, such as receivables management, cost explanation, national health insurance, the Taft-Hartley Law amendments, shared services, inflation accounting; PL 92-603, job enrichment, materials management, the financial manager's role, antidiscrimination laws, communications, and public relations. A four-part series on public relations by Rummer attracted widespread interest, and reprints of the series were liberally distributed. A debate by HFMA Fellows on the all-inclusive rate theory, and interviews with internationally known economist John Kenneth Galbraith, with internal control expert Norman Jaspán, and with a Department of Health, Education and Welfare (DHEW) official added to the broad array of staff-written, current topic articles.

Other Departments

In the mid-1960s, President Robert Schultze resurrected the presidential column. Although the column had occasionally advocated or explained the association's position on an issue, it now more typically featured the president's personal views on professional, technical, and legislative issues. The column, written by the Association's chief elected officer, has continued to the present time.

Currently, with a national president who serves as chief salaried officer, HFMA has gained recognition and strength, and its opinion is sought on important matters of public policy; the president's columns have reflected that imperative.

As the number of chapters within the association continued to grow, the few paragraphs that the journal devoted to chapter news evolved into several pages. In the late 1950s, "Chapter News" became "Chapter Chatter," a feature that served as a communication link among chapters and as a practical resource about speakers, conference topics, and trends. Of special interest to members and chapter officers is the Graham L. Davis Award scoring chart, which has appeared in the journal every month since its introduction in the late 1950s.

Special columns provide a useful journalistic vehicle for technical material. For example, in the early issues of the journal, associate editor Robert Reeves supplemented his "Question Box" feature with a listing of "recommended reading" that referenced articles in other publications. In the late 1960s, Reeves developed "Quoteworthy," a column that included sentence-length quotes from the healthcare media.

In the early 1960s, Frederick E. Krizman, an attorney and former association board member, provided material for a legal series that reported on the tax status

of hospital-affiliated nonresident aliens, Form 990-A requirements, and FICA rulings. In the early 1970s, a short-lived "Tax Clinic" made its debut, followed by another column called "Payment Patterns." Authored by a staff member in professional affairs, this column focused on patient accounts receivable, using Hospital Administrative Services media figures published by the American Hospital Association. Other columns have been written over the years reflecting changing industry trends and interests of members.

Advertising Sales

Although association leaders from the beginning supported the concept of paid advertising within the journal, no aggressive action to solicit advertising was authorized by the board until 1969. In June 1951 the first journal advertisement made its debut. The black-and-white ad featured the McBee Keysort Charge Ticket System under the caption, "American's hospitals face their toughest case." Encouraged by this breakthrough, the board developed the base advertising rates of \$100 per page for a 10-issue contract, and \$125 per page for a single insertion.

Board members were assigned certain companies to solicit advertising, but responses to letters were meager. An interview with a consultant in 1952 disclosed that a circulation of 5000 copies was essential to attract commercial advertising. Under the experienced Hugh Brown, contacts were made, and more ads began to appear in 1958 and 1959 (rates had been increased despite circulation of only 3500 copies).

For several years thereafter, the association reevaluated the issue of external support for advertising sales by surveying the journal's readership. According to a survey that appeared in the August 1964 issue, readers not only read the journal but also shared it with other personnel in the hospital. Finance professionals saw the publication not as a throwaway item, but as a valuable reference for their libraries. This finding led association leaders to sell binders in which journal readers could conveniently retain their copies. In addition, because the association had obtained some data on how readers made their purchasing decisions, they were able to apply this information in appeals to potential advertisers.

By the mid-1960s, the journal's regular advertisers included Marshall and Stevens, Doctors Service Bureau, American Appraisal Company, Physician's Record Company, National Cash Register Company, and Royal McBee. In addition, the journal had carried short-term advertisements for IBM, Associated Credit Bureaus of America, Reynolds & Reynolds, the American Society of Hospital Pharmacists, W. B. Saunders Company, Industrial Appraisal Company, American Hospital Association, Monroe Calculators, and Standard Register Company. Despite the fact that the association had no external advertising support, revenues from paid advertisements continued to grow.

By 1969, in view of the association's success with advertising and its commitment to enhancing the journal's quality and uniqueness, the board authorized a contract with a publication consultant, Ned H. McCormack. He recommended discontinuance of third class mailing in favor of second class and membership in the Business Publications Audit of Circulation, Inc. (BPA), an organization that

audits a publication's circulation figures and develops reports for potential advertisers interested in gauging the impact of their advertising dollars. The association began to list the journal in *Standard Rate and Data*, a directory of publications referenced regularly by advertising managers and agencies. Professional advertising sales representatives were contracted with in New York, Chicago, St. Louis, Atlanta, and Los Angeles. Currently three sales representatives cover the East, Midwest, and West territories.

The journal carried 21 pages of commercial ads in 1969, and in 1981 there were 323 pages. By 1991, the journal carried 737 ad pages. Although the debate concerning the value of advertising resurfaced from time to time, by the early 1970s the association concluded that "the increase in advertising revenue (over) the past several years had enabled HFMA to improve the quality of its journal and of other activities." Also the board has always insisted on an acceptable ratio of advertising to editorial content.

Subscription Sales

Just as the issue of selling paid advertising had provoked conflict over the years, so did the issue of subscription sales and, more generally, the appropriate role of sales professionals within the association. In the 1950s, board members considered the issue of membership eligibility for commercial salespeople. After denying them membership, the board approved journal subscriptions at an annual rate of \$15 and subscriptions at \$10 for not-for-profit organizations.

In the mid-1960s, the association's Executive Committee considered a recommendation that chapters purchase and then donate subscriptions to the libraries of university schools of business. In the summer of 1967, the board approved special journal subscription rates of \$5.00 for one year and \$7.50 for two years to "students of schools requiring journal reading for hospital administration students, with a free copy to the instructor." Under this plan, the association sent journal copies in bulk to the instructor who then disseminated the copies to students.

Valued Member Service

During the 1980s, the association continued to make refinements to the journal to strengthen its usefulness as a member service and to further position the publication in the marketplace. Primary and secondary research showed throughout the decade *Healthcare Financial Management* remained the preferred industry publication among readers. Member market survey results showed *HFM* to be the most valued service provided to the membership, and by a wide margin, to have the highest satisfaction level over other products and services offered by the association.

By the middle of the decade, research was further supplemented with semi-annual advertising readership studies that measured the reader impact of the advertising printed in *HFM*. The adoption of the reader profile studies and advertising studies added to *HFM* sophistication in the advertising community. Throughout the 1980s the BPA audit helped HFMA document its phenomenal membership growth to the advertising community.

HFMA hired its first full time advertising manager in 1980. Prior to his hiring, the responsibility for advertising sales management fell to the editor. The addition

of the position resulted in increased organization of the sales effort and improved customer service. In 1989 a salesperson was hired to replace the independent representative in the Midwest sales territory to gain greater depth in sales and control of efforts.

Since 1982 advertising sales for *HFM* have quadrupled, making it the third largest revenue producer for the association and the second largest nondues-related revenue item.

Another Name Change

Raymond J. Cisneros, chairman of the board, wrote in his January 1982 *HFM* column, "Time to Act,"

During the past several years we have heard from Association members, chapters, committees, and councils that it is time for another name change to reflect the industry of today and to provide a better description of our function. It was suggested that the broader more comprehensive name Healthcare Financial Management, more accurately describes who we are in the broader arena in which we operate.

In June 1982, both the association and the journal adopted a new name when the word *hospital* was replaced with *healthcare*. This change was supported by an overwhelming vote of the membership in favor of the change.

During the 1980s the name was the last of the changes made to the publication. In 1985 *HFM* was completely redesigned to sport a more contemporary and readable format. During the same time, special reports were incorporated to allow for articles with similar themes to be tied together both graphically and editorially.

Growth during the 1980s came in the form of both advertising and editorial pages. After 1979 nine new columns were added to *HFM* to supplement the technical articles that have long stood as the basis for editorial content. Topics included management issues, legislation, treasury management, information systems, personal finance, and Medicare litigation. Most new columns were inspired by the changes in the industry and from input of the Matrix Council on Communication. This group played an increased role in editorial guidance after the demise of an editorial advisory board in 1984. For many years a peer review system gave the staff a means for measuring the timeliness, relevancy, and technical accuracy of feature articles submitted for publication, by enlisting three specialists to review each article prior to publication. The first editorial calendar for *HFM* was published in 1984 and served as a plan for editorial acquisitions and aided advertisers in selecting issues for ad placement.

To further measure the needs of the readership, reader profile studies became a common practice during the 1980s. The objective of these studies was to gather information on the readers of the journal and their readership habits. Basic demographic and buying influence were measured. This information was used to attract national advertisers to the periodical. These studies enabled the sales force to construct a profile of the reader/buyer reach available to advertisers placing space in *HFM*. In addition, the reader profile studies provided the editors with an excellent primary source on likes and dislikes of the readership.

Newsletters and Brochures

“Notes from National” and “PumPrimer”

In the late 1950s the association’s Committee on Chapters recommended the publication of a chapter officers’ newsletter to explain and advocate official association issues and encourage activity within chapters. Volume I, Number 1, of “Notes from National” was launched in 1956. The newsletter’s popularity and value prompted the association to use the same name on a series of special newsletters initiated in 1960 to communicate with members during the summer months of July and August until 1970, when the Journal began its 12-issue cycle. In 1964 the association began to send extra copies of “Notes from National” to each chapter’s president for redistribution to directors and committee chairpersons.

Sharing popularity with “Notes From National” was “PumPrimer.” First published in 1968, this newsletter was targeted to chapter newsletter chairmen who sought information on the mechanics of editorial production and copy or recommendations for content. Newsletter chairmen were expected to duplicate and use much of the material verbatim, and restricted distribution ensured that the information was fresh and new to the chapter’s readers. Other special interest newsletters were published from time to time for chapter membership chairmen (“Membership Matters”) and for program chairmen (“Program Pointers”).

“Patient Accounts”

Given the association’s success with publishing internal newsletters, it was no surprise to learn that readers would support four-page monthly newsletters sold on subscription in the areas of patient accounts management, data processing, and the concerns of the healthcare chief financial officer. Survey findings prompted the association to initiate plans for publication of a four-page “Patient Accounts” newsletter. Three-fourths of those surveyed had indicated they would purchase an annual subscription for such a newsletter. Launched in June 1978, more than 1500 subscriptions had been sold by October. Unfortunately, field testing of the other two planned newsletters did not reveal adequate acceptance, although a CFO-sponsored newsletter, “Chiefly Financial,” did appear from 1985 to 1987.

The first issue of “Patient Accounts,” launched in June 1978, was mailed to the entire membership accompanied by a subscription form: \$25 for twelve issues. When the idea of publishing a specialized newsletter first surfaced, some members were curious about how it would fit into HFMA’s existing publishing program. Specifically, staff was asked how such a publication would tie in with *HFM*. The association decided to concentrate on patient accounts management because readership studies and other feedback from the membership indicated a widespread interest in this area.

“Patient Accounts” was launched to meet the special interests of patient accounts managers. In addition, a newsletter format was chosen to allow for a shorter production cycle that would enable the editors to publish patient accounts news in a more timely fashion than was possible for *HFM*.

Through most of its history, “Patient Accounts” has retained the same appearance with minor corporate identification changes made in 1984. In August

1989 the publication was completely redesigned. Competition from other newsletters, expanded coverage of issues, increased appeal and attractiveness, and advertising space sales were the objectives of the new design strategy. The new 11-by-17-inch broadsheet format allowed for increased editorial copy as well as advertising, at little extra expense.

But it was soon clear that the editors hadn't "listened to the customers." Although most readers felt the new design was attractive, many found that the new format made it difficult to store the newsletter and share with others. The newsletter returned to an 8½-by-11-inch format in January 1990 and had some 2600 subscribers at its height.

"Career Advancement"

In response to requests from the Kentucky Hospital Association in the mid-1950s, the association developed job opportunity brochures for use by high school and university guidance counselors. After gaining the interest of the American Hospital Association, President Henry Hottum appointed a national Publicity Committee that developed a kit to promote healthcare careers for distribution during National Hospital Week in May 1957.

This was the first of many career-oriented initiatives. In the mid-1960s, the Special Educational Advisory Committee appointed to examine the educational foundation's programs argued for aggressive promotion of careers in hospital accounting and, as evidence, cited the growing need for top-quality financial professionals in the field. The appeal worked. With funds contributed by Indiana University, the association printed an attractive career brochure and arranged for its inclusion in the distribution of career information kits by the Accounting Careers Council, an organization supported by the American Institute of Certified Public Accountants, the National Association of Accountants, and other national accounting organizations. In 1989 a new brochure was developed on the theme, "Reach for Your Best," and some 1200 copies a year are distributed.

From the beginning, William Follmer received requests for assistance in job seeking, and the journal ran notices of job opportunities. The volume grew and was handled manually by various staffpeople as time permitted. Resumés from individuals were matched as closely as possible to job opportunities and were sent out to potential employers under a cover letter that contained an appropriate disclaimer. After Medicare was enacted and job opportunities mushroomed, AAHA purchased advertisements in the AICPA journal inviting resumés for jobs in the growing hospital field.

Book Publishing

In attempting to get a foothold in the hospital field in its formative years, leaders of AAHA appointed a Research Committee to seek out project ideas that would contribute to the field. In 1953 the committee decided to develop a guide for the retention of records. First viewed as applying only to financial records, the research showed that guidelines for other hospital-generated records did not exist, or where legally mandated retention rules existed, the guidelines had not been brought together in a convenient reference source. Working only with volunteer help,

progress was slow, but the committee pulled bits and pieces of such guidelines together.

In 1955 with AAHA then located in Chicago, the Research Committee, headed by Chicagoan Louis Sokol, discovered a record retention manual published by Records Control, Inc. Arrangements were completed with that company to publish a special edition of its manual including a hospital records insert. A questionnaire was sent to a number of hospitals to gather information on current practices of record retention, which resulted in "recommended retention periods" in the eventual booklet.

The manual, *Guide to the Retention and Preservation of Records and Destruction Schedules, Hospital Edition*, was published in 1958 and enjoyed six reprints over the years. In 1990, an expanded and much more sophisticated book, *Healthcare Records: A Practical Legal Guide*, by Jonathan P. Tomes, J.D., was introduced as a replacement of this "bestseller" manual.

In the early 1960s, the association, aware of the need for literature in the hospital field, worked to meet the needs of its members while getting extra mileage out of its more popular and respected journal articles. In developing compilations of journal articles, such timely topics as credits and collections, managing patient accounts, safeguarding hospital assets, planning hospital financial operations, and hospital business office management were covered. Interestingly, three of these publications were translated into Portuguese by an organization in Brazil. The edition that focused on managing patient accounts was so popular with members that it quickly went out of print and motivated the association to develop a complete book on the topic.

Vann Seawell's Contributions

In many ways the association's success with books was no accident. Book publishing had always been part of its heritage. In the 1950s, the association orchestrated negotiations between L. Vann Seawell and Physician's Record Company, the Chicago-based publisher that in 1960 published his text, *Principles of Hospital Accounting*. Originally developed as part of a correspondence course, Seawell's first major success in publishing eventually led to his second book, *Hospital Accounting and Financial Management*, in 1964 (also used as a correspondence course text). So popular was Seawell's first effort that in 1968 the association's board authorized a rewrite of the then 10-year-old manuscript and offered to publish it under the association's name. Since its first publication, *Principles of Hospital Accounting* has sold more than 5000 copies, and its companion practice set has sold more than 2000 copies.

Indiana University reported that the basic correspondence course had attracted more than 2500 participants since it began in 1955. So critical was the role of correspondence courses to the association's total education program that in the late 1960s the Committee on Education authorized the revision of Indiana University's three courses. The hospital accounting profession had changed radically since the advent of Medicare in 1966, and the committee wanted to assure the American Hospital Association, which had endorsed the courses, of their ongoing quality.

But even more significantly, the committee wanted to reinforce the association's central role in publishing written materials and texts for the finance and accounting professions. Among the reasons cited for increased association involvement in publishing were lack of uniform quality in current publications and the track record that other national accounting organizations had established in publishing. In addition, committee members sensed the advantages of offering association members yet another vehicle for professional development, and later authorized underwriting the development and publication of a revised accounting principles textbook. It was decided that the book would be targeted to those persons who had hospital bookkeeping or accounting responsibilities, but who had little or no formal training or experience in accounting.

In addition, it was stressed that Seawell would write a text with a financial rather than an administrative approach and develop the material in such a way that readers would experience the equivalent of one college-level course in accounting. Furthermore, it would conform with procedures outlined in the 1966 *Chart of Accounts* published by AHA.

Assurances were received that Indiana University would revise its correspondence course when the textbook became available. In January 1968 the board authorized the expenditure of not more than \$24,000 to publish the association's first textbook. After negotiating a release from the author's contract with Physician's Record Company, the association published *Introduction to Hospital Accounting* in May 1971. Writing in the *Journal of Accountancy*, David Drinkwater, CPA, professor of accountancy at Babson College, in Massachusetts, wrote:

There is no question that this text will make a contribution toward interesting those persons not now engaged in the hospital field and thereby increase the supply of professionally trained administrative professionals—a supply upon which the demands are great.

Drinkwater's opinions concerning the book proved to be correct. In just three years after the initial printing, the book sold some 3000 copies and subsequent editions updated the text. So popular is this text that it has been updated and a new edition of the complete package—textbook, *Solutions Manual*, and *Practice Set*—is being published in 1991.

Although the association wanted to move ahead with the revisions on Seawell's second classic, *Hospital Accounting and Financial Management*, the project experienced several delays. Eventually, the association shifted gears and recommended the development of a brand new intermediate text. This new text would reach beyond the needs of professionals who had completed their first correspondence course with Indiana University and were ready to enroll in the second. It would also serve qualified, experienced accountants who were new to the hospital field, financial managers and administrators who needed a reference on hospital accounting, and faculty and students in master's programs in hospital accounting. The book was eventually published in 1975 under the title, *Hospital Financial Accounting Theory and Practice*.

Meanwhile, the Physician's Record Company had sold its stock of the 1964 publication and had released the contract and copyright to Seawell and the association. Only two years passed before the book sold out and the association ordered a reprinting.

Office Management and Management Accounting

The association's publishing efforts continued. After being approached by Beaufort B. Longest, Jr., Ph.D., then assistant professor at the Institute of Health Administration at Georgia State University, the association moved toward publication of a basic book on hospital business office management and, in 1975, published *Principles of Hospital Business Office Management*. Unfortunately, the book never reached the popularity of the Seawell texts.

However, the association's fourth venture into publishing was a different story, a direct result of the Executive Graduate Program created by the association's Educational Foundation with grant funds from the W. K. Kellogg Foundation. Two professors at the University of Colorado, James D. Suver, DBA, and Bruce R. Neumann, Ph.D., outlined the need for a definitive text on management accounting targeted to healthcare organizations. Because the proposed text would focus on the managerial aspects of accounting, the authors argued that the book would supplement rather than compete with the Seawell text, *Hospital Financial Accounting Theory and Practice*. The association approved the project, and *Management Accounting for Healthcare Organizations* reached the marketplace in the summer of 1981 and was further revised in 1991 with the help of a third co-author, Keith Boles.

Expanded Publishing Program

In the past two decades additional references and books were published for the member, academician, or student in healthcare degree programs. The association saw book publishing as an extension of its education and information role, as a way to exert its influence in setting professional standards and procedures within its field, as a method of raising its own visibility and credibility within the field, and as a supplement to association revenues other than dues. At various times it employed a book editor to assist in these projects, and in 1988 employed a book acquisitions manager, Alice McCart, to increase the association's depth in both content and revenues in this area.

SIX

The Washington Branch as Our Eyes and Ears



History is past politics, and politics present history.

Sir John Robert Seeley

The concept of an association office in the nation's capital had surfaced among some association leaders from time to time. Serious thought and discussion about a Washington office emerged during the years of the Economic Stabilization Program (ESP) from 1972 to 1974. ESP was a thorn in the side of all industries, and the healthcare industry was particularly stricken with regulations that may have been feasible for others to apply but were unwieldy, confusing, and disastrous to healthcare institutions.

Amid the blizzard of rulings and regulations, dictates and contradictions, the membership asked questions: "Why doesn't HFMA go to the scene of the action?" "Why don't we know what's happening on a day-to-day basis?" "Why is no unified voice of technical expertise heard?"

Advocacy

In response to this membership desire for action, the Executive Committee met in June 1973 with Gregory H. Moses, Jr., CPA, director of the Health and Exceptions Division of the Office of Price Monitoring within the Cost of Living Council, the administrative authority for ESP. President Ida Milanese had already proposed using the journal to highlight regulatory issues.

When Moses learned what the association intended, he responded that nothing could be as valuable to HFMA's initiative as a full-time staffperson based in Washington. He acknowledged that the government frequently changed rules, and that even though these changes were published, organizations such as HFMA had a responsibility to find out about the changes themselves.

Acting on the Executive Committee's recommendation, the board authorized me to investigate establishing a Washington liaison. In the summer of 1973, I interviewed a partner at Arthur Young & Co.'s Washington office. I also checked

on the feasibility of linking with one of the many Washington-based organizations that furnished information services to other associations.

After reviewing Arthur Young & Co.'s proposal to represent HFMA, the Executive Committee concluded at its August 1, 1973, meeting in Chicago that working with a CPA firm presented too many obstacles. Furthermore, clearly most Washington-based consulting and public affairs firms could not offer the specialized technical expertise HFMA needed. The committee decided that the best way to fulfill the membership's need for timely feedback and action on regulatory and legislative issues was to establish a Washington office staffed and managed by HFMA personnel.

An August 3 memo from President Milanese outlined the background of the Executive Committee's recommendations. "Public accounting firms can and will provide us with Washington representation," she wrote, but she identified limitations inherent in that approach, including:

- *Identity:* "The firms would likely retain their own identity and HFMA would remain faceless."
- *Advocacy:* "The firms could only advocate positions with which they were in agreement."
- *Scope:* "Affiliating our service with other [organizations] might be complicated by the multiple agreements and clearances necessary."
- *Competition:* "This close affiliation with a single firm could damage affiliation with other firms. Even within a single firm there would be a pull between client needs and HFMA needs."
- *Priorities:* "This alternative would continue to require most of [technical services staff] effort on legislative matters, leaving other technical areas still unsatisfied."

The report concluded that although other organizations could provide representation, they lacked technical competence in healthcare financial management, making their use "practical only as an adjunct to another approach and not practical if considered alone."

Milanese's memo also estimated the costs of operating a Washington office for one year but noted that the proposed budget was considerably less than those submitted by CPA firms for a full-scale program. Moreover, she indicated that prior to the Executive Committee meeting she, Ron Kovener, Joe Legel, and I had met with John Alexander McMahon, president of the American Hospital Association. Milanese and her colleagues advised McMahon of HFMA's intent to establish a presence in Washington and pledged HFMA's commitment to avoid duplication of effort or conflicting views. McMahon appeared amenable to the plan and promised to discuss the decision with Leo Gehrig, director of AHA's Washington office. A conference call among members of the board of directors on August 8 resulted in a 12-to-1 decision to proceed with the establishment of an HFMA office in Washington with the first year's budget set at about \$70,000.

On August 23 the Executive Committee met again in Chicago to act on the board's decision to establish a Washington office and to develop plans for implementation. One member of the Executive Committee, immediate Past-President Ron Kovener, was deliberately absent from the meeting because of his expressed interest in serving as manager of the new office. At the conclusion of its

deliberations, the committee offered Kovener the position. Shortly thereafter, I traveled to Washington to secure temporary office space, which fortunately was offered at no charge through the Hospital Council of the National Capitol Area.

The office was officially opened on October 15, 1973, with Ronald R. Kovener, HFMA's newly named associate executive director, as its manager. In making the announcement, Milanese noted that a Washington office would offer members "timely information about pertinent regulation and legislation and create a channel through which HFMA can inject technical knowledge into the development of proposed regulation and legislation." She concluded by reiterating HFMA's intention "to work as closely with the American Hospital Association in this endeavor as we have done in our other activities over the years."

The association established these objectives for the Washington office:

- Collecting information about regulations and legislation that affect the healthcare financial management profession
- Communicating pertinent information to HFMA's members
- Offering input into the development of regulations and legislation
- Facilitating legislative action by HFMA members
- Coordinating these efforts with related organizations

The First Year

The Executive Committee outlined duties and responsibilities for Kovener and, shortly thereafter, met with HFMA staff in Chicago to discuss the integration of Washington activities. When Kovener agreed to take the new position, he resigned as chairman of HFMA's board of directors and became the second immediate past-president to become a staff member. The board of directors appointed William Van Lopik to fill the vacant board position. Shortly thereafter, Kovener and I spent two days in Washington to meet with William Bucher, director of the Hospital Council of the National Capitol Area, personnel from AHA's Washington office, and officials of the U.S. Chamber of Commerce.

HFMA established its first Washington office at 1812 K Street, N.W., an arrangement that continued until December 1974. Then the association signed a two-year lease for new office space at 1712 I Street, N.W. The new office location was close to the AHA's Washington office and to several other organizations with which Kovener had established contact. In December 1975 the Washington office moved to its present location at 1050 17th Street, N.W.

Despite widespread support for HFMA's Washington presence, not all members of the association agreed to its value. Milanese responded personally to several written complaints, and the board of directors developed a carefully crafted rationale for its decision. Anticipating some resentment and opposition, the board also agreed that there would be no dues increase during the two-year startup period. In this way, the board hoped to short-circuit complaints that members' dues had been used to fund the Washington office.

Kovener's First-Year Priorities

Kovener's first anniversary report revealed a remarkably busy year. Following a management by objectives methodology and a list of job responsibilities outlined by the board of directors, Kovener reported that he had spent 35 percent of his

time collecting information as background for official decisions and communications. Most of the information came from the Cost of Living Council and related to the Economic Stabilization Program. Facilitating communications via WASH-LINE; preparing "Updata" news pages for the journal; responding to members' calls and letters; and making appearances at national, chapter, and other educational programs consumed 45 percent of his time. Offering technical input to the Cost of Living Council consumed 10 percent. In keeping with the board's direction, he spent little time in legislative activity.

Kovener's arrival in Washington coincided with indications of new regulations to continue cost control of hospitals. Although the government had liberated most industries from cost controls, it continued to exercise control by extending its regulatory power over the healthcare field. Representatives from AHA and HFMA met in Chicago to develop a plan of action in the event that Phase IV regulations that applied to hospitals were enacted.

Previously AHA had asked HFMA to consider the kinds of information and management systems that institutions needed to cope with the economic constraints of the admission control proposal anticipated in Phase IV and to develop educational programs to address anticipated budget and financial controls. Because AHA had expressed public opposition to Phase IV, it was unable to indicate its intent to comply with eventual regulations. HFMA, in contrast, had advanced no public position and was free to plan for the anticipated changes.

John D. Twiname had been appointed executive director for health to the Cost of Living Council in early 1973. Twiname and I had known each other since the 1950s, and the long relationship set the stage for cooperative efforts with Twiname in his new role. Twiname was invited to be a keynote speaker at an HFMA conference in Williamsburg, Virginia, in November 1973.

Immediately preceding the Williamsburg conference, Twiname called a press conference in Washington to announce the new price control regulations. His keynote address to more than 300 institute registrants was covered by the electronic and print media. Several times during the question-and-answer session, Twiname turned to Kovener, who had wisely offered to drive Twiname to Williamsburg, and remarked, "Ron, we'll have to consider that when we get back to Washington." Ultimately, Congress failed to renew the presidential authority to continue the price controls on hospitals and the Phase IV program expired on June 30, 1974, before it was fully implemented. Unfortunately, the hospital industry never had the opportunity to discover HFMA's role in formulating comprehensible information about an otherwise-incomprehensible control program.

Reaffirming the Washington Presence

Fortunately, at the end of the two-year period, HFMA had established a strong presence in Washington and had achieved recognition for its vigorous leadership on regulatory issues. Aware of the two-year experimental period, a growing number of members expressed concern that the association might terminate its Washington presence. Several specially appointed association committees evaluated Washington office operations and recommended that the initiative be continued.

In 1970 the American Hospital Association began to hold annual meetings in Washington. At this January session, AHA installed its new officers, and state hospital association delegations met with legislators to discuss current issues and pending legislation. HFMA's president and I regularly attended these meetings and found them a valuable resource on new and emerging trends and healthcare management strategies.

Before AHA's 1974 meeting, HFMA advised chapter presidents to consider getting more involved in governmental issues by being part of these state hospital association delegations. Acting on the suggestion of HFMA's Louisiana chapter, Ron Kovener arranged for a reception for HFMA representatives at the Washington Hilton. The event evolved into a tradition and is often frequented by government officials. Each year the association invites chapter presidents to arrange representation in state hospital association delegations and attend an HFMA-hosted briefing and reception.

Contributions of the Washington Office

WASHLINE: News Service for Healthcare Professionals

In February 1974 the association inaugurated WASHLINE, a three-minute weekly recorded message that summarizes current actions and events related to healthcare financial management. HFMA's service was modeled on a similar daily service of the U.S. Chamber of Commerce. Records of callers document that WASHLINE provides an indispensable service to the hospital industry and that it has, on some occasions, scooped other media with timely news coverage. Several associations, universities, and CPA firms have been so impressed with the service that they audiotaped messages for distribution to colleagues. Facsimile subscriptions to this service are now available as well.

Code of Action

The end of Phase IV controls also ended the looseleaf notebook service called Hospital Economic Controls and the HFMA-sponsored series of Phase IV educational programs. Alert to what a lack of external controls might bring and aware of the need for management cost constraints, Kovener drafted a memo that outlined possible actions by HFMA. Following review by HFMA Fellows asked to comment and by the Executive Committee, the board of directors approved the HFMA Code of Action on Controlling Hospital Costs. Published in the December 1974 issues of the journal, the code of action began

In a relieved atmosphere free of legislated economic controls, hospitals are able to make price and wage decisions in the customary way, but there should be an awareness that controls may be reimposed.

The code followed with nine actions that healthcare financial management personnel could initiate to practice effective cost management. The second section of the code encouraged hospitals to "mount an aggressive campaign of information and communications concerning the nature of hospital costs" and suggested how HFMA could assist in these actions. For several years the Code of Action appeared in the journal at least once annually. In late 1978, when the hospital industry was trying to forestall a new threat of economic control through

its Voluntary Effort Program, the Code of Action was updated to reflect the new environment.

Strengthening the Washington Role

When HFMA opened its Washington office, the board of directors expressed a desire to develop one or more projects that would generate revenue and cover some operational costs. But the board developed a policy that entitled HFMA members to receive regular information and assistance from the Washington office as a component of their dues, which precluded the publication of a subscription newsletter. Nonetheless, the Washington office provided information and services on a temporary or project basis to other organizations for fees.

Institutes on Current Financial Issues

With education as the cornerstone of HFMA's activities, Kovener outlined a proposal in early 1975 to develop an educational program that would highlight current issues. Kovener's rationale was that events in Washington had a profound impact on the field of healthcare financial management and that professionals would benefit from a concentrated briefing on the status of topics within healthcare finance. Kovener recommended a standardized program format with variations to keep pace with current issues and concerns. Advance promotion identifying speakers would be intentionally vague so that HFMA could make last-minute adjustments in presenters and topics. Because of the program's contemporary, highly informative focus, HFMA believed that it would attract financial managers with broad responsibilities as well as other key healthcare financial professionals.

The educational services department in HFMA's Chicago office was to handle promotion, and the Washington office was to assume responsibility for selection of program topics, coordination of speakers, and on-site arrangements. The first Institute on Current Financial Issues was held in Washington on August 6 and 7, 1975, with 84 participants. The second program, held on November 6 and 7, 1975, attracted 111 registrants. In 1976, four programs were scheduled for the months of February, May, August, and November. Because only 35 people registered to attend the February program, it was canceled. The May program, however, was conducted as planned, and the three programs scheduled for the 1975 to 1976 fiscal year produced a total registration of 286.

The development of these institutes offered Ron Kovener an opportunity to make contact with critical government spokespersons. At the May 1976 session, the institute addressed such topics as malpractice insurance and anticipated government-mandated uniform accounting and reporting. In addition to offering a luncheon with a noted speaker, the institute featured two nationally recognized healthcare financial management professionals who synthesized the total program during a special closing session.

Although quarterly programs had been scheduled, the legislative process moved so slowly that information on certain topics had become repetitive. In 1978 HFMA decided to conduct only two institutes annually. Nevertheless, the programs continued to attract top-level professionals and received excellent ratings from participants, which testified to the institute's high level of technical quality and exploration of diverse key issues.

Evolving Objectives

When Kovener moved his family to Washington in 1973, he told them that the project would last two years—or perhaps a little longer. In 1990, the 17th anniversary of his employment with HFMA, Kovener changed his role and narrowed his focus to activities that related to financial issues, including work with the Principles and Practices Board, FASB, GASB, and AICPA. At that time, Wendy Herr picked up Kovener's reins as vice president and directed HFMA's policy and government relations activities.

HFMA's objectives have remained the same since the Washington office was launched. As the organization moves toward the 21st century, the goals of collecting information on regulatory and legislative action are implemented through close contacts with government agencies and offices and with other organizations.

Communication, a second objective of the office, is achieved in several ways, including the weekly WASHLINE message. Each year, this service reports a growing number of listeners and continued to adapt to technological advancements when it became available for facsimile transmission to subscribers in 1990.

The technical staff of the office reviews journal articles and provides technical oversight on educational program development. Of special importance to the Washington operation is the opportunity to provide technical review and recommendations to various government agencies.

Much of the input for official HFMA positions comes through the view of chapter task forces. Aware of the growing influence of HFMA's positions on contemporary issues and conscious of the need to accurately reflect the combined opinions of the healthcare financial management field, the board of directors adopted a process for position development early in 1983. The process accommodates reactions in short response periods and long-term development of in-depth policy guidelines. To develop positions on issues relating to accounting and financial reporting, HFMA created its Principles and Practices Board and uses special task forces to study key issues in depth each year.

The office coordinates with other Washington healthcare organizations in building coalitions on mutual interests. A 1990 review examined the role and activities of chapters and the national HFMA office regarding state and local advocacy efforts. A chairman's task force on HFMA's advocacy at state and local levels concluded that chapters were comfortable with their level of involvement in advocacy, and generally underrated their own contributions and level of involvement. Chapters coordinated their efforts with their state hospital associations, as well as with metropolitan associations and with HFMA chapters in states that have multiple chapters.

HFMA's Washington office has built a solid reputation within the membership, other professional organizations, and with government officials. With its eyes and ears always on the alert in our nation's capital, HFMA has evolved into a vital resource and advocate for the healthcare industry.

SEVEN

The Professional Affairs Vineyard



*They sow fields, and plant vineyards,
and get a fruitful yield.*

Psalm 106:37

Professionalism, or the knowledge of the technology of a field, was the root of the tall oak that grew from the seed planted by William Follmer. Over the years, Follmer saw to it that the roots of the association were nurtured by individuals who were committed to improving accounting practices. Follmer, William Dawson, and other members of the Organizing Committee repeatedly attested to the questionable state of hospital accounting and supported the improvement of practice through a national association of hospital accountants.

Unfortunately, disagreement prevailed over the newly created association's objectives. Because of controversy over wording, ratification of the constitution and bylaws consumed more than a year. Some members advocated very specific objectives that spoke of such issues as uniform accounting, uniform statistics, cost accounting, and explaining costs. Others, in contrast, believed in more generally stated goals with specific objectives to be realized through association activities. The five objectives that eventually emerged featured only one technical element—uniform accounting—and used the verb *promote*, not *achieve*.

Because the names of William Follmer and Frederick Muncie were known in the hospital accounting field, both received numerous requests for technical advice and invested significant time in an attempt to address these queries. Although they may have had some personal desire to answer detailed requests for information, they were far more motivated by serving the interests of the fledgling association.

Technical Experts

In the association's early years, some letters expressed disappointment that the association had no committee of "qualified experts" to cope with "interpretation of vexing problems in hospital accounting." In response, Follmer tried to fill this

void by supplementing newsletter mailings to the membership with reprints or copies of technical articles. Later, the association's commitment to provide technical assistance gave rise to the "Question Box" feature in the journal edited by Robert Reeves. Between 1950 and 1955, Fred Morgan responded personally to numerous requests for technical information, aided by the extensive library of pamphlets and clippings he had accumulated and that he subsequently turned over to the association after its move to Chicago.

Although there are no records of how technical queries were handled in the association's early years in Chicago, Bill Pierce probably fielded many of the requests, but his replacement, Hugh Brown, lacked technical competence in accounting issues. The continual flow of inquiries eventually brought about the formation of an accounting reference committee, described in the January 1959 journal as a "group of 22 specialists, largely comprised of Fellows, [and] pledged to aid anyone in the hospital field interested in concrete answers to hospital accounting or bookkeeping problems." Selected committee members were asked to respond directly to a referred question, supplying the national office with a copy for its information files.

When a new class of Fellows was certified, each new Fellow learned of the workings of the Accounting Reference Committee and was invited to participate in its activities. The practice continued until 1971, a year after the association's technical services department was organized, when full-time staff were hired. Staff continued to rely on Fellows and other specialists for advice and support on such issues as pending regulatory proposals, and these interactions, in turn, helped to bring about the development of chapter task forces.

Lending Library

Fred Morgan had given his vast library of articles, original papers, pamphlets, and books to the association. A new lending library service would include more than 2700 papers cataloged under 52 headings, with the single category of "hospital" divided into 18 subheadings. Described as a resource to solve current problems, compare current methods, and develop papers and presentations, the library was also supported by Morgan and AAHA office staff who pledged to continually add to the library's files "keeping it in tune with the times." Invited to submit materials that would help the library maintain its vigor and visibility, members received the following instructions on service:

Your request for information in any given subject will be filled by mailing to you the entire folder of material pertinent to the subject. It will be loaned to you for a thirty-day period. At expiration of that time, folder should be returned intact to this office, or a letter written asking for an extension of time in retaining the material. We know you will welcome this reference library as another of AAHA's services to its membership. Your suggestions for its improved operation will be welcome.

A year later the library consisted of more than 2900 pieces.

But despite these successes, the abundance of material in the library evolved into a major problem. Although new materials were continually added to folders, much of the older material was not removed. AAHA lacked the staff needed to

maintain the library well. As a result, the library received complaints about the confused subject index, which Morgan had developed on his own but which failed to meet the needs of the current hospital environment. Therefore, the association hired Records Control, Inc., to establish a new indexing system, recatalog materials, and develop an indexing and filing system for internal correspondence.

In April 1968 the journal announced "AAHA's new lending library" and listed an index of more than 100 categories with key letters that identified subject categories and with numbers that designated subclasses of a subject (such as A—Accounting; A-3—Accounts Payable and Payroll—FIN—Financial Management; FIN-2—Financial Management Investments).

Hired as an editorial assistant, Patricia Weide was also given the assignment of librarian. When she became journal editor a year later, a full-time secretary-librarian was also hired. Never restricted to association members, the library was available to answer all requests. Moreover, as the field of healthcare finance evolved, new folders were developed. In a typical year (1973–1974), almost 900 folders were sent out to 242 borrowers, representing slightly more than 2 percent of the total membership. The library also addressed about 190 requests for specialized information that required research.

Over the years, the association built a reference library of textbooks, manuals, and reference books on accounting and hospital-related subjects. In most cases, the reference library was used by HFMA staff to research topics and respond to members' questions and was not circulated. Unfortunately, the format and structure of the lending library made it difficult for the association to sustain its status and strength. The volume of material expanded almost geometrically, and because users paid no charges, the association was compelled to subsidize all costs.

Although the field of healthcare finance suffered from an authentic void of technical literature in the 1960s, the association quickly filled that void with its ever-expanding collection of reference library material. Moreover, the association made a personal contribution to the body of literature through journal coverage of healthcare finance issues and strategies and through publication of manuals and textbooks. After carefully reviewing the decision, the board of directors discontinued the lending library service in 1979.

At present, technical staff respond to inquiries from the field by forwarding copies of material by mail or by conducting telephone conversations with members and colleagues in the field. The Washington office, in turn, furnishes information on regulatory and legislative issues. In the Westchester office, staff responds to inquiries through the association's Technical Resource Center, which is available to visitors.

Correspondence Clubs and Forums

As hospitals developed greater interest in data processing in the years after 1963, the association appointed a committee to evaluate the future role of computerized information. The association quickly recognized that electronic data processing technology usually came through the accounting office and that in the early years the hospital's accountant or controller frequently assumed the role of data processing supervisor. As computer applications increased, the controller either increased the level of personal involvement or stepped aside in favor of a data

processing supervisor recruited from industry. After studying the issue, the committee recommended that AAHA membership be made available to hospital data processing personnel so they could become more familiar with hospital accounting procedures, develop programs for national institutes, and write articles on automatic data processing for the journal.

Because of the highly specialized nature of data processing personnel, the association looked for a strategy that would focus the interests of these new professionals. In early 1971, I recommended that the board of directors establish a correspondence club for data processing managers. A correspondence club was set up within HFMA "for data processing managers and other HFMA members who are directly involved in computer problems," according to a journal article. It noted that "the expansion within hospital financial management ranks has created the need for specific information for those with special job functions and that administrative computer problems plague many hospitals, as disclosed by HFMA's computer survey reported in the February 1971 journal." The article explained how the correspondence club would function.

A copy of all correspondence exchanged among club members was to be sent to HFMA to establish guidelines for planning journal content and institute programs. HFMA would also periodically distribute articles of other special material of interest to club members.

Correspondence Club Membership

Thirty-five individuals mailed in applications to join the HFMA data processing management correspondence club and were subsequently sent a questionnaire that requested a statement of background and experience as well as data processing equipment and programs in use. Of the 29 applicants who returned the questionnaire, 26 were from hospitals and of the 26, half were data processing department managers and half were nontechnical professionals from administrative and financial areas. The largest number of computerized applications existed in the financial area, with some hospitals reporting computer use for general ledger transactions and budgeting. Although several hospitals had personnel and medical records computer applications, only a few had applications for medical department functions. Because respondents only had a limited number of common interests, the project faltered and died.

Fortunately the broad concept of a correspondence club continued to thrive. By 1975, the association noticed that more budget officers and internal controllers had become HFMA members. As a result, it resurrected the concept of the correspondence club to assist in the acquisition and exchange of information on these two critical functional areas.

In October the journal announced the creation of specialized correspondence clubs for budget officers and financial managers with annual dues of \$7.50. Of the 57 applications to join these clubs, 26 were for the auditors' group, 22 for the budget managers' group, and 9 for both groups. To permit club members to communicate with each other, the association provided members with self-adhesive mailing labels.

To gather data on members and their immediate work environment, the association distributed a background survey that included such questions as "What

do you consider the most annoying aspect of your work?" Responses mentioned communication failures, the need to perform clerical tasks, inadequate cooperation among department heads, misunderstanding of the function's need, and incomplete and inaccurate information. In subsequent years, the clubs addressed these issues, and staff in the technical services department developed and distributed several newsletters.

Club Membership Eligibility

Although the correspondence clubs were well received by association members, several problems remained. Clubs were restricted to bona fide HFMA members and required payment of an extra \$7.50 dues. Some members of the council on chapters argued that the clubs should be open to nonassociation members as a "foot-in-the-door" motivation for full membership. By 1978, the association was already experimenting with the divisional or sectional concept within chapters and had examined membership requirements for specialist groups. The issue of membership eligibility for correspondence clubs touched many areas of the association. Nevertheless, it was concluded that correspondence club membership should be restricted to HFMA members.

Following the 1976 decision to establish the annual educational program at Ohio State University as an institute for healthcare financial specialists, the association recognized that correspondence club members had an opportunity to establish a pattern of meeting annually. Because of turnover within the technical services staff at the national office, correspondence club activity had declined. But after David Pearson, director of technical services, joined the staff in 1977, club members for several years received a newsletter that included pertinent technical material.

In late 1978, the council on chapters studied the idea of a correspondence club for patient accounts managers. "Patient Accounts," a specialized newsletter, had already been introduced and had received a positive response. The council noted that the journal served the interests of patient accounts managers, whereas the newsletter communicated more specific information. The council also noted that organizing and operating correspondence clubs demanded a significant commitment. Following this decision by the council, the concept of a correspondence club for patient account managers faded.

Forums

For many years, association leaders had studied the concept of decentralization of services to specialized members, and, in 1989, the task force on organization and structure recommended the creation of two special-interest groups called *forums*—one for chief financial officers and one for patient financial services managers. The forum concept is intended to enhance member networking and to broaden services to these two groups. Services offered include information sharing and input for advocacy on issues, a peer directory, a regular newsletter, roundtable discussions during cluster educational meetings, "hot topic" information via FAX transmission, conference call discussions among forum members on specific subjects, and publication discounts. Only HFMA members may join a forum and a modest fee is charged in addition to regular dues.

Chapter Task Forces

The earlier technical task force concept, the development of stand-by chapter task forces in 1973, and the opening of HFMA's Washington office encouraged the association to formalize the chapter task force structure. At a March 1974 board meeting, the committee on financial arrangement with third-party agencies recommended that the chapter task force program be continued in the new fiscal year.

In a letter to chapter presidents, incoming President Arnold Silver requested a chapter task force be developed to deal with technical issues. According to Silver, staff would develop a modus operandi and copies of task force requests and a summary of responses would be furnished to the appropriate matrix group and board members. Silver's letter also outlined the critical role of chapter task force feedback in responding to government issues and pledged that at least one task force in each of the association's 11 regions would be involved, to some degree, in every issue, but that not every task force would be required to deal with every issue. In addition, records would document issues under discussion as well as the actions taken. Finally, it was recommended that a chapter task force include 5 to 10 individuals and that separate ad hoc task forces within a chapter be used to deal with other issues.

The chapter task force program was promoted at the annual chapter presidents' meeting, and a September 1974 issue of "Notes from National" listed chapters by region that had already established task forces. An example of the task force concept was provided and appreciation was expressed to chapters with task forces, which "have the satisfaction of doing their part to shape thinking on vital issues and problems" and "have access to the thinking of other task forces."

A revised chapter task force manual issued in 1977 explained the purpose of the task force program, which by then had been expanded to encourage exploration of long-term issues and to solicit feedback on short-term regulatory issues. Also presented were suggestions on the chapter task force's organizational structure, qualifications of members, and standard operating procedures. The program also incorporated the concept of "feedback of final results," which asked task forces to provide a copy of their response to the original requesting agency.

The chapter task force concept has grown into an invaluable tool for HFMA as it develops positions on important issues. Currently, the *Chapter Officer Manual* includes complete information on the purpose of chapter task forces, the process for organizing them, qualifications desired of task force members, how issues are assigned, how responses are to be handled, and how final results are communicated back to chapters. Chapter task force efforts continue to be an important part of the Graham L. Davis Incentive Program.

From time to time, the association gives assignments to special task forces or forms special task forces when input from professionals with specialized background or interests is needed. To establish these task forces, HFMA staff searches skill inventory files for people who previously indicated interest or expertise in a subject area.

The Voluntary Effort and Cost Effectiveness Contest

In 1977 the hospital industry confronted a serious threat to its well-being in the form of proposed legislation popularly known as the Carter Cost Caps. The Hospital Cost Containment Act of 1977 immediately won the industry's undivided opposition under the leadership of the American Hospital Association and the Federation of American Hospitals.

The Committee on Cost Containment

On June 1, 1977, HFMA members received a letter signed by HFMA President Joseph P. McCue that affirmed the association's strong opposition to the legislation and its support of AHA's proposed alternative courses of action. Members were also informed that HFMA had detailed the areas of inequity, deficiency, and danger within the bill in a letter to Congress. Through a Mailgram sent to all hospitals, AHA had also urged its members to communicate promptly with members of Congress and detail ways in which the bill would affect individual hospitals. HFMA members, in turn, were urged to supplement their organizations' letters with personal letters that described the bill's potential impact on a single hospital.

The heavy outpouring of letters to Congress prompted Representative Dan Rostenkowski (D-Ill.), chairman of the House Ways and Means Subcommittee on Health, to challenge hospital associations to craft a voluntary program that would control costs and forestall more punitive legislation. Hospital associations accepted the challenge and mounted an expanded voluntary cost containment program that soon became known as the Voluntary Effort (VE).

The AHA formed an advisory panel on voluntary cost containment to advise on a strategy needed to execute the voluntary effort. I represented HFMA and served with other panel members representing selected state and metropolitan hospital associations, the Catholic Hospital Association, the American Osteopathic Hospital Association, the American Protestant Hospital Association, the Association of American Medical Colleges, the American College of Hospital Administrators, the National Association of Children's Hospitals, the American Nurses Association, and the Canadian Hospital Association.

Immediately following the first meeting of the panel in November 1977, I held a staff meeting to develop recommendations on HFMA's role and conducted a conference call with the executive committee that allowed committee members to assess plans and offer additional suggestions.

The result of this call was a second letter to the HFMA membership in December 1977, which cited AHA's recent appeal to hospitals to "reassess . . . plans (for 1978) to see if anything further can be done to reduce increases in charges" and to remember that "financial managers have an important responsibility in this effort." The letter further argued that financial managers "are in the best position to sharpen their pencils to calculate the smallest possible increases in charges, and, as a member of the management team, offer strong arguments in favor of implementing only those charge increases which can be fully supported in terms of the hospital's accountability to its public." This letter was also sent to associate members "who are primarily representatives of Blue Cross Plans,

insurance firms and CPA firms . . . so that assistance and advice can be given, where applicable or when sought, in this exceptional challenge to hospital personnel."

HFMA President McCue appointed a national Committee on Cost Containment with Past-President Joseph Clancy as its chairman. Other members included Past-President Ray Everett; John Glavas, executive director, Dallas-Fort Worth Hospital Council (a former HFMA staff executive); Larry Hixon, controller, National Medical Enterprises, Los Angeles; and Gordon Butler, administrator of Memorial Community Hospital, Jefferson City, Missouri. The committee was charged to develop ideas to enable HFMA to contribute to the national voluntary effort and to develop concepts and recommendations for national programming and publication of cost containment ideas for the national matrix councils and committees.

Furthermore, the national committee was urged to develop ideas for programming and education of chapter members and ways to implement liaison with state voluntary committees and state associations.

The Chapters' Role

The national committee met on May 24, 1978, and developed a number of ideas designed to comply with the charges assessed. "Meet the Challenge of Cost Containment" was adopted as a theme and used to spur action by matrix councils, committees, and HFMA chapters. Each chapter was asked to form a Cost Containment Committee that included its board of directors and was provided with suggested assignments in working with hospitals, state hospital associations, and the general public. A special cost containment booklet was developed and distributed to attendees at the June Annual National Institute where there was also a cost containment information booth. In addition, Clancy made a presentation on the issue of cost containment at the Fellows' and CMPA breakfast meetings at the ANI. Finally, incoming Chairman Herman Guenther led a discussion at the chapter presidents' annual meeting on how to achieve recommendations outlined by the cost containment committee.

On August 31, chapter presidents and secretaries were sent a special memorandum from the national office that addressed the chapter's role in the VE, explained recommended activities of the chapter's Cost Containment Committee, and urged chapters to conduct educational programs on cost containment. An extensive bibliography was attached and referenced as a source for program development. Chapter officers received updates on new and significant events in the nationwide voluntary effort. Moreover, they received fresh advice on the role of chapters through a supplement to "Notes from National." Meanwhile, the journal carried articles that focused on the philosophy of cost containment and effective strategies and techniques.

Cost Effectiveness Contest

The national committee on cost containment was extended into the 1979 year by Chairman Guenther and into the 1978 to 1980 year by Chairman Satterfield. At a second meeting in May 1979, the committee reviewed HFMA's role and expressed satisfaction that HFMA had responded on both national and chapter levels

to organizations that had spearheaded the VE. The committee also met in 1980 to judge the annual cost effectiveness contest.

The concept of a national cost containment contest was first proposed in a 1972 report from the executive director to the council on publications. The council liked the idea and recommended that I follow up with additional data on rules, awards, and chapter procedures. Because of the pressures of the economic stabilization program, further development of the concept was postponed, but several years later, the idea was resurrected as HFMA marked its 30th anniversary.

Submitted by Glenn Black, director of fiscal affairs for Kennestone Hospital, Marietta, Georgia, the 1978 winning entry was selected and endorsed by the national committee for embodying the truism that "the most effective attack on cost-related problems could be waged only when the department manager accepted it as part of his or her job."

The intent of the cost effectiveness contest was to regularly publish selected entries in the journal that members of the association could easily replicate or adapt. Eventually selected ideas were published in a loose-leaf binder under the title "Cost-Effectiveness Notebook." The first edition of the notebook appeared in early 1978 and contained 62 key ideas gathered from cost effectiveness contest entries. The 1980 update contained 140 contest ideas and a bibliography on cost containment practices. The Cost Effectiveness Contest and the notebook were discontinued in the mid-1980s.

Financial Analysis Service

Strong ideas that are ripe for implementation usually occur in different forms and emanate from several sources. Such was the case in 1978 with the concept of a ratio analysis service. The idea of selling a specialized service to the hospital industry was hardly new to the association. In 1971 the association had seriously considered a vendor's proposal to underwrite the cost of the first survey of hospital information systems. On other occasions, staff had investigated the prospect of establishing a collections program that could be marketed to hospitals. National President Arnold Silver had argued for the development of a service and proposed a clearinghouse for information on hospital information systems. But none of these ideas was considered practical enough to gain the board's approval.

The board of directors considered a proposal to develop a national ratio analysis service that would provide hospital subscribers with detailed profiles of financial statements. The service would also analyze trends and compare data from groups of hospitals of similar size or in common geographical areas. The board agreed on the need for such a service and urged further investigation. In order to provide for a thorough consideration of the three submitted proposals, a special meeting of the board of directors was called for December 1, 1978, in Chicago.

It snowed heavily all day—the first snow in one of Chicago's record-breaking winters. Planes were grounded and six weary board members felt blessed when they found a single hotel room where they could wait out the storm before flying homeward. Each of the proposals was evaluated in terms of credibility, approach, continuity, stability, technical expertise, contractual relationships, control features, process and timeliness, ownership and risk, and benefits to HFMA.

Before making its final selection, board members dismissed the notion that HFMA could develop and market a ratio analysis service independent of a second party. In discussing a contractual relationship it was agreed that the minimum criteria for a final contract would be determined prior to affixing official signatures. HFMA's relationship with the American Hospital Association, which operated the HAS/CAP programs, was also reviewed. AHA officials knew of HFMA's interest in the ratio service and reported no opposition to the program. After evaluating the merits of each of the proposals, the board agreed to negotiate a contract with Ohio State University in Columbus.

Conducting a market survey was identified as a staff responsibility, and Jim Whitman asked me to take the lead. Although the association contacted several market research firms, it viewed professional services as a luxury and decided to conduct its own survey. Initial thinking was that the survey of 1200 hospitals would produce a 50 percent return and that feedback from 600 hospitals would provide reliable marketing data. Among the research requirements was that hospitals surveyed consist of those with more than 100 beds. More than 90 percent of hospitals in this size category already had HFMA membership representation, and the remaining 10 percent consisted of Veteran's Administration and federal and state long-term hospitals.

A decision was made to maintain regional identification and select hospitals in direct ratio to the HFMA membership population in that region. In addition, a decision was made to refine that selection by establishing the number of hospitals to be selected by ratio of bed size in each state (in 100-bed groups) as identified by the *American Hospital Association Guide to Hospitals*. A further refinement involved selecting only one individual from each hospital through the HFMA membership printout, with preference given to the chief financial officer, controller, or administrator.

More than 600 responses were received to the single-page questionnaire mailed on January 18, 1979. Of the six questions posed, one was critical: "Using a scale of 1 to 10, indicate your opinion as to the importance of ratio analysis in today's hospital financial management environment." Survey responses indicated that estimates of importance ranged between 7 and 8. On the issue of whether respondents would be interested in subscribing to an HFMA-sponsored ratio analysis service, more than 77 percent responded affirmatively. Additional comments provided helpful feedback as the association negotiated a contract and began to market the service.

Introduction of the Service

The new service was introduced to potential registrants of the national institute through a simple brochure followed by a more sophisticated brochure mailed to all hospitals. In addition, the November journal contained a short article by President James T. Whitman that presented ratio analysis as an indispensable management tool and introduced the financial analysis service under the direction of William O. Cleverley, Ph.D., associate professor of hospital and health services administration at Ohio State University.

The promotion stressed that the data used would have a high degree of reliability and comparability, because it emanated from audited financial statements. By using audited financial statements, subscriber hospitals would be spared the burden of completing special forms.

After two years, the financial analysis service had developed and computed 29 ratios presented in an easy-to-follow report format on a trend and peer comparison basis. In addition to participating in peer comparisons in the four categories advertised, hospitals could also participate in up to four special groups—depending on the availability of a group and the hospital's characteristics. Thirty-three special groups were cited, with 20 of these groups representing states.

In addition to the financial performance report and the user's guide, subscribers received "The Hospital Industry Analysis Report," an annual release that provides regional and bed size peer groups as compared with the groups in which a particular hospital was categorized.

Program Expansion

The Financial Analysis Service expanded several times during the 1980s under the direction of Eugene Sandleback, director of Association Services. In January 1985, the previous comparative bed size category of 1 to 199 beds was divided into two categories—0 to 99 beds and 100 to 199 beds—to allow more accurate financial analysis for institutions with less than 200 beds. In addition, groupings based on total revenue were added, because bed size did not always provide the most accurate peer comparison. In 1987 four new or upgraded services were added: a Strategic Operating Indicator (SOI) package, a personal computer diskette service, a PC equity planning model (EPM), and an improved graphics service that enabled clients to produce copies or transparencies. The Hospital Industry Analysis Report found a ready external market among banks and credit granting organizations.

After 11 years of operating growth, the FAS-PLUS database in 1990 boasted more than 2500 hospitals with over 11,400 years of financial information. Its companion, SOI-PLUS database, had grown to 1000 subscribers with 4256 years of data submitted. Announced in this same year was a Receivables Analysis Service (RAS-PLUS), which defines industry standards by six major categories of payers. A new Medicare Cost Report (MCR-PLUS) database originates from national data collected by the Health Care Financing Administration (HCFA) and will afford a wide variety of information from a database of more than 5000 hospitals.

Addressing Other Technical Issues

Medicare

"Accountants Await Word on Medicare" was the title of a 1966 article of a Durham, North Carolina, newspaper. The article interviewed national HFMA Treasurer Jeff Steinert. Steinert reported that "information on the program is released each week, 'piece by piece,'" but "we just don't have much on the mechanics." Lack of solid, official information on implementation of this revolutionary health-care program prompted the association to publish its history-making journal issue

in June 1966 and to become increasingly involved in training hospital accountants in cost report filing.

Medicare legislation and regulations caused hospitals to professionalize their accounting practices and pushed the American Association of Hospital Accountants into the limelight. Over the next several years, the board of directors discussed various Medicare issues and went on record in support of such issues as the 8.5 percent nursing service differential and in opposition to such issues as the elimination of the 2 percent allowance factor.

In November 1968 the Social Security Administration (SSA) forwarded drafts of proposed revised hospital cost reimbursement forms to HFMA for comments. These forms were subsequently sent to a dozen selected individuals across the nation and their responses were compiled and forwarded to the agency. In 1971 the SSA asked HFMA to comment on proposed revisions to HIM-15. However, HFMA was not on the mailing list for comment on most of the proposed regulatory revisions.

In 1971 Past-President Steinert alerted current officers to the problem of new "surprise" Medicare regulations. This, in turn, led to the establishment of an AHA/HFMA joint committee that provided input into AHA's policy development process and that indirectly influenced the regulatory revision process. The establishment of HFMA's technical services department in 1970 and increased access to national and chapter task forces enabled the association to present its position on changing issues most often in concert with AHA.

In one instance, an official of the Social Security Administration contacted HFMA to express disappointment at the lack of hospital involvement in the periodic interim payment (PIP) program. In response to this official's request to publish an article that discussed the program's merits, HFMA solicited an article from a representative of a CPA firm who had advocated the program to its hospital clients. This article subsequently generated more articles on the PIP system, which earned the recognition and appreciation of the SSA.

Currently, response to Medicare and Medicaid issues are coordinated by the HFMA Washington office through chapter task forces, opinions compiled from the field, and in close cooperation with the AHA.

Chart of Accounts

Late in 1959 the American Hospital Association published and distributed the *Uniform Chart of Accounts and Definitions of Hospitals*, its revised manual on uniform hospital accounting. AHA asked me to write a book review of the manual for *Hospitals*, the AHA's journal. The review commented that the 10 years that had passed since the document's last revision was far too long and expressed hope that the next revision would be completed within five years.

Working closely with AHA's accounting specialists in the early 1960s, AHA and AAHA agreed that AAHA would obtain input from accountants in the field on suggested revisions. In May 1962 AAHA sent a request to officers of its 63 chapters requesting that ideas and suggestions on manual revisions be transmitted to the AAHA office. Some chapters devoted part of their regular meetings to discussion of the issue; others assigned the task to an individual or committee. Twenty chapters responded by the deadline and offered a variety of suggestions

for revisions. A report was subsequently submitted to the AHA with copies of various chapter reports appended. Suggestions for revisions ranged from the elementary to the sophisticated and far-reaching.

Work on revisions proceeded within the AHA structure and in October 1964, AAHA was asked to provide review and evaluation of a draft. A cover memo addressed to all Fellows accompanied the draft and invited comments. Because the Fellows produced thoughtful responses, the association was able to transmit excellent critical opinions to AHA.

The primary reason for the 10-year delay in publishing the 1959 version of the uniform accounting manual was the difficulty of obtaining uniform definitions. In preparing the revised version, AHA decided to withdraw the chapter on definitions and statistics and publish the information in a separate document. In 1966 the AHA developed a questionnaire on uniform definitions and statistics for hospitals, which AAHA distributed to its Fellows. Once again, the response was generous and helpful.

With the implementation of Medicare on the horizon, many hospitals were in the process of improving their accounting systems to cope with new financial accounting demands and eagerly awaited the publication of the AHA uniform accounting manual. In response to several inquiries, AAHA obtained AHA's permission to reproduce the outline of the chart of accounts and provide them to association members prior to the manual's 1966 publication.

In 1971 the AHA again reconsidered revision of the uniform accounting manual. In August HFMA's Bill Fill wrote to George Coldeway of AHA's division of finance and reimbursement.

Alerted to the problems of adapting the chart numbering system to electronic data processing applications, Coldeway asked for feedback from the field on difficulties encountered and asked HFMA to pursue the issue. Communications from the Matrix Committee on Information Systems and Data Processing and HFMA Fellows revealed no problems. It was concluded that the numbering system was adequate for electronic data processing or that experienced computer programmers could develop their own numbering system to match the AHA chart of accounts.

Immediately before the HFMA matrix meeting in October 1974, the AHA council on financing reviewed the exposure draft and commentaries and agreed to defer publication of the revised chart of accounts.

HFMA President Arnold Silver immediately sent a letter to AHA President Alex McMahon in which he expressed concern about the deferral on the ground that "HFMA feels a revision is timely and important." Silver outlined an option:

Due to the importance we attribute to this project, we would like to proceed with development of a revised chart of accounts under HFMA sponsorship if AHA decides not to publish promptly. Such a chart would not include accounting principles, but will focus on procedural matters that would not conflict with AHA's role with respect to setting policy.

Reaction from AHA was swift. It noted that the letter from AHA's Bureau of Fiscal Services, on which the understanding mentioned within Silver's letter was based, contained an error and that a corrected letter had been received. In 1976

AHA published its revised chart of accounts with the chapter on estimated depreciable lives of assets published as a separate document.

Statement on Financial Requirements

The AHA's "Statement on the Financial Requirements of Health Care Institutions and Services" sent shock waves throughout the healthcare field when it was introduced in February 1968. It was highly praised in some quarters; it was severely criticized in others. At the April 1968 AAHA board of directors meeting, Past-President Harold Hinderer explained the statement's potential harm and asked that the association reject it totally. The AHA had presented the statement as "an all-or-nothing-at-all" document, and AHA's request that AAHA participate in a critique of the document was interpreted as an invitation to express an official position. President Joseph Clancy was authorized to express the board of directors' formal rejection in writing. Because of its position of total rejection as opposed to strict financial analysis, Clancy's letter provoked strong criticism within the AHA.

AHA's council on financing revised its original statement at its May 1968 meeting. But at its June meeting, AAHA's board of directors noted that the changes failed to cure the problems inherent in the financing provisions. Incoming President Jeff Steinert appointed a special committee regarding the AHA statement, and in September, the committee reported that it had met with Dr. David Wilson, the elected AHA president, and had offered detailed commentary on the association's opposition to financing provisions. Several HFMA chapters also got involved in the process and developed their own positions on the statement. National office offered chapters guidance on how to handle position statements locally and eventually developed a policy on chapter-generated position papers, which remains incorporated in the handbook distributed annually to chapter presidents.

In February 1969 President Steinert reported that the special committee had met with AHA representatives and that a number of HFMA's suggestions had been incorporated into a revised statement. The consensus was that the statement was now acceptable and the board of directors voted approval in a letter to Dr. George Graham, AHA's current president, supporting its position. A letter to chapter presidents, which expressed appreciation for their valuable input and looked forward to further cooperation on statement implementation, was also approved.

President Jeff Steinert was appointed by AHA to an ad hoc committee on implementation of the statement on financial requirements. The committee developed a document called "Policy on Implementation of the Statement on Financial Requirements for Health Care Institutions and Services," which was subsequently endorsed by the HFMA board of directors in October 1970.

Assigned the responsibility to study the AHA's statement and its implementation, HFMA's council on principles and practices recommended that the board of directors request all chapters to take the lead in carrying out the AHA policy on implementation in cooperation with state and local hospital associations.

AHA had developed a packaged education program for use in the field, and the program materials were furnished to HFMA chapters as an insert in the section

of the chapter program manual devoted to “programs—other sources.” The package consisted of a model speech that outlined the provisions of the statement on financial requirements, a question-and-answer reference sheet, an accounting illustration of the financial requirements approach, and a short multiple-choice quiz. The suggested scheduling called for a three-hour program, although a full-day program could be arranged by inviting representatives of third-party agencies to present their views on the statement of financial responsibility.

A difference of opinion between HFMA and the AHA council on financing arose in 1972 and revolved around AHA’s intention to combine the recently revised statement on financial requirements and the policy on implementation of the statement. HFMA’s position to not combine was debated at length at the council meeting and was defeated by a margin of one vote. Later, the AHA general council overrode the finance council’s recommendation, and HFMA’s recommended view prevailed.

In April 1977 AHA called upon HFMA to review and comment on proposed revisions to the statement on financial requirements. Designated matrix committees and the council on principles and practices carried out a variety of assignments, and HFMA suggested that AHA develop an interpretation of the statement. In September, a new document was referred to matrix groups for comment.

Uniform Billing

Everyone in the hospital business eventually experiences annoyance and frustration with the myriad designations and content variations of third-party billing forms. At times the patient who pays his own bill at fully billed charges receives less information about services and supplies than third parties who may pay fewer dollars for comparable care. The desire to standardize billing forms for all payers emanated from a desire to reduce the confusion inherent in these forms.

Efforts to generate uniform billing had gone on for many years. As far back as 1953, correspondence between Fred Morgan and Hiram Sibley, executive director of the Connecticut Hospital Association, on a uniform billing program sponsored by the Rochester Regional Hospital Council revealed that a standard machine bill using NCR equipment was in place in the Philadelphia area. Eventually, Connecticut became the first state to develop and use a uniform bill for all payers. A 1957 issue of “Notes from National” lauded the South Carolina chapter for joint development with the South Carolina Hospital Association of a standard billing form that was accepted by Blue Cross, the state industrial commission, and all hospitals. A uniform revenue classification was also adopted as part of this arrangement.

In September 1968 President Jeff Steinert informed the board of directors that he had spoken to Thomas Tierney, director of the Medicare program for the Social Security Administration, about the development of a uniform bill and had offered HFMA’s services in executing the program. However, Tierney preferred the AHA to undertake the project with the assistance of the Blue Cross Association, the principle Medicare intermediary. Steinert expected that HFMA would supply technical assistance.

AHA appointed an advisory panel to examine the potential for and feasibility of replacing the many national forms and sets with a single uniform set, and

Steinert was appointed as the HFMA representative to the panel. Further investigation revealed that there were more forms than originally anticipated, that the variety of forms contributed to billing delays and errors, and that the cost of preparation and errors was unnecessarily high. State, local, and county governments and Blue Cross plans remained satisfied with their own uniform billing, and insurance companies had adjusted to their own forms and procedures. The advisory panel proceeded against these almost insurmountable odds and determined that it was not only feasible and practical but also economically necessary to introduce a single uniform billing set to the hospital industry.

Unfortunately, progress during the next few years was slow. Records of the joint AHA/HFMA committee suggest that the project was dormant for a time. Although the uniform billing project appeared to be underway at the time of the joint meeting held in February 1970, it went unmentioned in the AHA's 1970 and 1971 annual reports to the joint committee.

In January 1972, Steinert reported that he had attended a meeting of the AHA advisory panel during which Social Security representatives stated that the SSA had determined that the medical information within the bill was inadequate. The SSA had been working on the development of a medical abstract that would serve the agency's purposes. In April Charles Anderson asked HFMA staff about the project's status and determined that "some slippage" had occurred with SSA and Blue Cross, and that the project had been referred back to the advisory panel.

Eventually a form suitable for field testing was designed. Edward McCalley, a forms expert from Standard Register Company, had worked with the advisory panel to ensure that the form would be compatible with data processing equipment, mechanized bookkeeping machines, and other office hardware. The field test of Form UB-14, the fourteenth form to be designed, began in Atlanta in June 1973. UB-13, another version of the form, went into testing in Wyoming. UB-15 removed "diagnoses" and "procedures" from the pay claim area of the form.

Atlanta was selected as a test site because it represented an excellent cross section of the hospital industry and contained small and large institutions and teaching hospitals under various types of ownership and control. Wyoming was selected because it represented an entire state and had relatively small hospitals that would probably experience more problems assimilating the system.

AAHA anticipated that the field testing would consume a period of six months at each of the two sites and that the experiment would be completed in March 1974. Moreover, the expectation was that after successful field testing, AHA's board of trustees would approve the system and third-party purchasers of care would permanently accept the uniform billing form. Educational programs for both hospitals and purchasers were planned to explain the system and train professionals in conversion techniques.

Meanwhile, practitioners in the field grew impatient over the time required to implement the change. The West Virginia Hospital Association was urged to use a uniform bill in that state. Hospitals and payers in Memphis were already using a form that had been developed in Tennessee. HFMA informed AHA that such forms might interfere with the eventual implementation of a national uniform billing form. In response, the AHA developed and distributed a three-page fact

sheet, which provided the background and status of the uniform billing project and which was referred to HFMA at the joint committee meeting in February 1974.

South Carolina hospitals exhibited the greatest impatience and irritation. In his role as a member of the national board of directors from 1973 to 1975, Robert Fox of Charleston tried to light a fire under the project. In January 1974, T. Robert Ward, president of the South Carolina chapter, wrote to the AHA and said the state had been using the A-92 R billing form since 1968 and the form was accepted for Medicare use in October 1970. "We in South Carolina cannot understand several points," wrote Ward. "One: Why our form, that is working, is not being used as one pilot project, and two: why some of our members who helped design and are now still in daily contact with the form are not being used as advisers."

Fox forwarded a copy of Ward's letter to HFMA President Ida Milanese, expressed general dissatisfaction over AHA's handling of the uniform billing project, and criticized HFMA for "ignoring the South Carolina success story." AHA responded to Ward by pointing out similarities between the A-92 form and the UB version, which had been successfully modified to meet hospitals' needs, and added that, as a former member of the advisory panel, Jeff Steinert had provided input into the development of the UB form.

The status of the UB project was included in the board of directors' March agenda through the official report of the joint committee meeting and the AHA explanatory fact sheet. Fox reiterated South Carolina's frustration with the slow national progress and with the alleged slight of the South Carolina program. In June, Fox recommended to the board of directors that HFMA draw on the South Carolina experience if the AHA project continued to falter, and, in September, Fox reported that he and his colleagues in South Carolina had outlined the content of a series of seminars that they would be willing to conduct across the country under the auspices of HFMA to train hospital personnel in converting existing systems for the new form's implementation.

After the completion of field testing for the two versions of the uniform bill, the advisory panel made several minor revisions and a new form, known as UB-16, appeared on the scene. The AHA's board of trustees approved UB-16 in November 1974—subject to minor changes—and AHA presented the form to third parties for assessment. By early 1975 all parties had accepted the current format. *Hospital Financial Management* rushed into production with its April 1975 issue. The lead article asked, "Wouldn't it be nice if we had only one bill?" and responded, "Now, we do: UB-16."

Unfortunately, the scoop was premature. The representative from the Social Security Administration, who had indicated his acceptance of the final form, was overruled by his superiors. The journal article included the following disclaimer: "As HFMA goes to press, UB-16 is being analyzed by representatives of major third-party payers. The final uniform bill is expected to differ from UB-16 in some respects but not in overall concept."

The March 3, 1982, issue of "Hospital Week," AHA's weekly newsletter, announced that "after more than 10 years of negotiation, the AHA chaired national uniform billing committee, which represents major payer and hospital

groups, has decided on a standard hospital billing form—the UB-82.” In 1991 UB-82 continues in use despite some adjustments in format and despite the requirement of some payers for supplementary data.

Data Processing

The September 1968 issue of the journal—the first issue published under the new masthead of *Hospital Financial Management*—included an article by the executive director titled, “What HFMA Means to the Data Processing Supervisor,” which was positioned adjacent to a companion article, “What HFMA Means to the Credit Manager.” Both articles were developed to convey how these functions would evolve in the hospital business office environment and how HFMA would relate to them. An analysis within the data processing article reflected the association’s legacy on the issue:

About five years ago, when hospitals began to evince more than passing interest in automatic data processing, a data processing committee was appointed by the president to study and to determine the association’s role with respect to this revolutionary newcomer. The committee recommended that membership in AAHA be made available to hospital data processing personnel so that they might be familiarized with the intricacies of hospital accounting, that national institute programs be developed, and that ADF articles be featured in *Hospital Accounting* on a regular basis.

In 1967 the ongoing Systems and Data Processing Committee developed the following statement, which was approved by the board of directors:

Statement of AAHA’s Role in Electronic Data Processing

The systems and data processing committee, AAHA, has agreed that the objective of the association in the systems and data processing field should be to assist members and hospitals in achieving the best possible systems for accumulating and reporting the necessary, accurate and timely financial and statistical data, taking into consideration the data requirements of all facets of the organizations’ operations.

To accomplish this role, objectives were spelled out. To implement this role, AAHA developed two systems courses. One was intended to help hospital personnel with the basics of systems design, flow charting, and forms design, but the course ignored computer applications. The second program, *Systems Approach to Automatic Data Processing*, was designed to implement the six steps outlined in the role statement and became one of the many courses offered at the annual national institutes beginning in 1967.

Since early 1964, the journal covered various phases of automatic data processing and touched on philosophy, procedures, applications, shared services, and surveys. As computer sophistication increased and the art of information systems evolved, the journal’s articles kept pace.

In 1965, the board of directors approved a recommendation that chapters share the responsibility and establish a Data Processing Technical Committee that would help members develop technical expertise with computers and would advise on the development of chapter programs. This committee and the Technical Committee on Credit and Collections were integrated into the specimen chapter bylaws as mandatory technical committees.

The matrix organization created in 1968 incorporated a Technical Advisory Committee on Systems and Data Processing, which covered the areas of systems and procedures, automation, computers, source documents, microfilming, information retrieval, and flow charting. HFMA expected to continue to work with AHA in integrating broad concepts of hospital computer applications.

The association's role in the data processing environment received a shot in the arm with the 1971 publication of the results of a survey conducted by Harris Kerr Chervanek & Co. in cooperation with HFMA. Described as "the most comprehensive to date of the information processing needs of hospitals," the study was widely regarded as superior to a 1968 survey by the U.S. Public Health Service. The results were published in the February 1971 issue of the journal under the revealing headline, "Hospitals Haven't Realized the Potential of Data Processing." According to the article's opening paragraph, "Too often, hospitals seem to have wandered into data processing with insufficient expertise, without first defining their requirements fully and realistically, and without establishing their short- and long-range objectives."

This statement was one of the "inescapable conclusions" of the survey, which represented responses from 40 percent of the nation's 7000 hospitals. Survey responses were tabulated by hospital size, geographical location, type of services, and financial control. Although no trend correlations were possible, the survey presented a "balance sheet" on the state of the art without delving into income statement data of gains or losses experienced by hospital data processing. The AHA had permitted use of its magnetic tapes, which contained background information on member hospitals and which allowed for microanalysis of findings. The final report, "The State of Information Processing in the Health Care Industry," was sent to all responding hospitals with additional copies provided at no charge to requesters.

In 1974 HFMA received numerous inquiries, including one from the U.S. Department of Labor, on the association's plans to undertake a follow-up survey. With the cooperation of Chervanek, Keene & Company, a nationwide survey was undertaken in 1976. Reflecting returns from more than 3000 hospitals, the survey's findings were published in the February 1977 issue of the journal with an opening sentence that read, "A quiet revolution in information processing has occurred in American hospitals these last six years."

The article explained that a growing number of hospitals had invested in data processing and that previous users had automated many new areas. Specialized service bureaus had become a major factor, and general service bureaus had lost influence. At the same time, minicomputers and real-time operation were gaining wide acceptance. "More than \$100 million a year is being spent for hospital data processing equipment, personnel and services," according to the article. "Despite lower costs per unit of service, that total is rising yearly." Bearing the same title as the original report, the newly published version was released to HFMA for distribution and sent out on request.

The initial survey generated a proposal from the principal survey underwriter. Larry Chervanek argued for the development of a universal software package for hospital accounting and business operations for which HFMA would serve as an

adviser in the early stages of development and later as the marketing organization. Although the board advised Chervanek that HFMA was in no position to enter into a profit-making venture, it indicated its interest in making a universal software package available to the industry. HFMA made contact with the National Center for Health Services Research and Development in the hope that this organization's experience and expertise would benefit the proposed effort.

President Charles Anderson, who was instrumental in bringing about HFMA's involvement in the original survey, appointed an ad hoc committee to meet with IBM representatives in Poughkeepsie to surface information processing needs within the healthcare field and on March 24 and 25, 1971, six HFMA representatives met with the same number of IBM representatives in Poughkeepsie. A representative of the National Center for Health Services Research was invited to participate, but the invitation was declined. Later, it was learned that the center was unable to pursue the proposal.

Following the IBM confab, the board voted not to participate in the further development of a universal software package. Because of vendor competition, the questionable feasibility of applying one package to the needs of all hospitals, the potential early obsolescence, and the ability of the resource to perform as indicated, the board doubted the package's ultimate success.

In 1974, the Metropolitan New York Chapter, HFMA, served as a sponsor of one of the miniconferences conducted for INFO '74, an exposition and conference on information systems. The miniconference on applications of information systems for hospital management was one of 17 vertical programs offered. The following year, the national HFMA was asked to serve as hospital program sponsor and agreed to do so if the Metropolitan New York Chapter furnished the planning and participatory manpower. INFO '76 was held in Chicago, and the First Illinois Chapter took over the operation of the hospital oriented miniconference. In subsequent years, the program alternated between New York and Chicago, and HFMA participated through its chapters. In April 1979 the board of directors adopted an updated statement on HFMA's role in information processing management.

EIGHT

Ascent to Professional Excellence



*Life affords no higher pleasure than
that of surmounting difficulty, passing
from one step of success to another.*

Samuel Johnson

When William A. Dawson, one of the association's 16 organizing members, responded to Bill Follmer's 1946 request for comments on the draft of the AAHA's constitution and bylaws, he advocated that provisions be made for Fellowships and that "recognition . . . be given to the hospital accountants scattered around the country who have plugged for better accounting for many years."

The organizing committee deferred action on the issue of Fellowship classification but resurrected the subject at a 1954 board meeting.

Sister Mary Gerald noted that having a core group of members who had achieved predetermined standards of excellence could be the impetus for a higher class of membership and a higher level of professionalism within the association.

In 1955 the Committee on Structure and Program recommended that the association establish the membership classification of *Fellow*. The committee's recommendations were publicized in *The Second Decade Report*, in which the concept of Fellowship was explained. "A Fellow must be a member whose ability is certified by the passing of a written examination," the report stated.

A board of examiners was appointed to handle the myriad details and decisions necessary to develop a fair, comprehensive eight-hour examination, including these:

- Design of format for questions
- Timing of questions through field testing
- Eligibility requirements, which eventually evolved into a point system that awarded points for education, experience, and authorship
- A method for credentialing applicants
- Grading protocols
- Examination fees
- Proctored sites

President Robert Reeves appointed Henry Hottum to chair the board of examiners with Sister Mary Gerald, Stan Pressler of Indiana University, and Lauretta Paul of Pontiac Hospital, Michigan, as members. The board of directors had already set parameters for the examination process, including prohibition of examination waivers and "grandfathering" of Fellows.

To ensure that they were headed in the right direction, the board of examiners solicited input from 75 hospital accounting experts across the nation, and the national office offered all 42 chapter presidents the opportunity to provide input on the new Fellowship examination. The board of examiners spent more than 18 months preparing the examination and the first exam was scheduled for Saturday, July 20, 1957, in Bloomington, Indiana, following the annual national institute (ANI), as well as at 10 other college sites. Details for preparing to take the exam were published in the January 1957 issue of the journal, explaining eligibility requirements, fees, deadlines for filing, credential checks, 10 categories of technical competence covered within the exam, and a bibliography of American Hospital Association manuals and other reference books. The journal also advised participants of established grading procedures:

Each examination paper will be graded independently by at least three graders. To ensure complete impartiality, the names of the graders will not be announced. Each examination will be graded by number only. Any identifying marks on a paper would automatically cause it to be ineligible for grading.

Forty-seven candidates from 20 states and three Canadian provinces participated in the exam. Of the 65 candidates who applied to take the exam, 52 were accepted, but five decided to postpone their attempt. Of the 47 examinees, 23 were males and 24 were females. Of the 24 females, 21 were Catholic sisters. Candidates learned about exam results on October 1 when individual notifications were sent. The December 1957 issue of the journal celebrated the success of 19 professionals who had passed the exam and achieved Fellowship status.

The board of examiners had decided that no examination scores would be transmitted to candidates and that the Fellow who had earned the highest score would be identified and honored with a plaque. The high scorer for the first examination was Harold Hinderer, who later served as AAHA's president in 1966–1967. His 1957 classmates included Sister Loretta Marie, national president in 1960–1962; myself, national president in 1958–1959 and executive director from 1959 to 1978; and several individuals who served as national treasurer for a term or more; Sister Constance Marie, William E. Culbertson, Hilmar M. Lohmann, and Alice W. Sandstrom. Over the years, most of the 19 classmates eventually served on the board of directors or on national committees.

Promotion of the Fellowship Examination

In 1958 only 14 members applied to take the exam and eight passed. In 1959 eight out of 18 candidates joined the Fellowship ranks. Although members of the board of directors continually addressed the low number of Fellowship applicants, they remained adamant in their desire to maintain high standards for the exam and for applicants. As one board member stated, "The day will come when this examination will be recognized nationally as a criterion of quality."

Promotion of the exam within the journal was confined to announcements of the annual date, brief statements by Fellows on "What Fellowship Means to Me," and coverage of high scorers each year. In addition, the association distributed press releases to candidates' home town newspapers and other publications.

Board Actions

After three years of experience, the board of directors developed a greater sense of confidence in the exam's high standards and noble purpose. But by February 1960 the board also recognized the need for some changes. It therefore expanded exam eligibility by allowing members to earn one point under the category of education through completion of each of the three Indiana University correspondence courses.

The board also allowed candidates to sit for the examination before checking their employment and personal references. Although the association had tried to maintain total confidentiality in the examination process, checking references prior to the exam often alerted candidates' supervisors. Members who were afraid of the embarrassment that might come from failing the exam were reluctant to apply. In addition, checking references of candidates who had passed the exam reduced the workload of staff.

Vann Seawall's Fellowship Study Manual

In 1959 the association published a Fellowship study manual authored by L. Vann Seawall and distributed copies to all chapter presidents with the request that they promote the exam more aggressively. Complimentary copies were forwarded to candidates whose applications for the exam had been accepted. The association updated the study manual in 1962 and supplemented it with a packet of questions and suggested solutions from all previous examinations.

Strategies for Test Preparation

Despite these innovations, the board of directors was perplexed by the limited number of members who took advantage of the Fellowship opportunity. In 1960 only seven candidates sat for the examination, and the following year, just 14 candidates took the exam. In 1962 only three of nine candidates were given the right to use the initials FAAHA after their names. Although board members were tempted to compromise on the quality of the exam, they clung tenaciously to their high standards. At one point they considered a split exam that would allow candidates to take the exam in two sections. If candidates passed one section and failed the other, they would need to repeat only the section they had failed. At the same time, it was decided to promote the exam more aggressively and build recognition of the value of the AAHA credential.

Conditioned tests were finally introduced in 1987. Of the four topic sections within the Fellowship exam, two had to be passed in the initial sitting, whereas the remaining two had to be passed within a stipulated time period.

In 1962 the board of directors began to encourage chapter presidents to provide members with coaching sessions for the exam. The February 28, 1963, issue of "Notes from National" featured a profile on Fellowship exam coaching courses, including a discussion of methodology and coaching techniques. The correspondence courses at Indiana University were cited as an excellent strategy for obtaining a thorough review of exam material. In order to preclude charges of

unfairness, the board of directors established a policy that prohibited the national office from conducting these sessions but maintained its involvement by developing detailed outlines on a variety of technical subjects for the chapter program manual.

When the board of directors established the matrix organization in 1968, it charged the technical advisory committees to update existing outlines and develop new outlines for the chapter program manual. Several years later the policy was amended and prohibited anyone who was involved in generating the exam (that is, national matrix and board of examiners) from also serving as an instructor for a coaching session.

To strengthen the promotion of coaching courses, the Graham L. Davis Award for Chapter Achievement granted chapters project points for coaching sessions. Through this innovation, chapters could earn two additional points under the category of individual effort when any of their members passed the exam and achieved Fellowship status the following year. Despite the earlier prohibition on having nationally affiliated professionals conduct coaching courses, the national office offered a workshop for chapter leaders involved in conducting coaching courses in 1986. This workshop subsequently became a popular biannual event, dealing with organizational issues and the special problems of the adult learner.

Study Guide Revisions

Every two years the national office has updated its examination study guides with new questions and suggested solutions. In 1970 the association issued its study guide in two sections. Section one contained general information about the exam and offered suggestions on preparation, while section two provided specimen core and supportive questions as well as problems and suggested solutions. Each section of the study guide was sold separately and section two was aggressively promoted as a tool for group coaching sessions.

In 1974 the association developed a separate coaching course manual. After 1979, all manuals were updated biannually and sent to chapter presidents and presidents-elect so that each had the information needed to appoint coaching course leaders or coordinators.

The Credentials Committee

Between 1957 and 1962 an appointed Credentials Committee ruled on the eligibility of members who applied to take the Fellowship examination. Although eligibility requirements were clearly stated, members would often question the interpretation of these rules. Questions such as, "Why must a person be a member of AAHA for three years before becoming eligible for the Fellowship examination?" were answered in a July 1960 report from the board of directors.

The report noted widespread support for the established point system but added that the three-year membership requirement was an emblem of status that required much more than passing a written exam. It was agreed that the association had to demonstrate some degree of stability. The Credentials Committee had always relied on initial screening of applications by staff and gave detailed consideration only to those applicants whose eligibility was unclear. After 1962

the Credentials Committees concept was abandoned and staff screening was looked on as adequate for most situations. For example, other eligibility discussions had focused on individuals whose membership classification was questioned on the basis of compliance with the three-year requirement. The board of directors usually ruled on such cases on an individual basis.

Advanced Membership

In 1968 the association found a permanent solution to the credentialing process when it created the category of advanced membership, which incorporated Fellowship eligibility requirements. In this way, eligibility requirements were screened throughout the year by the membership department rather than just at exam application time.

In 1961 the board of directors discussed granting educational points for attending the annual national institutes. It was noted that correspondence courses, for which points were given, involved class hour credits, whereas the ANI did not, and it was decided that points not be granted for institute attendance.

Fellowship exam requirements were reviewed frequently by the council on professional excellence, and more recently, association leaders discussed making associate members eligible for the Fellowship exam. This change was based on the belief that the experience of associate members in the hospital field compared to experience gained by members working in hospital environments. This issue was eventually resolved when the associate membership category was merged into regular membership.

Eligibility requirements for Fellowship were changed in 1986 when the minimum of three years of prior HFMA membership was established and the basic requirement for educational points became a bachelor's degree from an accredited college. A waiver of the bachelor's degree requirement was granted to anyone who passed the requirements for advanced membership before May 31, 1986.

Release of Examination Materials

Policies on the release of examination questions, solutions, and grades, and promotion and grading of the exam were ongoing topics of discussion. From the earliest days of the exam, the board of directors had decreed that the association would not release grades and that candidates would be notified of results through personal letters mailed to their home address. The purpose of releasing exam questions and suggested solutions was to help candidates develop a better understanding of their performance. For several years, exam questions and suggested solutions were withheld until the completion of the grading process—typically 90 days after the exam date. Later candidates were allowed to take copies of exam questions when they turned in their exam answer sheets. However, the association continued to withhold suggested solutions until the grading was completed. At this time, questions are not released.

Unsuccessful candidates expressed dissatisfaction with this procedure. Every year, one or two candidates who either wanted more information or wanted to have their grades released appealed to the council on professional excellence,

which periodically presented a proposal for reform to the board of directors. In 1967 the board approved the release of grades on request to candidates in brackets of 25 scored points, and in 1973 the grade ranges were released at the time of notification of grading results in a 10-point percentile range, up to 69.

This action complemented the board of examiner's regular practice of examining every borderline paper (percentile range score of 70 to 75), adjusting grades up or down based on the grader's consistency, and by reviewing a candidate's test answers. Borderline papers would either be upgraded to the passing percentile of 75 or downgraded to 69.

Symbols of the Fellowship

From the beginning the association instituted the practice of recognizing the high scorer for each year's round of examinations with presentation of a plaque. Certificates that identified one as a Fellow were issued, and a Fellowship key was created and made available for purchase.

Several years later a new Fellow complained that the certificate lacked dignity. The board of directors concurred and voted to develop a larger certificate that featured the association's seal and the signatures of the president, chairman of the board of examiners, and executive director. New certificates were made available retroactively to all members who had achieved Fellowship status.

In 1964 the association notified chapter presidents of the names of new Fellows so that colleagues could provide appropriate recognition at the next chapter meeting. In addition, the national office informed chapter presidents that a certificate would be sent to them for presentation and that the chapter had the option of purchasing a Fellowship key for presentation. Although the association never required this custom of chapters, a majority enthusiastically adopted it.

Designed to resemble a fraternity key, it was also available in a pin for female Fellows. In 1980 it was reduced in size and made available as a tie tack or lapel pin.

Retention of the Fellowship

The board of directors periodically considered whether a Fellow was still a Fellow if he or she had failed to renew membership within the association. Prior to 1965 the bylaws viewed Fellowship as a membership classification and did not permit former members to claim the Fellowship title. But the bylaws changes voted in August 1965 to delete Fellow as a membership category and establish it as an earned title. Through these changes, Fellows could retain their titles even if they chose to discontinue their membership. A new bylaws provision stated:

A person who ceases to be a member of AAHA may maintain his status as a Fellow by paying an annual fee as set by the board of directors.

A person who relinquishes his status as a Fellow may have such status reinstated by paying a reinstatement fee as set by the board of directors.

In 1977 the board of directors repealed these provisions because out of the 20 members who had dropped their membership, only one chose to accept special status. The present bylaws state the following:

A person who ceases to be a member of HFMA relinquishes his status and designation as a Fellow and all rights pertaining thereto,

Upon reinstatement as a member, Fellowship status shall be simultaneously restored subject to criteria established by the board of directors.

These criteria are embodied in the certification maintenance program adopted in 1981.

HFMA's leadership periodically studied the issue of how to encourage continued involvement and currency in healthcare subjects aware that certification in a previous year did not constitute a contemporary status of professionalism in the association. A program designed to encourage continual upgrade of one's professional status was designed that did not require retesting but did require a record of continuing education as a student or institute registrant, or service as a teacher or presenter in an educational setting. Other service activities were spelled out as qualifying activities. All such continuing activities are measured by a point system, and it is necessary to earn 100 points over a three-year period to be considered for current status. Applications for current status are required, and appeals are allowed in event of rejection. Emeritus status is granted on becoming a retired member. Certification thus became more than merely qualifying for the examination and passing it.

Certified Manager of Patient Accounts Program

In 1962 the association reviewed its role in hospital credit and collections and expressed the hope that it would develop a separate examination for credit and collections personnel. In 1967 the Credit and Collections Committee recommended that consideration be given to a means for recognizing achievement in that field. Two years later the council on professional excellence recommended that the association "take immediate and aggressive action to recruit and offer services and certification to credit managers from hospitals and other health care institutions." The board concurred and directed the council to develop the certification program for qualified personnel.

The CMPA Examination

Action proceeded swiftly. The council met in March 1969 to prepare an outline for an examination and assigned certain subjects to council members who would then develop questions. At the June meeting it was decided to accelerate exam development and conduct it for the first time in November 1969. The Executive Committee approved the eligibility requirements for the exam and agreed to identify a successful candidate as a *certified manager of patient accounts (CMPA)*. Forty-five candidates sat for the first CMPA exam and the 22 who were successful saw their names and photos in the February 1970 issue of the journal.

In June 1970 the CMPA exam was offered for the second time and was subsequently held concurrently with the Fellowship exam. In response to the growing role of credit managers affiliated with other organizations, the board of directors adopted an expansion of the membership tenure requirement that stated members must "have held membership for two full years at (the) time of application or have held HFMA membership for one full year, plus two full years membership in a recognized hospital credit managers group."

Program Promotion and Requirements

The strategy for promoting and administering the CMPA was similar to the strategy used with the Fellowship exam. For example, the association developed study guides for the CMPA exam that resembled Fellowship study guides. In addition, the association encouraged chapters to conduct CMPA coaching sessions. Grading mechanisms, notification procedures, and certificates were similar in process and design. CMPA jewelry was also created.

Just as with the Fellowship examination, eligibility requirements for CMPA status changed throughout the years. The certification maintenance program ensures that CMPAs maintain current status.

Work with the Educational Testing Service

The council on professional education in 1969 recommended that "in view of the growing scope of HFMA," the association investigate obtaining expert assistance in exam development. In August 1969 a program director from Educational Testing Service (ETS), Princeton, New Jersey, visited with the council to share principles of test development, which included the following:

- Establish an overall test plan.
- Establish basic requirements that all candidates must pass (identified as "core" subjects), supplemented by supportive subjects to be selected for inclusion in the annual examination.
- Establish separate passing points for core subjects and for supportive subjects in lieu of an overall passing point (offered as an option to the current system).
- Weight point values of question on a 2 to 1 ratio, that is, 5 points, 10 points, 20 points, or 40 points. Eliminate, for example, 15 and 25 point questions.
- Assign point values on the basis of timing and the relative weight of one subject to another.

ETS also recommended that the association shift from essay and problem-oriented questions for core subjects to a multiple-choice format. Unfortunately, the board of examiners had problems creating multiple-choice questions. Although the association's 1972 exam adopted the core/supportive question format, most of the exam questions were still of the essay or problem-solving variety.

In addition, the board of examiners also had problems finding sufficient materials to construct multiple-choice questions. In the past, the board of examiners had developed a new examination each year by creating new questions or materially altering previously used questions.

A significant backlog of material was nonexistent. ETS therefore suggested the development of a reservoir of at least 700 subject-related multiple choice questions. In a proposal that outlined how the association could achieve this objective, ETS reported that their cost for creating one acceptable examination item was \$30.

Although the board of examiners recognized that such a program would eventually conserve resources, it found the program too extravagant because of

the limited numbers of exam candidates. ETS agreed and, as an alternative, suggested that the association appoint a full-time staff member whom ETS would train to write multiple-choice items. In addition, ETS suggested that it train a voluntary team of members to develop a reservoir of core questions. Ultimately, this group came to be known as the *examination generating group*, which national office staff lovingly called "the EGG-heads."

In the next few years, ETS continued to educate members of the examination generating group and critiqued exam questions. In addition, the board of examiners sought the advice of ETS on specific issues, including the use of calculators in the exam room. In 1976 the board of examiners began to allow calculators into the exam room and retimed exams for the use of calculators. In addition, ETS communicated with the association on government regulations that might affect the exam. But the ETS relationship was terminated in 1977 and the EGG-head concept was abandoned.

The Council on Professional Excellence and the Board of Examiners

According to the *modus operandi* for professional examinations, the council on professional excellence had ultimate responsibility to determine appropriate subject matter for the two exams, select questions to be used in the exam, administer and grade the exam, and certify candidates. In the early 1970s the association expanded the council by adding two new Fellows and two CMPAs who assisted in preparation of the two examinations and in the grading and certification process. This expanded group was called the Exam Writing Group (EWG).

In 1978, after terminating the examination generating group, the board of examiners was expanded by four members, who, with the chairman of the council on professional excellence and a second council member, served as members of an examination writing group that met twice a year to develop exam items.

Presently the council on professional development and the board of examiners exist as separate bodies with no overlapping membership. The board of examiners has responsibility for administering the certification program; the council on professional development deals with long-term planning and conceptual issues.

Maintenance of Certification

The decision to maintain certification within both examinations so that members could obtain current status was not made overnight. In 1973 the council on professional education opened discussion on the concept of recertifying HFMA professionals. Following a discussion at the Fellows' meeting at the 1974 ANI, the association forwarded a questionnaire to Fellows that explained that recertification had emerged as a major issue in many professions and that the HFMA needed to assume a leadership role. Responses from the field revealed a strong objection to recertification through reexamination, but a general acceptance of recertification achieved through other means. A key issue was whether attaining Fellowship and CPA designation had proven competency for a particular time period or these individuals had achieved a competency that would extend indefinitely into the current environment.

To address this issue, the council on professional excellence requested the board of directors to adopt a working definition of *Fellow* and *CMPA*. Not all board members were convinced of the need for recertification, but after a lengthy debate, the following definition was adopted.

Fellowship and the certification as a Manager of Patient Accounts are distinguished designations awarded by the Hospital Financial Management Association to those members who have attained a high level of professional requirements and by passing an examination. Once having achieved a designation, one has a continuing responsibility to maintain professional knowledge and actively contribute to solving the problems that face hospital financial management.

Approval of this resolution by the council gave official sanction to the concept of recertification and the authority to move ahead to develop supportive criteria. Members of the council were especially impressed by the maintenance criteria promulgated by the American Society of Association Executives for its Certified Association Executive (CAE) program. Held by HFMA's executive director, this designation served as an important benchmark for an arduous process that took several years to complete.

In October 1980 Gerald W. Fuller, chairman of the board, notified HFMA Fellows and CMPAs of a program to encourage and continually update professional status within healthcare financial management. In May 1981 HFMA Fellows and CMPAs received a booklet that described the HFMA Certification Maintenance Program as well as procedures and point values for maintaining current status. The booklet was accompanied with an application for current status that Fellows and CMPAs were asked to submit to the national office no later than July 1. If approved, current status would remain in effect for a three-year period.

As of June 1981, all Fellows and CMPAs were granted current status for three years. But an incentive was also introduced to encourage Fellows and CMPAs to apply for current status in 1982 and 1983, thus staggering future renewal schedules. The December 1986 journal published the names of all Fellows and CMPAs who had earned current status through May 31, 1989. This listing is still published and updated annually and candidates who sit for either examination to attain professional status are well aware of the requirements to keep that status current.

In the spring of 1991 a chairman's task force on certification brought forward a number of recommendations for changes in the scope and operation of the credentialing program. At this writing, the board of directors was reviewing members' comments on the proposed changes and was expected to give final consideration to the recommendations before early 1992.

NINE

Relationship with Others in the Grove



Do not stand in a high place under an isolated tree.

Quoted by William C. Van Lopik
President, HFMA 1971-1972

Since 1920 the American Hospital Association had made accounting services available to its members through its Committee on Accounting and Statistics and through the publication of two accounting manuals. In 1943 the committee endorsed the creation of a national association of hospital accountants. By the end of World War II the AHA had hired its first accounting specialist, who laid the groundwork for more in-depth study of hospital accounting techniques by association staff and the committee.

Developments at the AHA matched developments within the profession. In the 1940s most hospitals were able to make slow but steady progress in improving accounting and business practices. The AHA cosponsored institutes at Indiana University from 1941 to 1946 that helped spark interest in hospital accounting and generated support for a national association of hospital accountants.

When William Follmer crystallized his plans for a national association in 1945, he expected "that the association will cooperate in all ways with the American Hospital Association, state hospital associations, and local groups or councils in their endeavor to promote uniformity of hospital accounting."

His high expectations were understandable. Because Follmer worked for a hospital council, he had faith that a close relationship between AAHA and the AHA would eventually evolve into some sort of endorsement or cosponsorship arrangement. Moreover, he fervently believed that AHA members and other hospital executives could only benefit from the advancement of hospital accounting. Although other leaders in the profession supported Follmer's desire for AHA approval, they also believed that if AHA refused to cooperate "we should (not) tuck our tail between our legs and go back to the dog house."

AHA's Committee on Hospital Accounting and Statistics failed to clarify the relationship between AHA and the new association. AHA remained concerned

about the new association's promise and withheld approval until it received anticipated membership figures and an operating budget. Nevertheless, Follmer felt enough confidence in AHA's interest in and support of the new association to draft a constitution and bylaws.

William Markey Coordinates Efforts with AHA

In 1946 AHA hired William H. Markey, Jr., as its first accounting specialist. A CPA and former administrator at Shadyside Hospital in Pittsburgh, Markey promoted the concept of an association for hospital accountants in his consultant's column in *Hospital Management* magazine and offered his help in developing the new association.

Although AHA officials subliminally supported the new association, AHA continued to withhold official endorsement until Executive Director George Bugbee could present the matter to AHA trustees. The mood of watchfulness was best expressed in a memo from Fred Muncie to William Follmer:

It is my honest opinion that we shouldn't be too eager to press for an official endorsement by the AHA. I believe from what we've been told that we will accomplish just as much by biding our time and working through their Board of Directors with the members and friends we have outside.

In 1948 Graham L. Davis, president of AHA, recommended that Muncie meet with Markey to develop a coordinated program. Markey endorsed the use of the AAHA journal to promote the concept of uniformity in hospital accounting and offered to submit papers and articles for publication. Acting on this suggestion, Muncie wrote a letter to Markey in which he outlined several potential areas of cooperation. Markey thought enough of these proposals to call a meeting of the AHA Committee on Accounting and Statistics, which both Muncie and Markey attended. With the exception of two individuals, all committee members were also members of AAHA.

The personal charisma of Bill Markey was evident in numerous official transactions with the AHA. Follmer's news bulletin of August 15, 1948, advised AAHA members that AHA would provide advance notice of AHA-sponsored accounting institutes. On another occasion, Follmer shared a proposed chart of accounts with Markey, and the two men regularly exchanged feedback on positions available in the field as well as the names of possible candidates.

Finally, Markey gave Follmer permission to contact speakers who had appeared on AHA-sponsored accounting programs and request copies of their papers for possible publication in the journal. When professionals in the field wrote the AHA about accounting issues, Markey would often share the benefits of the newly formed association of hospital accountants. In another communication, Helen Yast, the assistant librarian at AHA, requested that Helen Yerger make copies of *Hospital Accounting* available for library use.

AAHA officers renewed their discussion of AAHA's relationship with the AHA in 1952 by focusing on AHA's recent decision to create "personal departments" of individual hospital disciplines within that organization. Several AAHA officers speculated that AHA might develop its own accounting organization and

that hospital administrators might then encourage accountants to join the AHA body. Because the AAHA leaders viewed AHA's decision as a formidable challenge, they elected to "do everything in our power to improve the quality of our journal and any other member services possible so that administrators and accountants would readily see the value . . . of AAHA membership."

Members further agreed that "we should at all times endeavor to cooperate to the best of our ability with AHA, but that we would not consider surrendering our prerogatives of the journal, membership fees, election of our own officers, and general administration of our association." However, signs of growing independence surfaced with the appointment to AHA's 1952-1953 Committee on Accounting and Statistics of three people: AAHA's Past-President Charles F. Mehler, current President John M. Stagl, and future President Harry O. Humbert.

Catholic Hospital Association

AAHA began a series of officially sanctioned joint committee meetings in 1954 with the AHA and Catholic Hospital Association (CHA). Among the issues discussed were the role of accountants in fulfilling the needs of hospitals and the current and future role of the association in fulfilling the needs of its members. Representatives from all three groups concurred that many CPAs were unaware of the AHA Uniform Chart of Accounts manual and that a uniform chart had yet to gain broad acceptance within the hospital field.

Furthermore, association leaders noted that hospital management tended to minimize the value of accounting. However, they also recognized it was their responsibility to promote accounting's potential contribution to health care. Finally, leaders discussed the difficulties of obtaining strong accounting personnel, problems in producing quality correspondence courses, and the challenge of using modern machine technology to perform accounting procedures.

Fortunately, association representatives had also considered solutions to these problems. They agreed to promote uniform accounting procedures at the local level through AAHA chapters. In addition, they sought to create in-service training aids for accounting through institutes, correspondence courses, publications, AAHA chapter programs, and state hospital associations, as well as management training programs sponsored by the AHA and CHA. Finally, they hoped to encourage the adoption of modern technology within hospitals by inviting vendors and manufacturers to appear on AAHA chapter programs.

State Hospital Associations

Association leaders also pledged to encourage chapters to work with state hospital associations on accounting issues and arrange for speaking opportunities at programs and conferences. The leaders believed that if an AAHA chapter could work through and with a state hospital association, it would be in a better position to assist a local hospital with a specific accounting problem. Finally, they endorsed distribution of a paper on uniform accounting to CPA firms and entertained the possibility of a "direct line" of communication between the AAHA and an advisory group within the AHA. Given the number of issues that these leaders

discussed, there was little doubt that they would meet again and that joint representation of AHA, CHA, and AAHA would become a permanent fact of association life. Shortly thereafter, AAHA's Committee on Structure and Program recommended establishing a permanent joint committee with AHA.

The Joint Committee

In December 1955 Sister Mary Gerald informed AAHA's board that AHA was "very pleased with the Coordinating Committee concept." At a February 1956 meeting in Chicago the committee elected Robert Reeves, president of the AAHA, as temporary chairman. Also present were William Pierce; Maurice J. Norby, the deputy director of the AHA; and Ann S. Friend, also of the AHA, who served as secretary for the meeting. Members established a purpose for the joint committee and agreed to invite representatives from the Catholic Hospital Association.

After reviewing current projects, they agreed that although all three associations sponsored educational programs and published journals, little overlap existed. AHA shared its plans to develop "an intensive educational program to improve financial management in hospitals" through a special grant, and the committee agreed that AHA should formulate and recommend policies and procedures and CHA and AAHA should assume responsibility to establish standards.

Duties of the Joint Committee

One of the primary responsibilities of AHA's newly named committee on accounting and business practices was to develop closer relationships with national accounting and business groups. AAHA stated that it would try to assist hospitals with their credit and collection programs by working with existing credit groups. Despite gaps and problems within the area of accounting practices, association leaders recognized that much progress had already been made. For example, several state hospital associations had already added full-time accounting specialists to their staffs and hospitals were able to enhance management practice through more dependable accounting data.

Several years later, the associations differentiated between "general" and "special" institutes, a decision that led to the AAHA's first independently conducted regional institute in Philadelphia in 1959.

Over the next decade the joint committee met at least once annually to exchange information about educational programs and other projects. In 1961 the three associations began to exchange written reports and plans for the upcoming year. In addition, AHA regularly shared minutes of meetings of the Committee on Accounting and Business Practices. In an atmosphere characterized by trust, respect, and commitment to mutual goals, committee members routinely exchanged ideas, including suggestions for AAHA journal articles. On one occasion, the AAHA journal featured a series on budgeting concurrent with the release of the AHA's Budgeting Manual.

AICPA Joins the Committee

In 1964 the joint committee became increasingly involved in technical issues and in 1967 formalized its relationship with the American Institute of Certified Public Accountants (AICPA). Although AICPA agreed to join the new joint committee,

it also insisted that the joint committee's recommendations not be binding on the institute. In February 1968 the new joint committee convened under the following charge:

The Joint Committee of the American Association of Hospital Accountants, the American Hospital Association, the American Institute of Certified Public Accountants, and the Catholic Hospital Association reviews and assists in the coordination of activities and efforts of its four parent organizations toward improved financial management in healthcare institutions. The joint committee may propose but not implement action in the area of financial management; its function is that of providing opportunity for discussion, recommendation, and coordination among its parent organizations.

Audit Guide Issue

Among the critical issues to come before the joint committee in the early 1970s was AICPA's release of *The Audit Guide for Hospitals*. The joint committee noted that the proposed guide might curtail hospital efforts to attract philanthropic support and conduct reimbursement negotiations. But AICPA representatives retorted that the purpose of the audit guide was to establish generally accepted accounting principles and that philanthropic and reimbursement issues should be covered elsewhere. After listening to numerous complaints about the guide, AICPA representatives promised to carry these concerns to committee colleagues. Following its 1970 meeting, the joint committee produced a special report on the proposed audit guide that was widely circulated among members of HFMA's board and matrix, AHA officers, and committee personnel.

The AHA issued a letter to allied hospital associations along with two draft copies and suggested that HFMA chapters provide commentary and feedback on the document. HFMA subsequently issued a letter to its members, including associate members employed by CPA firms, and enclosed two letters to AICPA that outlined HFMA's objections to the guide. The letters also encouraged AICPA members to discuss the issue with their CPA firms and to contact AICPA officers for an opportunity to review a complete draft.

When John Quinn of Price Waterhouse took his seat at the October 1971 meeting of the joint committee, he encountered strong opposition to the audit guide. In addition, he heard protests concerning the composition of the 15-member AICPA Committee on Healthcare Institutions, which was responsible for drafting the guide but which had no representation from hospital-employed CPAs. The AHA had testified about the guide at one committee meeting but never had the opportunity to work with AICPA committee members on its development. Although joint committee members noted that hospitals could comfortably accept 95 percent of the guide's contents, it opposed other points.

When Quinn heard that HFMA had adopted a position that "healthcare institutions should continue to follow industry-accepted accounting methods as embraced in AHA's Chart of Accounts for Hospitals and policies, the *AICPA Audit Guide* notwithstanding," he quickly sought a go-ahead from AICPA to meet with industry representatives prior to its regularly scheduled committee meeting. The precommittee meeting session took place in Dallas with representatives from AHA, HFMA, and CHA in attendance. HFMA prepared a document detailing its

opposition to the guide, and it had a profound impact on the development of a final product that earned wide acceptance within the industry.

Dissolution of the Joint Committee

On numerous occasions the joint committee helped to coordinate the policy-making initiatives of AHA and AICPA. In response to sharp cuts for Medicare budgeting in 1970, the committee recommended an escalation of reimbursement to hospitals. When the U.S. House Ways and Means Committee invited AICPA to testify on proposed new Medicare regulations, it signaled the emergence of a strong alliance between the hospital field and public accounting field.

Despite its track record of cooperation, the joint committee had little clout within its member organizations. AICPA's decision not to send a representative to the 1972 meeting eventually led to the demise of the joint committee. In 1973 HFMA realized that ad hoc communications among the member groups were more than adequate and that it could work independently with AICPA to develop such ventures as a Medicare workshop. In addition, both the AICPA and HFMA were represented as guests on AHA's council on financing. Combined with the CHA's withdrawal of support, that change led to the formal dissolution of the joint committee in 1974.

AHA/HFMA Joint Policy Committee

Early in 1971 Past-President Jeff Steinert informed President Charles Anderson that reimbursement "is getting stickier than ever" and cited two recent Medicare rulings as evidence. Steinert questioned HFMA's role in responding to and shaping these rulings and added that the original purpose of the matrix principles and policies council was to review such items and make recommendations for action to the board. Anderson and President-Elect Bill Van Lopik focused on the most effective channel for setting forth HFMA's policy positions. Although the joint committee was available for airing these positions, it had no formal recognition within the AHA. For this reason, power rested exclusively in the hands of AHA staff who, in turn, had to influence AHA council and committee deliberations.

HFMA leaders sensed that working through the AHA would be beneficial to both organizations and recommended further discussion on the content and format of information coming from HFMA to AHA and a program for managing that input. HFMA realized that managing the flow of information between the two organizations would require cooperation at all levels within the HFMA—from the membership-at-large, chapters, matrix organization, staff, and members of the national board of directors.

In response to HFMA's suggestion, David Drake, AHA's director of financial management, recommended the development of a joint AHA/HFMA committee at the policy development level. AHA's board of trustees subsequently approved this committee and proposed administrative regulations that called for the committee to function as "a service agency to the parent organizations" and "provide a mechanism for periodic review of mutual problems with the opportunity to offer recommendations to the parent bodies for the resolution of differences on issues for conjoint action and for planning for the future in areas of mutual concern."

Structure of the Committee

Each organization was to have three voting seats with the exception of staff members who would serve in an ex-officio capacity. In addition, the committee membership would include one AHA representative from its council on financing and one HFMA representative from among its officers. The offices of chairman and secretary would rotate.

Among the issues discussed by the committee was the consolidation of such publications as the "Statement on Financial Requirements," "Policy on Implementation of the Statement on Financial Requirements," and "Guidelines for Review and Approval of Rates by a State Commission." Although AHA's council on financing wanted to reissue all three documents as a single policy statement, HFMA opposed mixing policy and guidelines on the grounds that it would confuse third party and hospital rate negotiators. Although HFMA's position was defeated by a single vote, AHA's general council eventually overruled the council on financing. After making some revisions, AHA issued separate documents.

Semiannual meetings of the joint committee continued through 1975. Both parties enjoyed a free exchange of information and the opportunity to work together on such issues as the Economic Stabilization Program, the Hill-Burton regulations, uniform billing, cost containment, and third party payment problems. During this period, HFMA established its Washington office and its principles and practices board. Although these actions caused some anxiety within AHA circles, HFMA allayed fears by assuring AHA that it would respect its policy-generating position.

A Memorandum of Understanding

By the mid 1970s meetings of the joint committee became less frequent. AHA interest and representation dissipated and important issues were no longer brought before the committee for evaluation by HFMA personnel. At times, even relationships among staff members seemed strained. Moreover, AHA terminated its cosponsorship of HFMA education programs. The deteriorating situation was finally resolved when the two associations signed a memorandum of understanding. In April 1981 the HFMA board approved the dissolution of the joint committee.

In the late 1950s an AAHA board member had suggested that the association present a "bill of rights" to the AHA that would explore the quality and character of the relationship. In 1977 staff from both organizations met to discuss a document that covered five areas: policy, communication, legislative and regulatory activity, education, and cooperative efforts.

In the document AHA recognized HFMA as "the primary external professional technical and educational resources in matters related to hospital financial management." It pledged to involve HFMA in identifying issues and developing policies and procedures. At the same time, HFMA pledged to avoid public criticism of AHA's views without first making a concerted effort to resolve differences. In addition, the memorandum called for communication between AHA's council on financing and HFMA's board of directors through a joint committee as well as communication at the local level through chapters and allied hospital associations.

The memorandum also called for AHA to assume primary responsibility for communications to legislative and regulatory bodies but recognized HFMA's role as "a major resource in developing policies on financial matters." Among the areas of common interest identified were collection of information on current financial management issues, dissemination of information to members, and delivery of educational services such as seminars and publications.

These activities and new programs being considered for development must be closely coordinated between AHA and HFMA as well as with other organizations in the healthcare field to assure consistency in content and to avoid wasteful duplication. . . . The communication lines outlined above will be the key to a coordinated successful effort.

Following approval by HFMA's Executive Committee, the memorandum was signed in December 1976 by President Clarence F. Legel and J. Alexander McMahon, AHA's president. Shortly thereafter, the joint committee distributed the memorandum in the form of a joint letter to state hospital associations and HFMA chapters.

When HFMA moved its headquarters office to Oak Brook in 1980, the opportunity for staff to meet casually or on an ad hoc basis vanished. The association staffs began to hold formal meetings quarterly or annually. Ongoing communication between the two groups now is accomplished primarily through their Washington offices and between the executive officers of the two associations.

In addition to codevelopment of several educational programs, HFMA and AHA worked together in 1982 to assess economic trends. Rather than developing its own position statement, HFMA decided to endorse AHA's Guidelines on Healthcare Data Management. In 1984, HFMA contributed to establishing the John Alexander McMahon Chair at Duke University in tribute to AHA's long-time president.

American Guild of Patient Account Managers

As discussed in an earlier chapter, AAHA always accepted as members hospital employees whose job titles indicated that their primary responsibilities were in the areas of credit and collections or accounts receivable. In most small hospitals, the chief accountant or business office manager typically wore many hats, including credit and collections. Even in hospitals where separate functionaries existed, managers saw the activities of credit and collections personnel as related to accounting.

In Follmer's October 1948 newsletter, Robert Reeves published an article entitled "Cash Receipts and Accounts Receivable Procedures." In 1949, a subsequent newsletter featured the article, "Hospital Credits, Collections, and Public Relations," by Allison E. Skaggs, a Battle Creek, Michigan, consultant who had delivered a similar paper at an AHA convention. In addition, most of the early annual institutes held at Indiana University with AHA sponsorship featured sessions on accounts receivable control and credit and collections. The 1949 program included sessions on Admissions of Patients in Various Categories and Related Effects on Accounting, Accounts Receivable Management and Control of Income

from Care of Patients, and Methods of Handling Blue Cross Patients' Accounts. Finally, chapters in such states as Tennessee welcomed representatives from commercial collection agencies who had provided input for chapter programs or hosted social affairs.

Although AAHA did not list credit managers on its original application form as being eligible for membership, it recognized their future role and potential contribution in the area of credit and collections. In 1962 it sponsored a conference with hospital credit managers to lay the groundwork for further exploration of the topic. Shortly thereafter, AAHA increased its coverage of credit and collections issues at regional and national institutes and within the journal. In addition, the national office encouraged chapters to offer programs that would attract credit managers or work closely with existing credit manager groups.

In 1967 AAHA mandated creation of a chapter-level Credit and Collections Committee to provide technical input for chapter programs. In some areas, existing credit manager groups merged with chapters while in other areas, separate credit manager groups were formed who worked closely with the local AAHA chapter.

When the AAHA became HFMA in 1968, the journal featured an article entitled, "What HFMA Means to the Credit Manager," which reviewed AAHA's past performance in credit and collections. The article noted that changes in third-party payment practices and the onset of government payment programs had revolutionized the credit manager's role and had catapulted more traditional non-accountant credit managers into the financial management arena. The article concluded with a pledge that HFMA was "prepared to assist hospital credit managers in coping with the new demands upon them."

In the early 1960s, AAHA consulted with the American Collectors Association and John W. Johnson, its president, appeared in numerous national and chapter programs, and authored several articles for the AAHA journal. Also a relationship existed with the Associated Credit Bureaus of America (ACBA)—just one of the commercial exhibitors invited to attend the 1962 annual institute at Indiana University. Because every institute class was required to visit exhibits, groups such as ACBA benefited from a captive audience. In addition, ACBA appeared on several AAHA sponsored programs at both national and chapter levels.

By 1966 several hospital-related credit manager groups existed in states on the east and west coasts. In most cases, these groups worked with local chapters and sometimes even cosponsored annual institutes. When AAHA learned that some of the eastern groups wanted to organize a national association of hospital credit managers, President Harold Hinderer wrote a letter outlining AAHA's activities in the area of credit and collections.

After a meeting with credit managers from New England states, New Jersey, New York, and Pennsylvania, AAHA agreed that committee representatives should report back to their respective groups and develop recommendations that might ultimately lead to merger with AAHA.

Attempts to Consolidate

Among the recommendations set forth by the credit groups was a name change for AAHA and the development of a professional examination for credit personnel. Although these changes were in development or close to implementation, other

recommendations were rooted in fears that credit professionals might lose their professional identity and uniqueness within HFMA chapters.

AAHA's Credit and Collections Committee, which was established to advise the board of directors on technical issues and educational programs, reviewed the recommendations and offered its reactions. Credit managers had asked AAHA to hire a paid division executive at the national level to focus on credit and collections. As an alternative, the national office hired an administrative assistant to handle internal operations, and the executive director pledged to devote more time to chapter relations and local credit and collections groups. Instead of capitulating to the demand to maintain separate treasuries when a local credit and collections group merged with an AAHA chapter, AAHA decided that funds within the treasuries of local groups should be disposed of when these groups dissolved or agreed to the merger of all funds.

Despite the forceful, logical arguments for a national association with AAHA, several local credit manager groups voted to form their own national association, the American Guild of Hospital Credit Managers, later named the American Guild of Patient Account Managers (AGPAM). The New York group elected to join the Metropolitan New York Chapter, in which certain autonomous privileges were provided. But not all hospital credit manager groups elected to join the new AGPAM organization. Those that elected to remain independent were closely tied to local or state hospital associations or to HFMA chapters. In some areas of the nation, HFMA chapters helped local credit managers to establish AGPAM chapters and they continued to work in harmony.

Mutual Cooperation Resolution

In 1969 HFMA's Matrix Receivables Management Committee reopened discussions on the activities of AGPAM and HFMA in credit and collections and passed the following resolution:

The receivables management committee recommends that the Hospital Financial Management Association position be that of mutual cooperation between HFMA and the American Guild of Hospital Credit Managers in developing more efficient management of patient accounts throughout the health field. It is further recommended that the HFMA in recognizing its responsibilities not diminish but strengthen its efforts to provide educational programs and information at the chapter as well as the national level in this activity.

Despite the HFMA resolution and a high level of cooperation among the officers of both groups, many AGPAM members were wary of a closer relationship with HFMA. The Guild's president appointed a special committee to identify the advantages of affiliating with a hospital-oriented organization such as AHA or HFMA. When Guild officials contacted AHA, they learned there was no provision for a special relationship other than a routine listing in the AHA's guide as a health-related organization.

In May 1970 AGPAM President Fay Page wrote to George Coldeway of AHA and relayed the following message: "Events of the past year have convinced me that the credit managers belong with HFMA, an opinion on which many of my associates now concur." However, she added that a vocal minority opposed any efforts to bring the two organizations together. Fortunately, the divisiveness was

short-lived. During his 1970–1971 term of office President Charles Anderson effectively used the recently inaugurated CMPA examination as a peace offering, and in October 1971 several prominent HFMA personalities appeared as speakers on the Guild's annual institute in Washington, D.C.

Rejection of a Merger Plan

As HFMA's president for 1972–1973, Ronald Kovener worked diligently to capitalize on the cooperative climate that existed between the two groups. He prepared a plan called "Principles of Cooperation" and circulated it to Executive Committee members. After earning their support for his plan, Kovener and I met with Fay Page, Tom Paton, and Joe Galente, then the Guild's president, in March 1973 to discuss specific terms of a merger plan. In a follow-up report to that meeting, Kovener stated that the concept of separate chapters was the cornerstone of any merger and asked all matrix groups to review the impact of the merger.

Prior to its June 1973 meeting, the council on chapters received background information on the consolidation of HFMA and AGPAM. In October the council recommended that the board of directors reject the consolidation plan as "not in the best interests of HFMA." The board subsequently approved this recommendation with the proviso that such action "does not limit for future study and review merger of AGPAM or any other technical specialty group."

The Issue of Certification

Early in 1976 HFMA learned of plans by AGPAM to establish a certification program through examination. HFMA officers empathized with the desire of AGPAM leaders to provide professional development services to its members, but feared that it might create confusion within the hospital field. The officers therefore proposed a modification of the eligibility requirements for the HFMA Certified Manager of Patient Accounts examination and offered to meet with AGPAM officers to discuss how the CMPA examination could be made available to AGPAM members.

A meeting of the minds never occurred. In April 1977 AGPAM announced its Certified Patient Accounts Manager (CPAM) program. HFMA's legal counsel advised that there was no legal recourse but recommended that HFMA's president write a letter of protest to Joseph Jordan, president of AGPAM. The letter argued that the two names would generate confusion within the field and would be "injurious to both designations, and most particularly to the long-established CMPA certification." It closed with a request that the Guild "change its certification designation to a name that is significantly different from . . . the designation used by HFMA." Although Jordan acknowledged the letter and indicated that copies would be forwarded to officers, board members, and legal counsel, HFMA heard nothing further on the issue.

In 1984 HFMA president Michael F. Doody reported to the board of directors that he had met with the chairman of the board of AGPAM to discuss how the two organizations could better cooperate. The April 1985 issue of the journal reported that the first meeting between the two organizations had produced "a list of 11 points of agreement," including the potential for joint sponsorship of educational institutes, joint efforts on book publishing, UB-82 issues, and journal

articles. A 3500-member organization, AGPAM conducted an educational session at the annual national institute in 1985. Moreover, HFMA gave AGPAM access to its professional registry and referral service and put AGPAM on its mailing list for task force issues related to patient accounts management. Finally, HFMA forwarded two articles for publication in AGPAM's magazine, and several AGPAM chapter newsletter editors took part in HFMA's workshop for chapter newsletter editors. While other discussions were held on occasion, no further efforts or serious cooperation took place after 1985. AGPAM engaged a management firm to run its operations and provide staff, with the apparent aim of strengthening its base and member services.

The American College of Healthcare Executives

Despite the proximity of the headquarters offices of the American College of Hospital Administrators (ACHA) and the AAHA at 840 North Lake Shore Drive and despite the friendly relations between the two staffs, there were few areas for mutual cooperation between the two groups. In 1959 Dean Conley, ACHA's president, conversed with me as AAHA executive director, and we concurred that mutual professional development interests made greater cooperation inevitable.

When Richard J. Stull replaced Dean Conley as ACHA's executive vice president in 1966, Rod Brutlag, AAHA's educational director, and I hosted a get-acquainted luncheon. Stull enthusiastically supported a cooperative, mutually beneficial relationship between the two organizations. In response, Stull was invited to be part of a planning session for the 1967 annual national institute where AAHA expected to unveil a program in financial management targeted at administrators. Excited about the opportunity, Stull also arranged for Everett Johnson, chairman of ACHA's Committee on Education, to be in attendance.

In April 1967 ACHA affiliates received an announcement that detailed a new jointly sponsored program at Ohio State University entitled *The Contemporary Administrator Inspects Financial Management*. According to the announcement, the program was "designed to acquaint the chief administrative officer with financial and statistical data which he must receive from fiscal personnel to enable him to identify certain problem areas." Although this program was terminated after two years, HFMA and ACHA collaborated again in 1971 to develop the course *Financial Management and the Chief Executive Officer*. With minor variations in title, content, and faculty, the course continued for several years at the annual national institute.

Through the years HFMA continued its close relationship with ACHA. The College's director of education routinely attended HFMA matrix meetings as an observer and served as a consultant to the council on education. In addition, ACHA invited HFMA staff to evaluate new educational programs such as *Expanding the Hospital's Revenue Sources* and to participate in ACHA's annual *Congress on Administration*.

Working with the Canadian College of Health Services Executives, the ACHA and HFMA co-sponsored a seminar at the 1980 American Hospital Association/Canadian Hospital Association convention in Montreal. ACHA recognized that hospital executive officers needed up-to-date financial management knowledge

and in 1982 requested HFMA's assistance in developing a jointly sponsored program on financial management for chief executive officers. First conducted in 1983 at four sites across the nation, this program was revised and presented until 1990 under the title Healthcare Financing Strategies.

Accounting Associations

Throughout the years AAHA continued to develop strong relationships with such organizations as the American Institute of Certified Public Accountants and the National Association of Accountants. Although the AHA and AAHA early had discussed the need for accounting releases applicable to the hospital field at their joint meetings, AAHA also thought it would be helpful to involve AICPA. Although the initial project fell through, the concept resurfaced several years later with the establishment of HFMA's principles and practices board.

National Association of Accountants (NAA)

William Follmer had patterned many of his formative ideas for AAHA on the structure and activities of the National Association of Accountants (NAA). NAA willingly shared information on awards, operations, chapter administration, and chapter workshops. AAHA often patterned its programs after NAA's and, in doing so, discovered many areas for enhancement as well as pitfalls to avoid. As HFMA grew it used NAA's organizational structure as a model. When NAA celebrated its 50th anniversary in June 1969, HFMA's president, Sister Mary Bertrand, attended as an honored guest.

American Institute of Certified Public Accountants (AICPA)

Through the years HFMA has viewed NAA and AICPA as horizontal organizations where accountants can keep abreast of general issues within accounting. At the same time, HFMA has realized its niche as a vertical organization that gives the greatest membership value to accountants employed in the hospital environment.

In 1967 HFMA solidified its relations with AICPA when AICPA joined the AHA and CHA as members of the joint committee. Even after this committee disbanded, AICPA and HFMA continued their relationship by planning and conducting Medicare workshops. AAHA worked closely with AICPA on its annual institutes for independent auditors. The economic stabilization program of 1973-1974 reinforced the working relationship between the HFMA and numerous CPA firms. In 1974 this legacy of cooperation reached its zenith when the HFMA presented its Board of Directors' Award to AICPA in recognition of the assistance provided by CPA firms nationwide in interpreting regulations and conducting educational programs.

HFMA's national office developed an outline for working arrangements between chapters and state societies in 1972 and recommended that state societies establish health service committees. Over the years there have been many formal and informal task forces, working parties, and liaison efforts. Since HFMA established its Washington office it has served as the focal point for cooperative effort on professional and governmental concerns.

Institute of Internal Auditors (IIA)

Although AAHA attempted to develop a relationship with the Institute of Internal Auditors, it was not until 1977 that HFMA joined with IIA to present HFMA'S Internal Control and Auditing Course. Although the course was repeated in 1978, IIA's name was omitted from the credits for the 1979 program and the two organizations had few official contacts.

Other Associations

Blue Cross Association

Like the ACHA, the Blue Cross Association was a tenant in the AHA building, making informal communication relaxed and comfortable. As the Blue Cross' intermediary role expanded in early years of Medicare, the organizations participated in a series of irregular meetings. In 1964 AAHA chapters assisted Blue Cross by helping hospital personnel understand coordination of benefits. At the same time, Blue Cross personnel assisted AAHA with its 1966 cost-finding workshops and its 1970-1972 Institutes for Intermediary Auditors. So appreciative was Blue Cross President James M. Ensign of AAHA's support that he sent the following note to the executive director:

Just a note during the first days of Medicare to tell you how much local chapters and the membership of AAHA have contributed to the success of preparations for Medicare. We have heard from a number of plans on this subject, and quotes like: "I would like to mention again the fact that the local chapter of the AAHA has volunteered its service gladly and at this time has given us hours of consultation." Thanks again to you and your membership for invaluable assistance at a time when the voluntary system is being put to an impressive test.

In 1967 AAHA joined the Blue Cross Association to conduct a hospital income study. The roots of this project were in South Carolina where the Blue Cross plan, state hospital association, and AAHA chapter developed a survey to determine sources of income and payment practices of third-party groups. So impressed was the national office with this initiative that it granted a special award to the South Carolina chapter. Because the project attracted national attention, the Blue Cross Association subsequently recommended similar cooperative projects with other plans and solicited the AAHA's assistance in building support and getting the word out.

In March 1967 representatives of the South Carolina Blue Cross Plan and the Blue Cross Plans of Pittsburgh; New York; and Richmond, Virginia, attended a planning meeting during which everyone expressed an interest in pursuing similar projects. Following the meeting, the Blue Cross Association developed a manual that explained the mechanics of conducting a survey and distributed it to member plans. The manual recommended that "each plan should seek endorsement and/or assistance from the state or local hospital associations and the local chapters of the AAHA." Responding to the request from Blue Cross to spearhead the project within AAHA chapters, the national office alerted chapters to the advantages of working with local Blue Cross plans on these surveys.

Association of University Programs in Health Administration (AUPHA)

During the October 1959 joint committee meeting attended by representatives of AAHA, AHA, and CHA, Harold Hinderer reported that the CHA had funded a project entitled "Accounting Reports to Management" and recommended that the three organizations work with graduate programs in healthcare management to ensure instruction in management uses of accounting and somehow involve the Association of University Programs in Health Administration (AUPHA). However, no action was taken because it was observed that AAHA was not yet in a position to offer advice to AUPHA.

In 1971 the AUPHA created a task force to study how to best strengthen its curriculum on hospital management issues. Harold Hinderer encouraged the chairman of the task force to invite me as AAHA executive director to the meeting. Subsequently, Gareth K. Hudson, a member of AUPHA's staff, and Hugh Long, a task force member from Tulane University in New Orleans, visited HFMA headquarters, and along with Howard Berman, task force member and professor at the University of Michigan, shared ideas and insights. Shortly thereafter, President William Van Lopik appointed Berman to HFMA's Institute Advisory Committee, and L. William Katz of George Washington University was contracted to develop an ANI course on management information and reporting.

The following year, the task force met to redraft its statement of mission and to design a two-day faculty institute on financial management to be given in the spring of 1973. Ralph Gayner, HFMA's director of education, assisted in the planning and attended the conference where he was able to identify many professionals who later developed programs or served as speakers for HFMA programs.

In 1975 an AUPHA project director sought HFMA's assistance in managing a project underwritten by the Department of Health, Education and Welfare to identify the health and behavioral science components for graduate programs in healthcare administration. The board authorized staff to prepare a position paper on the topic.

In 1976 AUPHA reconvened its task force on financial management and requested that HFMA appoint an ex-officio member to develop closer ties in light of the reality that "new plans for our task force . . . can only be accomplished with HFMA's cooperation." Ron Kovener, director of HFMA's Washington office, was appointed to serve. His involvement led to the development of a bibliography on financial management subjects that was published as a manual by AUPHA.

In 1990 AUPHA again sought to strengthen and update its financial management curricula. James D. Suver, a professor at the University of Kentucky, HFMA Fellow, co-author of a textbook published by HFMA, and past-chairman of AUPHA spearheaded this project and joint discussions between AUPHA and HFMA.

Epilogue



People are the common denominator of progress.

John Kenneth Galbraith

The preface to this history of the Healthcare Financial Management Association illustrates the forward thinking and planning of the early leaders as they foresaw the need for an eventual writing of the association's beginnings and evolution, even as they foresaw some of the forces that drove the association to achieve all that it has today. It would not have been possible to capture all of the atmosphere of the birth years and the years of development with their problems, issues, and travails without the detailed records regarded and guarded as inviolable.

My 19-year tenure as executive director saw the association through its adolescence and into adulthood, precipitated most certainly by the onset of Medicare. A few years prior, the association had untied the apron strings with Indiana University, and had launched a wide scope of educational programs. On July 1, 1966, we were in the wings and when we were exigently beckoned, we were ready to enter center stage.

As I looked forward to my retirement, I let it be known that part of my personal dream was to write the history of the association. The board of directors fulfilled that vision by contracting with me in 1981 to chronicle the association's life. The narrative that emerged almost a year later consisted of 1150 double-spaced typewritten pages, plus several hundred pages of appendix material. I understood that my effort must undergo a condensation before it could be economically published. This version, which marks the association's 45th anniversary, is the product of many months of editing, rewriting, and updating of the original manuscript.

I deeply regret the necessity of eliminating the names of many individuals who filled many roles in the evolution of the association; members and leaders at the national and chapter levels who made this story possible. We have striven to describe the roles of those persons whose names have been perpetuated by the association in the naming of awards and those persons who have led the association through the years.

Some of the early documentation that breathed life into the founding association has also been omitted. Details necessarily were omitted about some of the early educational programs that might have brought a thought from readers like, "Oh, yes, I remember being there—was it really November 1964 in Minneapolis?" or "That was the first ANI I attended and that was the course that was so helpful." However, the association intends to capture much of the omitted listings of persons and of events and the early documentation in its database system so that it can be brought up when needed and so that these essential segments of the association's history can be preserved.

It is my fervent hope that this abridgement will be as fascinating to the reader as the writing of the original narrative was to me.

A section on the important role that Indiana University filled in the founding of the association was eliminated, *per se*; however, the university's efforts are embodied in appropriate places throughout the text and in the biographical sketch of Stanley Pressler. Such was the university's stellar role that the association dedicated the first issue of its official journal "to INDIANA UNIVERSITY within whose walls hospital accountants first gathered and a dream became a reality."

Twenty-five years of my life and the bulk of my career was spent with the American Association of Hospital Accountants and the Hospital Financial Management Association. How many people have the advantage of reviewing their careers in reflective detail, and how many, even after nine years of retirement, have the good fortune to relive the events and the recollection of many friends and acquaintances as I have done during 1990 and 1991? When I retired I remarked that "had I been able to write my own career script, it could not have turned out any better!" And the melody lingers on!

On reflection, I also considered the events that led me to following a specific path. During my years as a supply officer in the military during World War II, I determined that I wanted to become involved in administration rather than pure accounting in my postwar pursuits. I also decided that I wanted to work for a service organization. After several years I found myself in the position of controller of the Mercer Hospital, Trenton, New Jersey. My predecessor was H. Burtis Skelenger, whose name is listed as a Charter Member of AAHA in Volume I, Number 1, of the association's journal. I eventually became a member of AAHA in October 1950.

After four years as a hospital controller, I became the administrator of the 50-bed Orthopedic Hospital in Trenton. Had I not then fulfilled my perceived destiny? Not yet, as events transpired. I attended my first annual national institute at Indiana University in 1953, and Fred Morgan asked me to take the lead in chartering a chapter in New Jersey.

Only a few months later I changed jobs and was unable to work on forming the chapter. However, when Sister Marie Lefebvre of St. Peter's Hospital, New Brunswick, issued an invitation in November 1954 to the then 20 AAHA members in the state, I willingly responded and was one of 10 persons who attended this exploratory session. I was elected chairman of the steering committee, and, in January 1955, when the chapter was organized with 75 charter members, with Fred Morgan in attendance, I was elected its first president.

The chapter had a highly successful and visible first year, and lo and behold, I was contacted late in the year by John Stagl, chairman of the national Nominating Committee, and asked to be a candidate for second vice-president. I attended my first board of directors meeting in Rochester in December 1955, just as the transition to Chicago was about to occur.

I was named chairman of the newly formed Committee on Chapters, whose agenda offered glorious opportunity for creative thinking. As chairman, I wrote the inaugural issue of "Notes from National." The Frederick C. Morgan Individual Achievement Award was created and groundwork laid for the William G. Follmer Merit Award. After serving as first vice president in 1957-1958 under C. Henry Hottum, I was elected national president for the 1958-1959 year. I was awarded national life membership in 1958, and I was always proud of the fact that my contributions were so recognized even before my term as president. My destiny had already passed my wildest dreams!

As the foregoing history states, I proclaimed that, as president, I was determined to conduct AAHA's first independently sponsored educational program to fulfill an agreement that AAHA had made two years earlier with the American Hospital Association. Arrangements for chapter cosponsorship of this endeavor were made during the first-ever regional meeting of chapter presidents held in August 1958 in Philadelphia. A date for the institute was set for October 1959, but little did I know then that the chore of planning and conducting this program would fall to me as executive director. Hugh Brown, who had replaced William Pierce as executive director early in 1958, resigned in February 1959, and the board of directors asked me to take the position. As it turned out, the highly successful regional institute in Philadelphia, followed by two regional institutes a year for the next several years, provided me with the experience and the assurance needed to move ahead with the association's first annual national institute in 1963 following our severance from Indiana University's program.

When I came on staff on June 1, 1959 (the day following the conclusion of my year as president), the AAHA staff consisted of three young ladies, the office space totaled 550 square feet, and there were about 3200 members and 58 chapters. Now I found myself doing administrative duty for a *national* service organization.

What would sages say about this strange coincidence? As I researched the beginning years of AAHA, I found that its actual birthday, consistent with the adoption of a constitution and bylaws, and the date set for recognizing charter members was September 30, 1946. This fact was borne out by an excerpt of a letter from William Follmer to Frederick Muncie dated September 25, 1946:

"You will be pleased to know that we have 211 senior members and 5 juniors to date, with the deadline being September 30th."

On this very date my second son was born, and at the very hospital where I began my hospital career almost three years later! When I discovered this incredible fact, my emotion was indescribable!

In 1972 I visited St. Peter's Hospital in New Brunswick to meet with Joe Galente, president of the American Guild of Patient Accounts Managers. As I walked past the nurses residence, I stopped suddenly in my tracks. I had been

there before—in November 1954, to discuss the formation of the New Jersey Chapter. Now I could not help but wonder what my personal circumstances would have been had I not responded to the invitation to attend that meeting. So much of my life had sprouted from that incidence.

At my first board meeting in Rochester, New York, December 1955, I was thoroughly awed by the presence of the well-known association leaders. The minutes disclose only that I was present; I obviously did not participate in making motions or seconding them. I do recall one humorous episode. Sister Constance Marie had been elected national treasurer, and discussion turned to the bonding of officers. Someone asked: "Can a Sister be bonded?" Sister Mary Gerald promptly replied: "Of course; however, the rates are much cheaper."

I never met Bill Follmer, Fred Muncie, or Graham Davis. Others over the years left indelible impressions that guided me throughout my career: Fred Morgan, who set the stage for association progress; Bob Reeves, a wise man who stated his beliefs in few, well-chosen words; Sister Mary Gerald, whose brain was always ripe for picking; Henry Hottum, my mentor during my vice-presidential years; John Stagl, whose office across the street from mine was always open when I needed sage advice; Hugh Brown, from whom I learned the fundamentals of magazine publishing; Ray Everett, the first president with whom I worked as executive director; and indeed, all of the association presidents who followed. When, during the 25th anniversary of the association in 1971, past presidents were asked to recall some highlights of their year at the helm, Sister Mary Gerald, reflecting on the arduous circumstances of that era, wrote:

I am reminded of my approach to a prospective candidate for the post of our first executive director. I told him that we were looking for somebody who was well qualified in hospital accounting, had editorial skills and the knowledge of graphic arts in order to get our journal upgraded; that he would need to have a good public relations approach and have lecturing ability. My potential candidate asked calmly, "Sister, how much will the job pay?" I replied with a very straight face, "We are willing to pay up to \$10,000 a year." He paused for a moment, and then said, "Sister, you are looking for a genius with a hole in his head."

I am not a genius, nor had I lost my faculties, nor do I have a hole in my head. I am exceedingly thankful, however, that I possessed the capabilities and the character to serve the predecessor organizations of the Healthcare Financial Management Association for three years as an elected officer, for nineteen years as its executive director, then three more years as an appointed vice president, and, finally, as its historian and the author of this history.

Of all the thrills and happy experiences I encountered during my very satisfying career, none could surpass the moment when, during the annual national institute in 1979, the Robert M. Shelton Award for Sustained Chapter Excellence was unveiled! My dream destiny was realized with the comprehension that my name would be perpetuated in the annals of this vibrant service organization of hospital accountants and financial managers.

An advertisement in *Healthcare Financial Management* in March 1987 carried this lead-in: "There's a great past in our future." I sincerely believe that this phrase aptly fits the Healthcare Financial Management Association in this year, 1991.

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ABOUT THE AUTHOR

Robert M. Shelton, FHFMA, CAE

Robert M. Shelton retired from the Hospital Financial Management Association in 1981 after more than 26 years of active involvement.

Shelton joined the American Association of Hospital Accountants (AAHA) in 1950, and five years later he organized and served as the first president of the New Jersey chapter of the AAHA. He became a national officer in 1956 and two years later was elected president of the AAHA.

In 1959 Shelton was appointed executive director of the association and served in that position until 1978, when he was appointed vice president after the Association was restructured along corporate lines.

Shelton became a certified Fellow of the AAHA in 1957 as part of the first class of members to take the Fellowship examination and achieve certification.

Shelton was awarded the Frederick C. Morgan Individual Achievement Award in 1971, which is the highest award for individual achievement. In 1979, to pay tribute to his many years of service to the association, HFMA named for him the Robert M. Shelton Award for Sustained Chapter Excellence, which is presented annually to HFMA chapters exhibiting five consecutive years of sustained achievement.

He and his wife, Ethel, live in Glen Ellyn, Illinois.



Chapter Charter Dates

001	First Illinois	10/15/48
002	Wisconsin	9/26/50
003	Northeastern Pennsylvania	5/24/51
004	Eastern Michigan	9/15/51
005	Mississippi	10/17/51
006	Rochester Regional New York	10/23/51
008	Greater St. Louis	5/7/52
009	Western Michigan	3/27/52
010	Connecticut	6/4/52
012	Minnesota	9/22/52
014	Northern California	12/1/52
015	Tennessee	12/31/52
016	Arkansas	1/8/53
017	Western Pennsylvania (Merger Date)	3/1/88
	007 Northwestern PA	4/7/52
	017 Southwestern PA	3/16/53
019	Iowa	5/13/53
020	Massachusetts	5/20/53
021	Southern California	8/18/53
022	Heart of America	10/9/53
023	Washington	10/22/53
024	South Carolina	12/10/53
025	Northwest Ohio	12/23/53
026	Indiana Pressler Memorial	2/16/54
027	North Carolina	1/19/54
028	Virginia	3/22/54
029	Utah	3/17/54
030	Northeast Ohio	4/10/54
031	Idaho	4/20/54
032	New Hampshire/Vermont	4/27/54
033	New Mexico	5/27/54
034	West Virginia	6/30/54
035	Oregon	8/7/54
036	Southwestern Ohio	11/20/54
037	Florida	12/3/54
038	Oklahoma	3/29/55
039	Georgia	6/1/55
040	New Jersey	1/10/55
041	Metropolitan New York	2/7/55
042	Central Ohio	8/18/55
043	Metropolitan Philadelphia	11/1/56
044	Central New York	12/10/56
045	Northern Metropolitan New York	1/23/57
046	Montana	3/28/57
047	Appalachian Pennsylvania	5/3/57
048	Northeastern New York	10/17/57
049	Louisiana	12/18/57
050	Maine	2/21/58
051	Sunflower Kansas	2/13/58
052	North Dakota	5/29/58
053	Lone Star (Merger Date)	4/1/89
	053 Central Texas	3/15/59
	077 El Paso	5/3/72
	080 West Texas	11/30/79
054	Southern Illinois	9/10/58
055	Rhode Island	4/28/59
056	Alabama	4/22/59
057	Arizona	6/10/59
058	Show-Me of Missouri	7/14/59
059	Great Lakes (Merger Date)	6/1/91
	059 Central Michigan	11/12/59
	072 N. Great Lakes	6/17/68
	074 N. Central MI	7/31/69
060	AK-SAR-BEN Nebraska	9/29/60
061	Colorado	12/5/60
062	Western New York	10/30/61
063	South Dakota	5/17/62
064	McMahon-Illini	3/28/63
066	Washington Metropolitan	11/21/63
067	Maryland	4/15/64
069	Texas Gulf Coast	1/25/66
070	Kentucky	1/21/66
	011 Western Kentucky	7/11/52
	013 Blue Grass, Kentucky	7/11/52
	018 Kentuckiana	4/21/53
071	Hawaii	4/13/67
073	San Diego Imperial	10/30/68
075	South Texas	10/27/70
076	Nevada	3/15/72
078	Wyoming	11/30/72
079	Puerto Rico	8/2/74

