hfma™
new jersey chapter

Spring 2022 • vol 68 • num 3

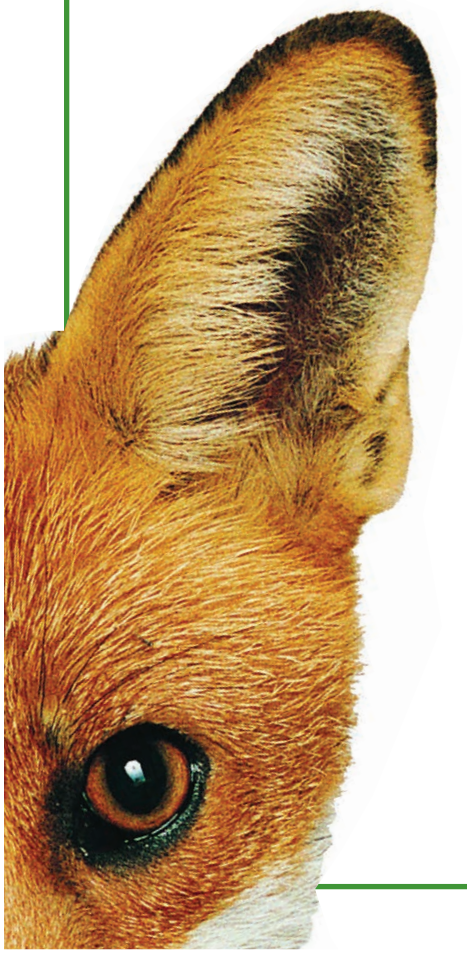
garden state focus

national excellence award winner

- Strategies for Price Transparency Sustainability
- Role of Diversity, Equity, and Inclusion in the Modern Healthcare Organization
- Advice on How to Navigate When Your Aging Parents Have Different Needs

OVERWHELMED BY THE PACE OF CHANGE IN HEALTH CARE?

WE HEAR YOU.



Fox Rothschild's Health Law attorneys understand the challenges hospitals and other providers face in the constantly changing world of health care. With in-depth experience and national involvement, we help our clients avoid obstacles and solve problems, so they can focus on what is most important: their patients.

Fox Rothschild LLP
ATTORNEYS AT LAW

950 attorneys | 27 offices

Elizabeth G. Litten
Partner and Chief Privacy & HIPAA Compliance Officer
609.895.3320 | elitten@foxrothschild.com

Princeton Pike Corporate Center
997 Lenox Drive, Building 3
Lawrenceville, NJ 08648

foxrothschild.com

focus •advertisers•

CBIZ KA Consulting Services, LLC

FoxRothschild

REVCO

Withum Smith+Brown

focus •cover•

Cover Courtesy of
Hermitage Press, Inc.

focus •points•

Who's Who in the Chapter 2

The President's View
by Jill Squiers 3

From the Editors
by Scott Besler 4

Who's Who in NJ Chapter Committees 10

Save The Date 13

Focus on Finance 14

New Members 16

Job Bank Summary 18

Certification 22

focus •features•

Strategies for Price Transparency Sustainability
by Tara Bogart 6

Role of diversity, equity, and inclusion in the modern healthcare organization
by Fatimah Muhammad and Lisa Weinstein 11

Advice On How To Navigate When Your Aging Parents Have Different Needs
by Millie Jones 17

Federal Efforts to Mandate COVID-19 Vaccinations, Testing and Masking: Overview and Status Update on Challenges in the Courts
by James A. Robertson and Jessica M. Carroll 19

Hospitals Feeling the Pinch of Staffing Shortages: Is this Just the Beginning?
by Sean Hopkins 23

2019 Supplemental Security Income Ratios Published
by Jonathan Mason 24

Your Path to Program Success: Expert Advice
How Can We Get More Efficient at Delivering Care That Benefits Everyone?
by Anne Beekman and Dan Halverson 26

The Rise of Smart Data: 8 Top Themes from HIT Leaders on Advanced Analytics
by Steve Lefar 29

Who's Who in the Chapter 2021-2022

Chapter Website .....www.hfmanj.org

Communications Committee

Brian Herdman, Director .....CBIZ KA Consulting
Scott Besler, Chair ..... Toyon Associates
Adam Abramowitz.....CBIZ KA Consulting
Teresa Bailey ..... Penn Princeton
Rachel Gisser.....WithumSmith + Brown, P.C.
Laura Hess, FHFMA ..... NJHFMA
Elizabeth Litten, Esq. ..... Fox Rothschild, LLP
Amina Razanica.....New Jersey Hospital Association
James A. Robertson, Esq. .....Greenbaum, Rowe, Smith & Davis LLP
Lisa Weinstein..... Bancroft

NJ HFMA Chapter Officers

President, Jill Squiers .....AmeriHealth New Jersey
President-Elect, Brian Herdman .....CBIZ KA Consulting
Treasurer, Heather Stanisci..... Arcadia Recovery Bureau
Assistant Treasurer, Heather Weber ..... Baker Tilly LLP
Secretary, Maria Facciponti .....Elite Medical Receivables Solution

NJ HFMA Board Members

Jonathan Besler.....BESLER
Scott Besler .....Toyon Associates
Michael Costa – Ex-Officio .....DocGo
Alex Filipiak – Associate Board Member.....RWJ Barnabas
Jason Friedman .....Hackensack Meridian Health
Michael George.....Pricewaterhousecoopers LLP
Jane Kaye .....Healthcare Finance Advisors
Kim Keenoy – Associate Board Member .....Bank of America
Dave Murray ..... Richmond University Medical Center
Fatimah Muhammad – Associate Board Member ..... Saint Peter's University Hospital
Amina Razanica, CHFP..... New Jersey Hospital Association
Nicole Rosen ..... Acadia Professional
Roger Sarao, CHFP – Ex-Officio .....New Jersey Hospital Association
Lisa Schaaf..... Children's Specialized Hospital
Hayley Shulman.....WithumSmith + Brown, P.C.

NJ HFMA Advisory Council

Stacey Medeiros.....Penn Medicine
Michael McKeever..... Retired
Erica Waller ..... Penn Princeton
Scott Mariani ..... WithumSmith + Brown, P.C.

DEADLINE FOR SUBMISSION OF MATERIAL

Issue Date	Submission Deadline
Fall	August 15
Winter	November 1
Spring	February 1
Summer	May 1

IDENTIFICATION STATEMENT

Garden State "FOCUS" (ISSN#1078-7038; USPS #003-208) is published bimonthly by the New Jersey Chapter of the Healthcare Financial Management Association, c/o Laura A. Hess, FHFMA, Chapter Administrator, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807

Periodical postage paid at Trenton, NJ 08650. POSTMASTER: Send address change to Garden State "FOCUS" c/o Laura A. Hess, FHFMA, Chapter Administrator, Healthcare Financial Management Association, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807

OBJECTIVE

Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to healthcare financial professionals and as to serve as a forum for the exchange of ideas and information.

EDITORIAL POLICY

Opinions expressed in articles or features are those of the author(s) and do not necessarily reflect the view of the New Jersey Chapter of the Healthcare Financial Management Association, or the Communications Committee. Questions regarding articles or features should be addressed to the author(s). The Healthcare Financial Management Association and Communications Committee assume no responsibility for the accuracy or content of any articles or features published in the Newsmagazine.

The Communications Committee reserves the right to accept or reject contributions whether solicited or not. All correspondence is assumed to be a release for publication unless otherwise indicated. All article submissions must be typed, double-spaced, and submitted as a Microsoft Word document. Please email your submission to:
Scott Besler
scott.besler@atlanticare.org

REPRINT POLICY

The New Jersey Chapter of the HFMA will not reprint articles published in Garden State FOCUS Newsmagazine. Individuals wishing to obtain reprint authorization must obtain it directly from the author(s) of the article. The cover of the FOCUS may not be used in the reprint; however, the reprint may note that the article was published in a specific issue. The reprint may not imply endorsement by the HFMA, directly or indirectly.

The President's View . . .

Jill Squiers

As we wait for April showers to give way to May flowers, I'm reflecting on this time of transition for the New Jersey Chapter of HFMA. My term as President comes to an end in just a few weeks, and I feel like we're riding out on a high following the Chapter's many successes in navigating the challenge of supporting our members during the COVID-19 pandemic. I know the Chapter's position as trusted education and networking resource for members, sponsors and vendors will continue under the dedicated leadership of incoming President Brian Herdman, starting June 1.

We recently enjoyed the return of the Women's Leadership & Development Conference, which had been postponed for two years while we waited for conditions to improve so we could safely meet. Throughout the year the Chapter hosted a mix of 17 virtual and in-person offerings, made possible by the effort of the planning committees and our sponsors who supported each event.

And just the other week we hosted our Annual Golf Classic on May 12, during which we recognized the passing of past-President Tom Shanahan, one year to the day after his death. After a few shared memories about Tom, the Chapter revealed that a group of Tom's friends pledged to fund a scholarship fund with the chapter in his name – stay tuned for an announcement about the scholarship fund! Joining us for dinner, memories and the scholarship announcement were Tom's widow Andrea and other members of Tom's family; Andrea was presented with Tom's name badge from his last HFMA meeting.

I encourage you to check hfmanj.org often for events throughout the Summer and Fall, please make special note of the dates for our Annual Institute, hosted this year on October 26-28 at the Borgata.

I couldn't be more impressed by the leadership team that has supported the Chapter during my tenure as well as the past several years when we had to sometimes quickly pivot plans to keep the Chapter moving forward. It is with heartfelt thanks that I acknowledge the following, which is not an exhaustive list of all the dedicated individuals who contribute their time and knowledge:

- Nicole Rosen and John Byrne for their leadership of the Membership & Networking Committee for devising creative ways to keep members engaged, as well as the trio of chairs heading the Education Committee: Sandy Gubbine, Lisa Weinstein and Haley Shulman. The work these teams do to ensure the Chapter is a great resource for knowledge and fun is immeasurable!
- Heather Weber, who for four years has served as Assistant Treasurer, bringing her expertise to the job of keeping the Chapter's finances on the right path;
- Scott Mariani, who is completing his four-year term on the Advisory Council of Past Presidents, contributing his knowledge and experience to the Board of Directors;
- The entire HFMA NJ Board for their guidance during this challenging year, with a special shout out to Michael George who is leaving after completing his fourth year;
- All the committee chairs, co-chairs and others who volunteer their time to aid in the continued success of the Chapter; and finally,
- Laura Hess, the Chapter's administrator who works daily to keep the Chapter on schedule and on point.

It's been an honor to serve as your President this year and I look forward to what the incoming Officers, Board Members, and Committee leaders will accomplish in the coming year! Congratulations Brian!

Jill A. Squiers

From The Editor . . .

Scott Besler

The season of spring is such an exciting time in the northeast – in previous years it has been a two-week respite between turning off our furnace and turning on your air conditioner. It is also a time for planning and beginning (and hopefully finishing) projects, both at home and work.

As our chapter begins to come out of their PHE hibernation and we can attend in-person events, it does seem that there is a new beginning for us. Many are completing their cost reports and reading the FFY 2023 IPPS proposed final rule.

I wanted to keep this letter brief and hope you can find the time to read the articles in this issue. The committee wanted to add updated content that not only mentions items and issues in our industry that impact reimbursement but also includes those factors that affect our daily lives both at work and home. Topics like diversity in the workplace, caring for our aging parents, and working with a reduced staff, are as important as price transparency, SSI ratios, varying analytics, and of course COVID-19 mandates that may be here to stay.

For many of us, our "real" jobs begin when we step away from the desk. Working remotely, does not always create a dividing line, between home and office – there never was one, but my wish is that we take time for ourselves and enjoy your spring!!!

Thank you and happy reading!!!

LOOKING FOR EXTRA CASH?

LOOK NO FURTHER...

Denials continue to be a problem for healthcare providers. According to Vyne Medical, through the third quarter of 2020, the average denial rate was up 23 percent since 2016. That could be as much as 3.3 percent of a typical health providers NPR, an average of $4.9 million per hospital. ***There's your extra cash!*** Revco has years of experience in appealing and collecting denials—inpatient, outpatient, administrative, and complex clinical. Our proprietary denials management software, robust follow up process, and professional negotiation skills yield results. Over the last several years we have recovered over $130 Million for hospital and physician groups in New Jersey. That money might have been written off and lost forever. Instead, it went right to our clients' bottom line. ***Just saying...***

REVCO™ SOLUTIONS

Formerly Known as ARMC Financial Services, LLC

Joe Hoban • 484-639-1961 • joe.hoban@revcosolutions.com • RevcoSolutions.com

Strategies for Price Transparency Sustainability

Tara Bogart

by Tara Bogart

The price transparency executive order is focused on bending the cost curve by making the healthcare market more competitive. Patients, payers, and providers will have access to more data with the goal of making healthcare more affordable for consumers. With increased market pressure, healthcare providers will need to focus on how to remain viable. Over the long term, organizations that incorporate and leverage the new data for improved operations and payer negotiations will be sustainable long-term.

Price Transparency – Just the Tip of the Iceberg

Price Transparency has several behind the scenes impacts that must be addressed in a strategic fashion going forward for both gross charges and reimbursement. Each one of these will require new tactical steps leveraging more data and broader analytics.

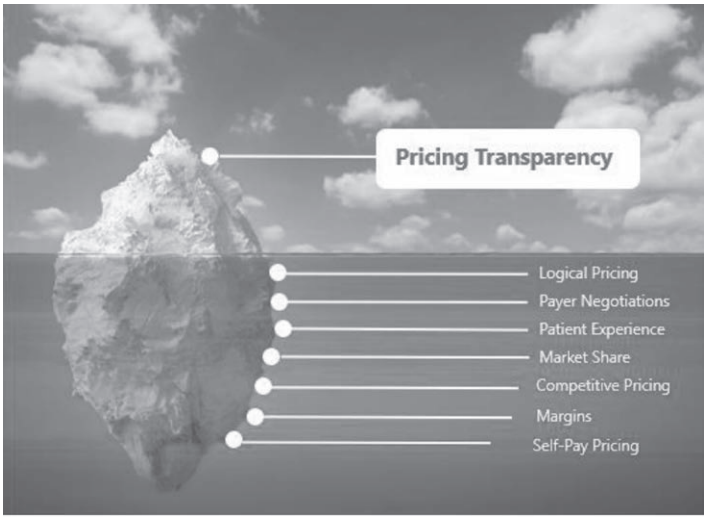
Logical pricing should be a focus for all healthcare providers as over inflated charges will face scrutiny from consumers and media. Providers need a rational and defensible pricing policy that can be explained and understood by consumers.

Payer reimbursement will be a focus as well. Over the past year, payers began coming to the negotiation table with a baseline understanding of contractual rates with their peers and subsequently pushing lower rates. This trend will likely accelerate, and payers will push more toward prospective payment and value-based contracts.

Patient experience, market share, competitive pricing, margins, and even self-pay pricing will be layered into the analytical equation going forward. At the end of the day, the availability of massive amounts of pricing data in the public domain will have impacts that we can't even see today – just like an iceberg.

Cash Price – An Easy Target

Today, many patient advocacy groups are gaining momentum. From appearing on national morning news programs, flying banners behind airplanes at beaches, to putting images on a legendary car for a NASCAR Cup Series, there are many movements and activists pushing to educate consumers on price transparency.



Marshall Allen, a consumer rights advocate and journalist, recently spoke about the high cost of healthcare and the right to price transparency at the New Jersey State Policeman's Benevolent Association at their conference in Atlantic City. His message to the police officers highlighted the noncompliance with the Hospital Price Transparency Rule in the Northern New Jersey-New York area and called out the variation among prices for patients at a local hospital based on data from their website. The example used to illustrate the point was a Level 3 Emergency Room visit where Medicare patients pay $223, Cigna patients pay $781, Horizon patients pay $818, UnitedHealthcare patients pay $1,718, and patients paying cash pay $256. Payers and providers understand the price variation, but this makes no sense to consumers.

The easiest price for consumers to understand are cash prices. Statistics from hospital web estimate vendors show that an increasing number of patients are generating estimates with and without using their insurance to understand the price difference. Many providers have not considered how their cash price compares to their reimbursement rates across payers but today it is critical to view the pricing from a patient's perspective.

PMMC selected 10 hospitals across New Jersey and reviewed the price transparency data that was posted on their websites for CPT® code 74176, CT Abdomen & Pelvis. Although many hospitals did not post the cash price, PMMC did find cash prices as low as $270 and up to $1,446. The most significant price variation occurs when you compare the discount rate across hospitals for self-pay patients. The range varied from 17% to 97%. These are variations that will need to be explained to consumers and most organizations are unprepared to do so.

2022 Rates from Sampling of New Jersey Standard Charge Files
CPT® 74176 - CT Abdomen & Pelvis

Hospital	3/2/2022 Machine Readable File	Discounted Cash Price		Aetna Commercial		Cigna Commercial		United Healthcare Commercial		Horizon BCBS Commercial	
	Charge	Rate	Discount	Rate	Discount	Rate	Discount	Rate	Discount	Rate	Discount
Hospital A	$936	$775	17%	$390	58%	$783	16%	$561	40%	$160	83%
Hospital B	$942	$320	66%	$390	59%					$526	44%
Hospital C	$946	$303	68%	$444	53%	$804	15%		100%	$411	57%
Hospital D	$1,898			$283	85%	$527	72%	$273	86%	$460	76%
Hospital E	$2,863			$460	84%			$364	87%	$345	88%
Hospital F	$4,621	$1,446	69%								
Hospital G	$6,091			$908	85%	$908	85%	$908	85%	$908	85%
Hospital H	$7,869			$557	93%	$1,132	86%	$2,662	66%	$780	90%
Hospital I	$9,500	$270	97%	$761	92%	$823	91%			$862	91%
Hospital J	$10,579	$348	97%	$992	91%	$4,591	57%	$2,399	77%	$3,988	62%

Sustainability Strategy #1 – Drive Rational Charges

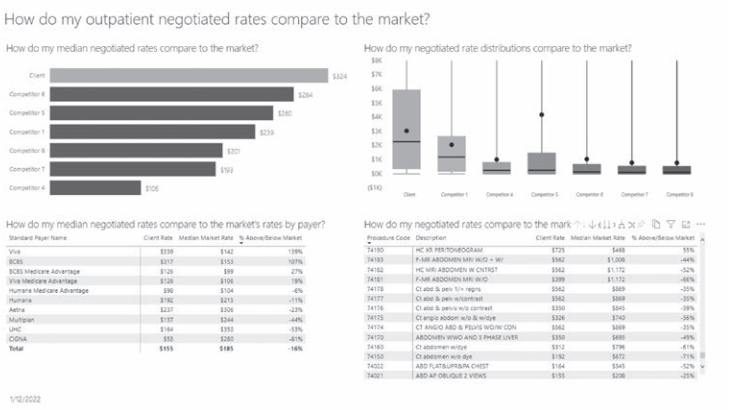
Available data and analytics should help providers drive to more rational charges. Charges have been elevated over the years due to a small number of payer contracts that are still reimbursed as a percent of charges. Going forward, providers will want to understand how gross charges, cash price and negotiated rates compare and will need to adjust so they are more rational in comparison with others in the market. Many organizations struggle to move toward more rational, defensible prices due to the lesser of charges contract language. To adjust prices and drive strong bottom line results, it is critical to model all charges through historical data and payer contracts to consider not just the rate but the reimbursement impact including lesser of charges at the case level.

Sustainability Strategy #2 – Drive Negotiations

Payer specific negotiated rates were posted by 6 out of 10 New Jersey hospitals that were analyzed. Although this is a lower compliance rate compared to other markets PMMC has researched, it still provides benchmarks that can be used to drive payer negotiations. For example, Cigna is paying one hospital in New Jersey 4.5 times Aetna's reimbursement rate for CPT® code 74176. If this is a pattern across a service line, the hospital needs to understand this ahead of a negotiation and be prepared for Cigna to ask for lower rates.

Another observation from the NJ data for CPT® code 74176 is that Horizon BCBS is paying one hospital nearly 25 times the rate of another hospital in the state. In the event the rate variation isn't an anomaly, the hospital receiving the lower reimbursement should leverage this data to push for increased rates.

Price transparency data provides line level insight, but this isn't enough to bring to the negotiating table. Payers have large teams performing data analytics and can perform robust modeling to identify and present the angle that supports them the most. Providers will need flexible modeling and the ability to summarize data going forward. Bringing in utilization data and aligning this with price transparency line level data will tell a better story.



Organizations with sophisticated modeling can move beyond aggregating line level data and instead insert competitor's rates into their claims data to understand estimated revenues using the competitor's reimbursement rates. Payers have looked at the data this way for years, and now, hospitals have the ability to level the playing field and utilize the same data to prepare for upcoming negotiations. The organization that leverages the expanded data and modeling capabilities will have greater insight and will be better positioned as the negotiation winner.

Execute Strategy

Historically, revenue cycle set charges and managed care negotiated reimbursement rates. Price transparency will lead to these departments working together in a more integrated fashion. As it relates to pricing and contracting, providers need to completely understand how they compare in the market by payer. Some areas will need a defensive strategy to protect revenue and other areas will need to leverage data to improve net revenue where pricing or contractual rates are not as good as once perceived.

As providers work through their pricing and contracting process, they need to think about pricing through the eyes of

continued on page 8

continued from page 7

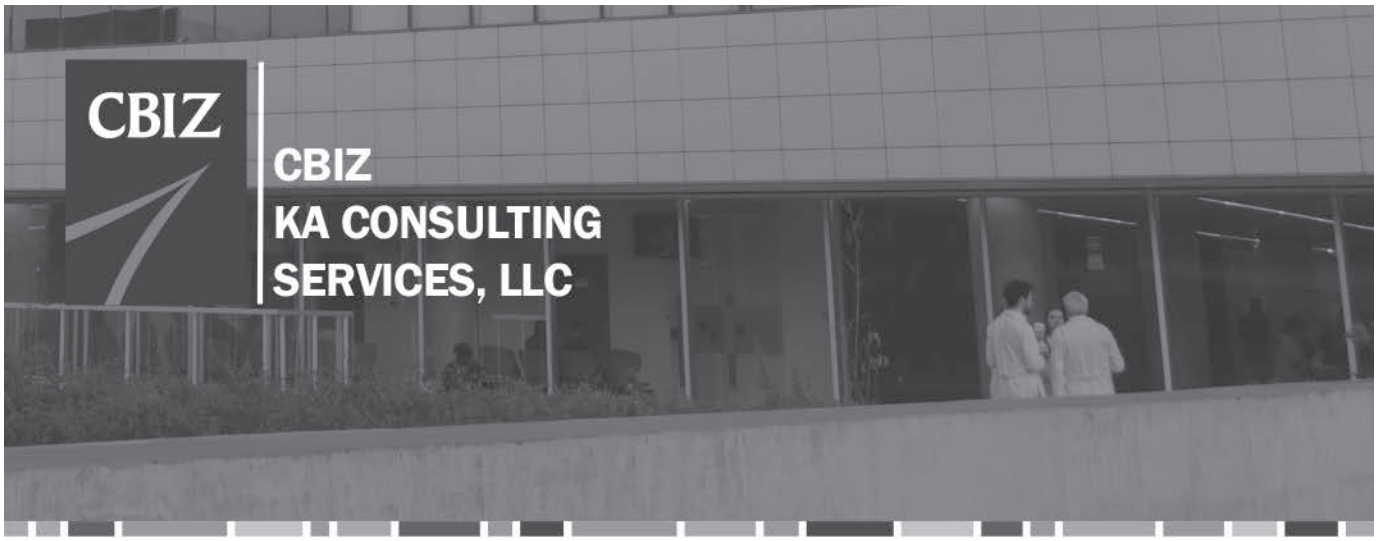
both the consumer and the payer. Under or over pricing one versus the other may lead to unintended consequences.

To remain viable, organizations need an integrated pricing strategy that connects the dots across negotiated rates, gross charges, and cash prices. Margins will continue to get tighter and as changes are considered to any of the components, contracts and rates should be modeled simultaneously to understand the overarching impact.

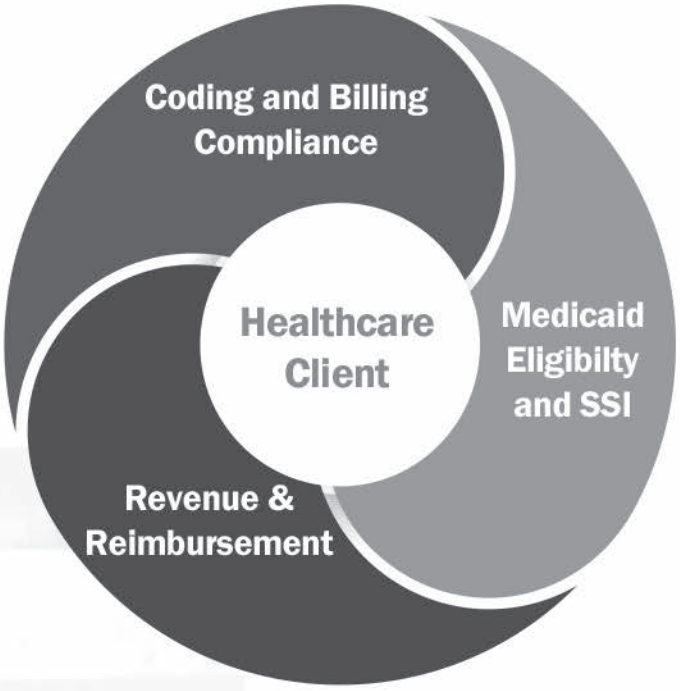
Allen, Marshall. "Calling the Cops on American Health Care." *Allen Health Academy,* Mar. 2022. https://marshallallen.substack.com/p/calling-the-cops-on-american-health?s=r.

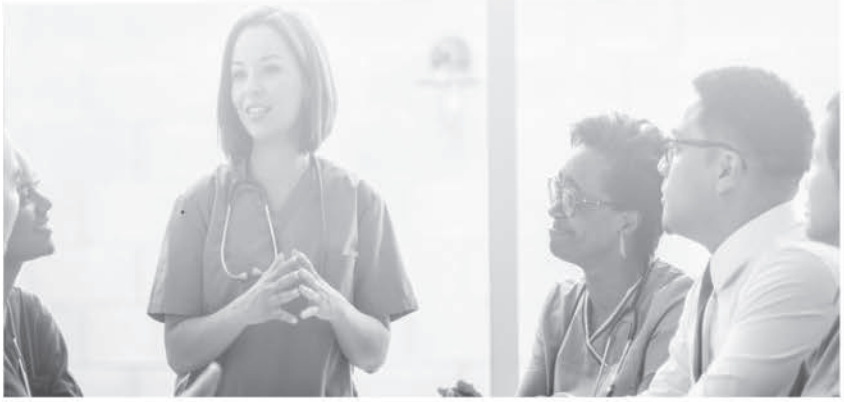
About the author

Tara Bogart is a Vice President – Revenue Strategy at PMMC, a leading revenue cycle management company. She has 20 years of experience working with hospitals on issues related to pricing transparency, charge master rate setting, and managed care contract negotiations. She has led PMMC's strategic pricing and RevenueMaster solutions as well as the organization's value-based care initiatives. Ms. Bogart previously worked in a business development/hospital planning department of a large healthcare system. She is a credentialed Project Management Professional through the Project Management Institute and is a Certified Revenue Cycle Representative through HFMA. She can be reached at tara.bogart@pmmconline.com.



Since 1978, CBIZ KA Consulting Services has partnered with New Jersey healthcare providers to deliver critical solutions producing results that have meaningful value.





www.kaconsults.com

Connect with us

Adam Abramowitz,
Senior Manager, Sales and Marketing

aabramowitz@cbiz.com
609-918-2093 x 169

•Who's Who in NJ Chapter Committees•

2021-2022 Chapter Committees and Scheduled Meeting Dates

***NOTE:** Committees have use of the NJ HFMA conference Call line.
If the committee uses the conference call line, their respective attendee codes are listed with the meeting date.

PLEASE NOTE THAT THIS IS A PRELIMINARY LIST - CONFIRM MEETINGS WTH COMMITTEE CHAIRS BEFORE ATTENDING.

COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 x8280	First Thursday of the month	Conference Call
Co-Chair: Ryan Peoples – Peoples2@virtua.org	(856) 355-0729 x50729	9:00 AM	(667) 770-1469
Board Liaison: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 x8280	Access Code: 473803	
Communications / FOCUS			
Chair: Scott Besler **(Editor)** – scott.besler@toyonassociates.com	(732) 598-9608	First Thursday of each month	Conference Call (667) 770-1479
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	10:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Hayley Shulman – hshulman@withum.com	(973) 532-8885	Second Friday of the Month	Zoom Meeting
Co-Chair: Sandra Gubbine – Sandra.Gubbine@atlanticare.org	(609) 484-6407	9:00 AM	(667) 770-1298
Co-Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code: 89425417190	via Zoom
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935		
Certification (Sub-committee of Education)		See Schedule for	
Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
Board Liaison: Chair: Amina Razanica – arazanica@njha.com	(609) 275-4029		
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Third Wednesday of each month	Conference Call
Co-Chair: Hanna Hartnett – Hanna.Hartnett@atlentcare.org	(609) 569-7419	8:00 AM	(872) 240-3212
Board Liaison: Dave Murray – dmurray@rumcsi.org	(856) 298-6629	Access Code: 720-430-141	via GoToMeeting
Institute 2021			
Chair: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881	Third Monday of each month	Conference Call
Co-Chair: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	2:00 PM	(717) 908-1977
Co-Chair: Stacey Medeiros – Stacey.Medeiros@pennmedicine.upenn.edu	(609) 423-8731	Access Code: 865290	
Board Liaison: Maria Facciponti – facciponti.maria@gmail.com	(973) 583-5881		
Membership Services/Networking			
Chair: Nicole Rosen – nrosen@acadia.pro	(862) 325-5906	Third Friday of each month	Conference Call
Co-Chair: John Byrne – JByrne56@gmail.com	(917) 837-2302	9:00 AM Access Code: 267693	In person Meetings
Board Liaison: Heather Stanisci – hstanisci@ArcadiaRecovery.com	(862) 812-7923	(667) 770-1400	by notification
Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Thursday of each month	Conference Call
Co-Chair: Jacqueline Lilly – jacqueline.lilly@atlanticare.org	(609) 484-6408	at 4:00PM	(667) 770-1453
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code: 196273	
Patient Financial Services			
Chairman: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	Second Friday of each month	Conference Call
Co-Chair: Steven Stadtmauer – sstadtmauer@csandw-llp.com	(973) 778-1771 x146	10:00 AM	(717) 908-1928
Board Liaison: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	Access Code: 120676	
Payer/Provider Collaboration			
Chair: Tracy Davison-DiCanto – tracy.Davison-DiCanto@scasurgery.com	(609) 851-9371	Contact Committee	
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	for Schedule	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month	In person Meetings
Board Liaison: Erica Waller – erica.waller@pennmedicine.upenn.edu	(609) 620-8335	8:00AM	with call in available
			via WebEx (Contact Committee)
Regulatory & Reimbursement			
Chair: Jason Friedman – Jason.friedman@atlantichealth.org	(973) 656-6951	Third Tuesday of each month	Conference Call
Co-Chair: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	9:00 AM	(667) 770-1419
Board Liaison: Scott Besler – scott.besler@toyonassociates.com	(732) 598-9608	Access Code: 382856	
Revenue Integrity			
Chair: Tiffani Bouchard – tbouchard@panaceainc.com	(651) 272-0587	Second Wednesday of each month	Conference Call
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	9:00 AM Access Code: 419677	(667) 770-1275
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

Role of diversity, equity, and inclusion in the modern healthcare organization

Fatimah Muhammad

by Fatimah Muhammad and Lisa Weinstein

Currently, most organizations are struggling to recover from the economic disruption caused by the COVID-19 pandemic. The significant drawbacks of the coronavirus pandemic on economic and business cycles have been further exacerbated by the on-going presence of race, gender and class-based disparities. The burden of economic recovery, in the aftermath of the global pandemic, has been unfavorably skewed against already-disadvantaged groups. Therefore, key business leaders in healthcare have an obligation to effectively address issues of disparities in the workplace. These gaps caused by disparities between and across groups in the workforce can be eliminated by an increase in the awareness of government and private employers. Industry leaders, and their respective top executives, need to cultivate an environment that appreciates and prioritizes issues of diversity, equity and inclusion.

The authors interviewed four individuals who are speakers at the upcoming HFMA NJ Women's Leadership and Development Program that will be held on April 27, 2022 to get their perspective on this important hot topic. We met with executives from Horizon BCBS of New Jersey, Waud Capital Partners – WCP Healthcare, Valley Health System, and Elite Medical Receivables Solution, we discussed the importance and role of diversity, equity, and inclusion in the workforce with an additional build-up segment on what can and should be done to actively promote these issues. The table below are the four individuals interviewed including a fun fact about them!

Name: Leslie Boles (LB)
Title: Senior Director of Compliance & Audit
Organization: Waud Capital Partners – WCP Healthcare
Fun Fact about You: I love to travel!

Name: Nicole Brenner (NB)
Title: Director of Compliance and Privacy Officer
Organization: Valley Health System
Fun Fact about You: I enjoy competitive horseback riding in my spare time.

Name: Maria Facciponti (MF)
Title: President
Organization: Elite Medical Receivables Solution
Fun Fact about You: I love glitter on everything!

Name: Valerie Harr (VH)
Title: Director, Community Health
Organization: Horizon BCBS of NJ
Fun Fact about You: I am a competitive endurance athlete

Lisa Weinstein

Our interviewees had shared the following about their experiences DE&I initiatives.

Garden State Focus (GSF): How has the pandemic affected DE&I training and implementation efforts in your organization? How do we keep people engaged over virtual meetings?

Maria Facciponti (MF): While DE&I training is very important to our organization, like many other items, it has become increasingly challenging to keep team members engaged remotely. One of the ways we have found to be successful is to limit meetings to 30 minutes. We have found in our organization; this keeps the agenda concise and keeps everyone on target and engaged.

Leslie Boles (LB): The pandemic has not slowed down our DE&I initiatives at Waud. We are using virtual platforms like Zoom or WebEx to keep everyone engaged throughout the pandemic. Our virtual meetings are interactive and our trainings are open forums for crucial dialogue amongst attendees.

continued on page 12

continued from page 11

GSF: Have you noticed if organized DE&I efforts have enhanced hiring efforts?

Nicole Brenner (NB): Yes, organized DE&I initiatives have enhanced hiring efforts, which have ultimately led to a more diverse and inclusive environment for our employees and the community we serve. The movement towards an inclusive and diverse organization requires continual evaluation, introspection, and meaningful measurement. Through the use of data metrics, employee engagement and candidate feedback, we have crafted an inclusive hiring practice that promotes race, ethnicity, and gender diversity.

LB: Yes, DE&I efforts is shattering the invisible walls around passive aggressive behaviors that has contributed to non-inclusive environments. Despite the long road ahead, I am proud of the progress being made.

GSF: What are the best ways to measure progress for DE&I practices? Are there specific goals that your organization is tracking and measuring?

MF: We have found the best ways to measure DE&I progress is by the following:

Dollars allocated to DE&I – by placing financial merit to the program, it shows leadership is serious about maintaining a positive DE&I culture.

Number of diverse employees within in the organization - including leadership positions

How long employees stay with the organization – people will dedicate themselves to an organization that respects them and fosters DE&I.

Number of incident reports – a very important but often misleading metric. While we want to keep the number of incents low, we also want to foster an open-door policy to report any situations that might make any team member uncomfortable.

Our organization takes each incident very seriously and top leadership reviews and gets involved with each incident through to resolution.

GSF: Has your organization evolved in terms diversity in leadership in your organization? Have organization leaders stressed diversity enough, if not why?

NB: Yes, Valley has evolved in terms of diversity in leadership, and we continuously evaluate new initiatives and practices to enhance our efforts. As with any large-scale change, cultural shifts require commitment and engagement from leadership, and we realize that our strategy will continue to evolve. The leadership team is dedicated to creating a meaningful vision for our organization and continually finds innovative ways to communicate our initiatives, promote education and celebrate our successes with the workforce.

GSF: Are diversity, equity, and inclusion a priority in your organization? If so, explain how and why?

NB: Yes, DE&I initiatives are a priority at Valley Health System, and we have implemented systemwide goals to continually evaluate our progress. Having measurable goals in place has enhanced accountability throughout the organization which has imparted our commitment to having a diverse and inclusive workforce. Our goals focus on leadership engagement, employee development, patient/family experience, operational alignment, community partnership and health equity.

Valerie Harr (VH): Yes, the Horizon BCBS CEO established a Pledge in June 2020.for a "Commitment to Positive and Lasting Change". The pledge outlined the steps Horizon Blue Cross Blue Shield of New Jersey is taking to listen to the communities it serves and that it will address health care disparities related to race and the social barriers that members face in accessing care such as

We will listen and learn from the communities we serve and our employees through active, ongoing conversations based on mutual respect and an appreciation for the value of diversity.

We will reflect the diversity of the communities that we serve throughout the organization so that we can achieve our mission to empower our members to achieve their best health.

We will promote equity, inclusion, awareness and understanding to confront racism, hate and discrimination.

The words in this Pledge are strong, and we know that to achieve their full meaning it will take our ongoing organizational commitment to action. My commitment, as Horizon's leader, is that we will do our part in this important work by using the Pledge as our north star. I have asked every one of Horizon's 5,500 employees to join and play an active role in this effort. As we stand together in support of what is right, we will also act together to achieve real change.

LB: Yes, at Waud Capital, DE&I is a top priority. We have a DE&I committee compiled of members from different levels of the firm. At Waud, we have identified the power of crucial conversation and the importance of empathetically listening to other's perspectives.

GSF: How does your DE&I initiatives align and match up with your community and the clients you serve?

VH: Horizon's Pledge to lasting change in DE&I includes a commitment to addressing health disparities of our members. Horizon has made significant progress in addressing social determinant of health needs of our highest risk members from our most vulnerable communities. Horizon is also committed to improving the diversity of our provider network to meet the needs of our members.

GSF: Do you think diversity, inclusion, and equity in organizations create unexpected challenges?

MF: I do think that DE&I in organizations may create unexpected challenges. At times, people fear exclusion so much that their actions may be misconstrued. Balance is essential. You want to maintain a diverse workplace and ensure that all people are represented for their talents. However, you want to be careful not to disregard other's accomplishments and talents because they don't fit "DE&I" criteria.

VH: Yes, the two challenges that come to mind are: 1. assisting all levels of staff in how to have conversations about race; and 2. the need to have better Race, Ethnicity, and Language data for both our providers and members**.**

GSF: Over the last two years, after DE&I training. what have you learned about yourself (good or bad) that you were not aware of?

NB: Over the past two years, I have learned the importance of ongoing education and increasing my awareness of implicit bias and inclusive language. By being aware of bias and how it can impact my decision making, I am able to retrain my thought process and reject biases and stereotypes.

MF: I have learned quite a bit about myself. I thought I was a seasoned leader and didn't have much to learn about DE&I because that was part of my management style and beliefs. However, I learned that there are preconceived biases that we must overcome to truly foster a DE&I environment. I am pleased to say that I learned that diversity in the workplace ensures a variety of different perspectives. I am surrounded by employees that have different characteristics and backgrounds which make them more likely to have a variety of different skills and experiences.

I learned that by having employees in our organization with diversity, afforded them access to a variety of different perspectives which proved beneficial in planning and executing our business strategies.

LB: One of the most powerful things that I have learned is that progress cannot be made, regarding DE&I, without self-awareness. We all have to be aware of our subconscious biases and stereotypes that we inadvertently advert onto others. DE&I training has taught me to broaden my scope towards others who may not share my same background.

Based on the interviews of the four top executives from across different facets of the healthcare industry it is evident that modern businesses that wish to succeed in the currently emerging diverse market demographic need to embrace and accelerate the adoption of DE&I initiatives that create a workforce that's representative of the diverse communities that they seek to serve.

About the Authors

Fatimah Muhammad is the 340B Pharmaceutical Services Manager at Saint Peter's University Hospital, Board Liaison for HFMA NJ Region 3, and Co-chair for CARE FORUM (Compliance, Audit, Risk & Ethics)

Lisa Weinstein is the Corporate Compliance and Privacy Officer of Bancroft, Co-Chair for the HFMA NJ Education Committee and Chairperson of the HFMA NJ Women's Leadership Event.

•Focus on Finance•

Provider Relief Fund Audit Requirements

Lisa Galinsky

By Lisa Galinsky

Q. Are Provider Relief Fund payments subject to audit requirements?

A. Recipients [both non-federal entities (states, local governments, Indian tribes, institutions of higher education, and nonprofit organizations) and commercial organizations (for-profit entities)] of the General and Targeted Distributions of the Provider Relief Funds are subject to the audit requirements under Title 45 U.S. Code of Federal Regulations ("CRF") Part 75, Subpart F.

Q. Are all recipients of Provider Relief Funds subject to the audit requirements or is there a dollar threshold?

A. Non-federal entities and commercial organizations that expend $750,000 or more in annual federal awards are subject to the audit requirements. For the purposes of the Provider Relief Fund, "expend" includes both expenditures and lost revenues. The total expenditure amount is reported on the Schedule of Expenditures of Federal Awards ("SEFA").

Q. What options are available to meet the audit requirements?

A. A non-federal entity is required to have a single audit if the entity had expenditures from one or more federal programs, but can elect the program-specific audit if the entity had expenditures from only one federal program. A commercial organization has two options: (1) A single audit, if the organization had expenditures from one or more federal programs, but may elect the program-specific audit option if the organization had expenditures from only one federal program; or (2) a financial-related audit of all U.S. Department of Health and Human Services ("HHS") awards in accordance with *Government Auditing Standards,* issued by the Comptroller General of the United States ("*Government Auditing Standards")*, if the organization received awards under only one or multiple HHS awards. This option is also referred to as a GAGAS financial audit.

Q. What is included on the SEFA?

A. The SEFA is prepared annually, based on the non-federal entity or commercial organization's fiscal year end and normally includes the total expenditures incurred during the fiscal year for each federal program subject to single audit. However, the timing for when to report expenditures, including lost revenues, on the SEFA for the Provider Relief Funds are different.

Q. When should Provider Relief Fund expenditures and/or lost revenue be reported on the SEFA?

A. Provider Relief Fund expenditures and/or lost revenues will be reported on the SEFA starting with fiscal year ends ending on or after June 30, 2021. The amount reported on the SEFA is based upon the non-federal entity or commercial organization's submissions to the Human Resources & Services Administration's ("HRSA") Provider Relief Fund Reporting Portal as summarized in the table below:

Fiscal Year End	What gets included on the SEFA
Before 6/30/21	Nothing is included on the SEFA
6/30/21 – 12/30/21	Total expenditures and/or lost revenues from the **Period 1** report submission to the PRF Reporting Portal.
12/31/21 – 6/29/22	Total expenditures and/or lost revenues from the **Period 1 and Period 2** report submission to the PRF Reporting Portal.
6/30/22 – 12/30/22*	Total expenditures and/or lost revenues from the **Period 2 and Period 3** report submission to the PRF Reporting Portal.
12/31/22 – 6/29/23*	Total expenditures and/or lost revenues from the **Period 3 and Period 4** report submission to the PRF Reporting Portal.

*Information obtained from the AICPA, which they obtained from a draft version of the Provider Relief Fund and American Rescue Plan (ARP) Rural Distribution section of the 2022 Compliance Supplement.

Q. What basis of accounting should be used to prepare the SEFA or the financial- related audit (GAGAS financial audit)?

A. For non-federal entities, the SEFA should be prepared on the accrual basis of accounting in accordance with accounting principles generally accepted in the United States ("GAAP") or a basis of accounting required by state law. For commercial organizations, the SEFA can be prepared on the GAAP basis of accounting or a special purpose framework, such as cash or income tax basis. It would not be appropriate for a commercial organization to use a regulatory or contractual basis of accounting because the HHS has not issued a regulation, contract or an agreement with specific financial reporting requirements.

Q. What is included in a single audit?

A. A single audit includes an audit of the entity's financial statements, including note disclosures, and the auditor will issue an opinion on the financial statements. In addition to being performed in accordance with auditing standards generally accepted in the United States of America ("GAAS"), this audit is also performed in accordance with *Government Auditing Standards*, and the auditor will issue a report on internal control over financial reporting and compliance and other matters in accordance with *Government Auditing Standards*. *Government Auditing Standards* requires the auditor to obtain an understanding of the entity's internal controls over financial reporting. The single audit also includes the SEFA and the notes to the SEFA and the auditor will audit the SEFA and issue an in-relation to (the financial statements) opinion on the SEFA as well as prepare a schedule of findings and questioned costs, including a summary of the auditor's results. The auditor will also perform an audit of the major program(s) and issue an opinion on compliance and reporting on internal control over compliance. The audit of the major program(s) includes testing internal controls over compliance.

Q. What is included in a program-specific audit?

A. A program-specific audit is an audit performed in accordance with GAAS and *Government Auditing Standards* and includes an audit of the SEFA, including note disclosures and the auditor issues an opinion on the SEFA. The auditor will also perform an audit of the federal program and will issue an opinion on compliance and reporting on internal control over compliance. Although this audit is performed in accordance with *Government Auditing Standards,* under this option, the auditor is not required to issue a separate report on internal control over financial reporting and compliance and other matters.

Q. What is a financial-related audit (GAGAS financial audit)?

A. A financial-related audit is an audit performed in accordance with GAAS and *Government Auditing Standards* and is considered an audit of a specific element of a financial statement. As a result, the schedule included in this report is not a SEFA, and instead the schedule will have an appropriate title, such as Schedule of Revenue of U.S. Department of Health and Human Services Awards (the "Schedule"). Although the Schedule has the word "revenue" in its name, "revenue" means "expend", and as noted above, "expend" includes both expenditures and lost revenues. The amounts reported on the Schedule under this option are the same as what is reported on the SEFA under the single audit and program-specific audit options. The GAGAS financial audit option will also include notes to the Schedule. Under the GAGAS financial audit option the auditor issues an opinion on the Schedule and also issues a report on internal control over financial reporting and compliance and other matters in accordance with *Government Auditing Standards*. In addition to *Government Auditing Standards* requiring the auditor to obtain an understanding of the entity's internal controls over financial reporting, it also requires the auditor to consider laws and regulations that are material to determining the amounts on the financial statement and the related note disclosures. Under this option, the auditor does not issue an opinion on compliance and reporting on internal control over compliance.

Q. When is the audit due?

A. Regardless of the option chosen (single audit, program-specific audit or GAGAS financial audit), the audit report is due the earlier of 30 calendar days after receipt of the audit report or 9 months after the fiscal year end. However, the Office of Management and Budget ("OMB") granted a 6-month extension for fiscal years ending on or before 6/30/21. The 30-day rule applies to this extension. Therefore, both 6/30/21 and 12/31/21 year ends have a due date of no later than 9/30/22.

Q. Where do the audit reports get submitted?

A. Non-federal entities are required to submit their audit report to the Federal Audit Clearinghouse electronically at https://harvester.census.gov/facides/Account/Login.aspx. Commercial organizations are required to submit their audit report via email to HRSA's Division of Financial Integrity at PRFaudits@hrsa.gov.

About the author
Lisa Galinsky is Associate Principal, Quality Control at Withum. She can be reached at lgalinsky@withum.com.

New Members

Amanda Anderson
Trinity Health
Billing And Follow Up
amanda.anderson002@trinity-health.org

Sarah Pinck
St. Josephís Health
Patient Registration/
Financial Representative
sbailey198000@gmail.com

Lisheon Thompson
Hackensack University Medical Center
Network Billing Manager
lisheonthompson@hotmail.com

Jamie Aponte
St. Joseph's Health
Director, Revenue Cycle Support
apontej@sjhmc.org

Jevon Hoskins-Presbery
The Brooklyn Hospital Center
Director of Health Information
Management
marqui853@gmail.com

Christina Sosa
Bergen New Bridge Medical Center
Manager Finance Analyst
csosa@newbridgehealth.org

Alexandra Pellock
KPMG
Advisory Associate
apellock@kPMG.com

Christopher Reidy
Community Medical Center- Toms River, NJ
SFO, VP Finance
chrisreidy@yahoo.com

Arielle Stewart
Hackensack University Medical Center
OP DRG Data Coordinator
ajstewart09@me.com

Ayushi Sharma
axsst430@mail.rmu.edu

Bernadette Gabriel
Chop-The Children's Hospital
of Philadelphia
Staff Accountant
bern.menke@gmail.com

Dana Ushakova Smolenskiy
Hospital For Special Surgery
X-Ray Technologist
dana.ushakovasmolenskiy@
student.uagc.edu

Hemang Rana
hpr20@scarletmail.rutgers.edu

Derrick Givens
derrick.givens@student.uagc.edu

Marissa Kass
Marissa.kass@Rutgers.edu

Darlene Braxton
darlene.braxton@student.uagc.edu

Walter Kim
walter.kim@student.uagc.edu

Aiden Gilliam
alg233@scarletmail.rutgers.edu

Areta Sargentini
St. Francis Medical Center- Trenton, NJ
Patient Access Manager
asargentini@stfrancismedical.org

Julissa Boglio Garcia
Cooper University Health Care
PSR
jmarie2248@gmail.com

Tmeaka Davis
Trinity Health
Coding Payment Resolution Specialist 1
tmeaka.davis@trinity-health.org

Rita Francis
Bayada Home Health Care
Reimbursement and Collections Associate
ritta_francis@hotmail.com

Natalie Colimon
Rutgers New Jersey Medical School
Senior Director of Administration
nc204@njms.rutgers.edu

Maria Chowdhury
mac814@scarletmail.rutgers.edu

Dheeraj Tommandru
dtomman1@binghamton.edu

Kevin Mcglynn
Advent Health Partners Director of
Business Development
kmcglynn@adventhp.com

Otito Okoye
Bergen New Bridge Medical Center
Access Center Manager
ookoye@newbridgehealth.org

Crystal Pagano
Bergen New Bridge Medical Center
Applications Specialist
cpagano@newbridgehealth.org

George Rausch
Bergen New Bridge Medical Center
Data Quality Analyst
grausch@newbridgehealth.org

Angelica Rodriguez
Bergen New Bridge Medical Center
Applications Specialist
arodriguez7@newbridgehealth.org

Joana Sarango
Bergen New Bridge Medical Center
Applications Specialist
jsarango@newbridgehealth.org

Italia Castillo Duran
Midatlantic Neonatology Associates, PA
Associate Director of Business and
Financial Operations
icastillo@brinj.org

Brandy Chikeka
Trinity Health
Billing And Follow Up Rep II
brandy.chikeka@trinity-health.org

Alicia Salazar
alicia.salazar@knights.ucf.edu

Matthew Bucci
Bayada Home Health Care
Supervisor, RS
buccimatt88@gmail.com

Jade Dennis
St. Francis Medical Center- Trenton, NJ
Insurance Verifier
jade.dennis@stfrancismedical.org

Ralphena Edwards
St Francis Medical Center
Patient Service Rep
ralphena.edwards@stfrancismedical.org

Ludween Eugene
St Francis Medical Center
Supervisor
leugene@stfrancismedical.org

Laura Guerriero
St Francis Medical Center
Registration
laura.guerriero@stfrancismedical.org

Rebecca Miranda
St Francis Medical Center,
Trenton NJ 08629
Healthcare Access Rep
rmiranda@stfrancismedical.org

Alexander Dietrich
Cooper University Health Care
Planning Analyst
alexander.dietrich05@gmail.com

Kristin Disandro
kristin.disandro@student.ashford.edu

Malinda Griffen
Hackensack University Medical Center
Supervisor
malinda.griffen@student.uagc.edu

Lavet Drake
Qualcare Therapy Center and
Sleep Diagnostics of NJ
Office Manager
lmdrake3@gmail.com

Dora Marques
Affiliated Healthcare Management
Group, LLC
Senior Vice President Business
Development
dmarques@affiliatedhmg.com

John Gibons
Bergen New Bridge Medical Center
Finance Analyst
jgibbons1@newbridgehealth.org

Cerica Harriott
Bergen New Bridge Medical Center
Junior Accountant
charriott@newbridgehealth.org

Malou Lara
Bergen New Bridge Medical Center
Accounting Analyst
mlara1@newbridgehealth.org

Ewa Magnuski
Bergen New Bridge Medical Center
Director Of General Accounting
emagnuski@newbridgehealth.org

Judith Mccann
Atlantic Eye Physicians
Revenue Cycle Manager
judymccann66@aol.com

Gail Seventko
Bergen New Bridge Medical Center
Accounts Payable Manager
gseventko@newbridgehealth.org

Lisakay Thompson
Bergen New Bridge Medical Center
Accounts Payable Coordinator
lthompson@newbridgehealth.org

Keith Needham
Baker Tilly
Senior Manager
keith.needham@bakertilly.com

Vito Mazza
Kinum, Inc.
Cash Flow Faster Consultant
vito.mazza@kinum.com

Advice On How To Navigate When Your Aging Parents Have Different Needs

by Millie Jones

When your parents got married, they probably envisioned their lives together until the very end. While they have done many things at the same rate, such as buying a house, having children, and probably retiring, sometimes, things change at a different pace with age.

HFMA New Jersey Chapter is happy to share today's post, which offers tips and advice on caring for aging parents when their needs are different.

Financial Matters

The national average for one month in a nursing home is around $7756. But, New Jersey is anything but average, and you can expect to spend around $11,254 each month for the same room. Because of this, it's important to know where the funds will come from to pay for nursing care. While Medicaid may cover the cost for low-income individuals, it's difficult to qualify for this, and your loved ones can only have $2000 in assets.

Most of us will be left scrambling for ways to fund care. Unfortunately, when one needs nursing care, they likely will not be able to live together any longer. Since many seniors have the vast majority of their net worth tied up in their home, you'll need to calculate their assets, and then decide if it makes sense to sell the home, allow one parent to continue to live there, or rent it out for a source of monthly income. If you choose to sell, calculate their home equity by figuring out how much you owe versus how much it's worth.

Practical Problems

The downsizing process can be emotionally painful. Some seniors view this as watching the collective sum of their lives be taken away and distributed to others or, worse, put into the dumpster. But, downsizing may be necessary, particularly if only one parent will need a home outside of nursing care. RetireGuide suggests that your parent decide where he or she wants to live and also which type of home will be the easiest to navigate. Help them go through their belongings, but be firm on what they can and can't keep. If your parent is a packrat, you have your work cut out for you. Remind them that it will cost more to put their stuff in storage than it would to simply let it go, but do listen to their concerns and let them hold onto their most cherished keepsakes.

Next up is the moving process. In most cases, it's almost always smart to hire a local moving company, preferably one with a good reputation and verifiable reviews (search "Angi movers" to find reviews from Angi). This takes strain off of everyone and frees you up for your greatest challenge yet: helping your parents through the process.

Compassion

When one parent is moving into nursing care and the other is not, compassion is key. While you may get frustrated at times, sit down and listen when they have concerns. You can further show you care by understanding the health conditions they each might face and also providing for their spiritual needs.

Another aspect of being compassionate is allowing your parents to have a say in where they wind up. Your healthier

Image via Pexels

continued on page 18

continued from page 17

parent may feel most comfortable in a single-story home close to family and friends. The one moving to nursing care will appreciate looking at locations close to their spouse, children, and grandchildren. Before you make any nursing home decision, take a tour. No matter how impressive the facility might look, pay close attention to how happy and cared for the residents seem, as this is the number one indicator of whether to keep it on your short list or not.

When one parent has a health condition that leaves them unable to care for themselves, and the burden is too much for the healthy parent, nursing care may be the best option. It's not easy, and there will be frustrations and heartaches along the way. But, with compassion and preemptive planning, you'll make it through the process together with your relationship intact.

About the Author

Millie Jones created SeniorWellness as a way to inspire older generations - including her own! - to embrace their wellness throughout their golden years. She hopes her site will help people of all ages feel young at heart. When she's not playing with her grandkids, Millie can be found writing, taking photos (film or bust!), or putting those skills to use via scrapbooking. Millie can be reached at millie_jones@seniorwellness.info.

•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

NJ HFMA's Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary Listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to NJ HFMA's **Job Bank Online** *at* **www.hfmanj.org.**

[Note to employers: please allow five business days for ads to appear on the Website.]

Job Position and Organization

CLINICAL DOCUMENT SPECIALIST
Cooperman Barnabas Medical Center

DIRECTOR, REVENUE CYCLE
ID Care, P.A.

ACCOUNTING SUPERVISOR
Deborah Heart and Lung Center

REIMBURSEMENT SPECIALIST II
Hackensack Meridian Health

MANAGER MANAGED CARE
Inspira Health

REVENUE CYCLE MANAGER
Bergen Gastroenterology and Medical Associates

DIRECTOR, REVENUE CYCLE SERVICES
Med-Metrix

MANAGER, REVENUE CYCLE SERVICES
Med-Metrix

TRAINER, REVENUE CYCLE SERVICES
Med-Metrix

SUPERVISOR, ACCOUNTS RECEIVABLE SERVICES
Med-Metrix

CHIEF FINANCIAL OFFICER
University Radiology Associates

BUDGET REIMBURSEMENT COORDINATOR
CentraState Healthcare System

FINANCE OPERATIONS ANALYST
CentraState Healthcare System

Federal Efforts to Mandate COVID-19 Vaccinations, Testing and Masking: Overview and Status Update on Challenges in the Courts

James A. Robertson

Jessica M. Carroll

by James A. Robertson and Jessica M. Carroll

In its ongoing efforts to address the COVID-19 pandemic, the federal government introduced numerous mandates requiring vaccination, testing, and masking of workers in a variety of settings. These mandates -- the Safer Federal Workforce Task Force COVID-19 Workplace Safety Guidance for Federal Contractors and Subcontractors, the OSHA Emergency Temporary Standard (ETS), and the CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule for Medicaid and Medicare providers and suppliers -- have been challenged in the nation's courts by employers, individuals, states, religious organizations, and non-profit entities, among others. This article provides an overview of each mandate and its status as of this writing.

Safer Federal Workforce Task Force COVID-19 Workplace Safety Guidance for Federal Contractors and Subcontractors

On September 9, 2021, President Biden signed an Executive Order (EO 14042) directing federal agencies to contractually require certain federal contractors and subcontractors to implement COVID-19 workplace safety measures, including a vaccine mandate with a no "testing" option. Specifically, the Order directed the Federal Workforce Task Force to establish safeguards requiring all covered contractors to be fully vaccinated by January 18, 2022, unless the covered employees were legally entitled to an accommodation. The safeguards apply to all "newly awarded contracts" at any location where a covered employee works, to all full-time or part-time employee of a covered contractor working on or in connection with a federal contract, and to any individual working at a covered contractor workplace.

Eleven states challenged the federal contractor vaccine mandate. The federal district courts in Kentucky, Georgia, Louisiana, Missouri, and Florida issued preliminary injunctions barring enforcement of the mandate after concluding that the Executive Branch had not followed various required procedures for changes to federal contracting requirements and/or lacked the authority to impose the mandate. As a result of these decisions, enforcement of the mandate is currently enjoined nationwide.

Of particular note is the nationwide injunction issued by the U.S. District for the Southern District of Georgia enjoining the enforcement of the federal contractor vaccine mandate. There, the Court determined that President Biden likely exceeded his authority under the Federal Property and Administrative Services Act by contractually requiring federal contractors and subcontractors to implement COVID-19 workplace safety measures, including vaccination requirements. The Court's

continued on page 20

continued from page 19

analysis focused on whether the President is authorized by law to issue the directives contained in EO 14042, or whether the EO instead signifies an enormous and transformative expansion in regulatory authority without clear congressional authorization.

The Court reasoned that if the law was construed to give the President the right to impose the vaccine mandate, the President could also impose "virtually any kind of requirement on businesses that wish to contract with the Government . . . so long as he determines it could lead to a healthier and thus more efficient workforce or it could reduce absenteeism." Accordingly, the Court found that the plaintiff states were likely to succeed on the merits of their challenge.

The OSHA Emergency Temporary Standard (ETS)

On November 4, 2021, the Occupational Safety and Health Administration (OSHA) released a set of emergency temporary standards (ETS) requiring employers with 100 or more employees to implement mandatory COVID-19 vaccination or weekly testing and masking requirements. Immediately thereafter, lawsuits were filed challenging OSHA's authority to enforce the mandate and on November 6, 2021, the U.S. Court of Appeals for the Fifth Circuit issued an emergency stay of the ETS, pending briefing and expedited judicial review.

On November 12, 2021, the Fifth Circuit reaffirmed its stay in a 22-page opinion, determining that the petitioners, which included states, individuals, and religious organizations, had demonstrated the traditional elements required for a stay pending judicial review.

Focusing on whether OSHA has the constitutional and statutory authority to issue and enforce workplace rules that are as far-reaching and burdensome as the ETS, the Fifth Circuit held that the challenges to the ETS "show a great likelihood of success on the merits." The Circuit Court held that the ETS "grossly exceeds OSHA's statutory authority" under the OSHA Standards and Regulations (specifically, 29 U.S.C. § 655(c)(1)) which authorize OSHA to issue an ETS and bypass the period of public notice and comment only if the agency determines that employees are "exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards" and the ETS is "necessary to protect employees from such danger." The Court Circuit concluded that OSHA did not demonstrate that the ETS met these requirements.

Further, the Circuit Court noted that the ETS "raises serious constitutional concerns" including that "it likely exceeds the federal government's authority under the Commerce Clause" and implicates separation of powers principles because there is "no clear expression of congressional intent in §655(c) to convey OSHA such broad authority." The Court also explained that the ETS was both improperly over-inclusive (because it covers employees with little-to-no risk of exposure to COVID-19) and improperly under-inclusive (because it does not cover employees who work for companies with fewer than 100 employees).

The Circuit Court determined that denying a stay would cause irreparable harm to petitioners, noting that the ETS substantially burdens the liberty interests of covered employees who do not want to receive the COVID-19 vaccine, imposes non-recoverable compliance and other costs on covered employers, and infringes on the states' police power over public health policy. Therefore, the Circuit Court held that granting a stay would not harm OSHA because "[a]ny interest OSHA may claim in enforcing an unlawful (and likely unconstitutional) ETS is illegitimate." Lastly, the Circuit Court held that granting a stay is in the public interest, not only because the ETS causes "economic upheaval," but also because the ETS raises constitutional questions and threatens individual liberty.

The federal government filed a motion asking the Sixth Circuit to dissolve the Fifth Circuit's stay of the ETS. On December 17, a three-judge panel for the Sixth Circuit granted the government's motion. Immediately thereafter, multiple petitioners filed emergency applications for an injunction to Justice Brett Kavanaugh of the United States Supreme Court, the Circuit Justice for the Sixth Circuit, asking for a stay of the ETS pending further judicial review. On December 22, 2021, the U.S. Supreme Court issued an order consolidating the emergency applications for an injunction and setting oral argument for Friday, January 7, 2022.

On January 13, 2022, the U.S. Supreme Court stayed implementation of OSHA's ETS. In a 6-3 decision finding that the parties opposing the ETS "are likely to succeed on the merits of their claim that the Secretary lacked authority to impose the mandate," the Court explained that although Congress has given OSHA the authority to regulate occupational dangers "it has not given that agency the power to regulate public health more broadly." The stay of the ETS will remain in effect pending the Sixth Circuit's review of the merits of the case.

CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule

In November 2021, acting through the Centers for Medicare and Medicaid Services (CMS) to combat the spread of COVID-19 infections, the Secretary of Health and Human Services issued a mandate to protect the health and safety of Medicare and Medicaid patients being treated by healthcare providers in hospitals, nursing homes, ambulatory surgical centers, hospices, rehabilitation facilities and other facilities.

Shortly thereafter, 24 states challenged the mandate and on December 2, 2021, CMS suspended the COVID-19 vaccine mandate for that group of states pending resolution of the applications for injunctions prohibiting its enforcement.

On January 13, 2022, the U.S. Supreme Court upheld the CMS mandate for healthcare facilities participating in the Medicare and Medicaid programs, requiring all employees, volunteers, contractors, and other workers to receive a COVID-19 vaccine unless the employee is granted a medical or religious exemption. Non-compliance would result in fines and termination of Medicare and Medicaid provider agreements.

In a 5-4 decision, the U.S. Supreme Court found that pursuant to 42 U.S.C. §1302(a), Congress authorized the HHS Secretary to promulgate this type of requirement upon healthcare facilities participating in the Medicare and Medicaid programs in the interest of the health and safety of patients receiving care during a health emergency. Given the rampant spread of COVID-19, as a matter of public safety, the majority reasoned that unvaccinated staff pose a serious threat to the health and safety of patients -- particularly the elderly, disabled, or those in poor health -- as this could lead to patients forgoing medically necessary treatments, staffing shortages, or disruption to patient care.

In its decision, the majority focused predominantly on the well-being of the patient. While the dissent focused on the rights of healthcare facility staff members, the majority was not convinced that compelling staff members to choose between employment and involuntary vaccination prevented the implementation of a nationwide vaccine mandate on Medicare and Medicaid providers. In short, the majority agreed that the mandate was consistent with the fundamental principle of the medical profession: "first, do no harm."

The Court was silent as to any dates or deadlines for compliance. As such, on January 14, 2022, CMS issued a memorandum to specifically address the new compliance deadlines for the 24 states that had filed for injunctions, and to reaffirm the previous deadlines for states that did not.

The new deadlines apply to the following states: Alabama, Alaska, Arizona, Arkansas, Georgia, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Utah, West Virginia, and Wyoming. The deadlines do not apply to Texas, as Texas sought an injunction separately from the other states and Texas' application is still pending resolution.

Healthcare facilities in these 24 states must demonstrate the following by **February 13, 2022**:

- Implementation of policies and procedures for ensuring all facility staff are vaccinated or have received an exemption, **and**
- Verification that 100% of staff have received at least one dose of the COVID-19 vaccine, **or** have a pending request for, or have been granted, an exemption, **or** have been identified as needing a temporary delay before receiving the vaccine.

Additionally, these same 24 states must demonstrate the following by **March 15, 2022**:

- Implementation of policies and procedures for ensuring all facility staff are vaccinated or have received an exemption, **and**
- Verification that 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series), **or** have a pending request for, or have been granted, an exemption, **or** have been identified as needing a temporary delay before receiving the vaccine.

Any state that fails to comply with the 100% standard by **April 14, 2022**, may be subject to enforcement action. Additional guidance is provided in the January 14 CMS memorandum. Guidance specific to provider types and certified suppliers is provided here.

For states that did not seek an injunction, the timeframes and parameters issued in the December 28, 2021 memorandum remain in effect. Those deadlines require implementation of policies and procedures for ensuring all facility staff are vaccinated, unless an exemption applies, along with:

- Verification that 100% of facility staff received at least one dose of the COVID-19 vaccine by **January 27, 2022**; and
- Verification that 100% of staff have received the necessary doses to complete the vaccine series (i.e., one dose of a single-dose vaccine or all doses of a multiple-dose vaccine series) by **February 28, 2022**.

In light of the U.S. Supreme Court's holding and the CMS memorandum, healthcare facilities should comply with all relevant deadlines and requirements for the vaccine mandate as applied within their respective states. Failure to comply could result in becoming ineligible for Medicare and Medicaid funding.

In Conclusion

The federal landscape for mandates regulating the health and safety of employees during the COVID-19 pandemic is

continued on page 22

continued from page 21

rapidly evolving. The U.S. Supreme Court stayed the OSHA vaccine mandate but allowed the CMS vaccine mandate for certain healthcare workers, and the enforcement of the federal contractor's mandate is currently enjoined nationwide. Employers must understand their legal obligations to navigate the impact of these federal decisions and take steps to keep their employees safe in the workplace. In addition, employers must remain well informed and be prepared to tackle the complexities of local and state requirements related to these issues.

About the Authors:
James A. Robertson is a partner and chair of the Healthcare Department at Greenbaum, Rowe, Smith & Davis LLP, where his significant expertise enables him to effectively counsel clients on a myriad of healthcare regulatory, corporate and litigation matters. He can be reached by email at jrobertson@greenbaumlaw.com. Jessica M. Carroll is Counsel in the firm, concentrating her practice in litigation with an emphasis in healthcare. She can be reached by email at jcarroll@greenbaumlaw.com.

•Certification Corner•

HFMA certified members who are due to maintain their certification by May 31, 2022 recently received a reminder on certification maintenance. HFMA provided several resources that include maintenance information available to Certified Healthcare Financial Professionals (CHFP) and Fellows of the HFMA (FHFMA):

Where can I find maintenance information?

- Reminders - sent starting about 6 months in advance of the due date, and then monthly.
- The CHFP congratulatory letter - this is available to download in the eLearning dashboard upon passing Operational Excellence exam, module II of CHFP.
  - In the email the member receives upon passing Operational Excellence, module II of CHFP.
  - The maintenance instructions document includes general certification maintenance information, tips for using the maintenance reporting tool along with a list of eligible CHFP/FHFMA maintenance activities.
    - On the HFMA website: Maintaining Your Certifications (hfma.org)
    - In the FAQs linked here: Maintenance FAQs (hfma.org)

Some common FAQs:

- How can you earn credit hours? As an all-access member you have access to all HFMA online educational content. On-demand webinars are a popular resource to earn extra hours. Upon completion of an on-demand session you can submit the activity via the online reporting tool (HFMA login required) to ensure you receive credit. Note: on-demand sessions can be used for maintenance but do not qualify for official NASBA approved CPE credits. Only live events offer CPE.
- How can I verify that I have submitted the required number of activities (60 points) for my cycle? You may run a report of your current total points using the report at the top of the online reporting tool
- I have submitted my activities and renewed my membership due for my renewal in May. When will I receive confirmation I am in compliance? HFMA's system will auto update, and you will receive an email confirmation at renewal for the next cycle.

May 31, 2022 is approaching quickly, do not be late! Questions? Feel free to reach out to careerservices@hfma.org or arazanica@njha.com.

Hospitals Feeling the Pinch of Staffing Shortages: Is this Just the Beginning?

Sean Hopkins

by Sean Hopkins

Growing staffing shortages and greater reliance on agency and traveler nurses are placing an increasingly greater strain on acute-care hospitals in New Jersey and there appears to be no end in sight. Several credit rating agencies have published sector analysis and project that these struggles will continue well beyond 2022. Hospitals in New Jersey generate approximately $27 billion a year in expenses and staffing is by and far the largest component of a hospital's expenses load, normally representing fifty-five percent of those expenses.

The Covid19 pandemic, with its peaks and valleys over the last two years has dramatically exacerbated what has been the cyclical workforce shortages in healthcare. While the pandemic prompted large shifts to remote work, care givers and specifically nurses require in-person performance. Not only has there been increased demand for direct clinical care providers, the pandemic has had a universally negative effect on the available workforce in general, with challenges in virtually all sectors of business and industry competing for talent at all levels. Healthcare job openings for both skilled and unskilled support workers are now harder and longer to fill with competition across the U.S. from all types of other industries offering flexibility, strong wages and incentives to attract workers from what has generally been a stable work environment.

In late 2021 and through February of 2022, the New Jersey Hospital Association began surveying hospitals about the explosive workforce shortage taking place in New Jersey. The results were alarming.

The final participation rate was robust with 70% of acute care hospitals responding representing 80% of all acute care beds in the state. The survey data captured data for CY 2020 and YTD 9/30/2021.

Data captured was related to

- Organizational data
- Financial impact data
- Talent information
- Turnover & vacancy

Observations were collected for

- Vacancy rates
- Turnover rates
- Overtime spend
- Time to fill vacancies
- Prevalence of
  - Sign on bonuses
  - Employee referral bonuses
  - Employee retention bonuses
  - Covid Pay bonuses

Findings:

- RN vacancy rates increased by 64% from 2020 to 2021 (going from 8.2% to 13.4%)
- Nurse Extender vacancy rates increased by 37% from 2020 to 2021 (going from 12.4% to 16.9%)
- Agency Nurse reliance increased by 66% from 2020 to 2021 (going from 3.6% to 6.0%)
- The spend on Overtime increased by 19% from 2020 to 2021 (going from $499 million to $592 million)
- The spend on agency and traveler nurses increased by 202% from 2020 to 2021 (going from $222 million to $670 million)
- Hospitals are anecdotally reporting the rates agencies are charging rose precipitously during the pandemic, and acutely with the recent surge in Covid cases related to the omicron variant.

The $93 million increase in spending on overtime combined with the almost $450 million increase in spending on agency and traveler nurses by themselves represents a two percent increase in expenses and is placing a crippling amount of pressure on hospital income statements and in some cases wiping out a modest bottom line.

The findings from the survey were included in an NJHA Center for Health Analytics & Transformation (CHART)

continued on page 25

2019 Supplemental Security Income Ratios Published

Jonathan Mason

by Jonathan Mason

The Centers for Medicare and Medicaid Services (CMS) released the latest Supplemental Security Income (SSI) percentages for fiscal year (FY) 2019.

Find important information about the publication of percentages below.

Key Information

Applicable Health Care Entities

CMS published SSI data for the following health care entities:

- Inpatient Prospective Payment System (IPPS) hospitals
- Inpatient rehabilitation facilities (IRFs)
- Long-term care hospitals (LTCHs) that bill Medicare Administrative Contractors (MACs) for Medicare beneficiaries' services

Resources

You can access the FY 2019 SSI percentages electronically on the CMS website, and the following pages focus on each applicable health care entity:

- Ratios specific to IPPS hospitals
- Ratios specific to IRF hospitals
- Ratios specific to LTCHs

CMS also released a corresponding MLN Matters article–MM12516.

Timing

On November 16, 2021, CMS issued a Change Request (CR) providing technical direction to MACs.

The CR states that Medicare Part A "contractors shall update their IPPS, IRF, and LTCH provider specific files prospectively, within 30 days of the implementation date of this CR, using the latest year's SSI Ratio posted to the CMS website as of the implementation date of this CR, except when explicitly directed otherwise by CMS."

The guidance took effect December 17, 2021.

Data

The SSI data files contain:

- The provider number or CMS certification number
- Provider name
- SSI days
- Medicare days
- The ratio of days for patients entitled to Medicare Part A attributable to SSI recipients

Methodology for Calculating FY 2019 SSI Ratios

Unlike past years, two separate SSI ratio data files exist for IPPS hospitals; one for hospitals under the Ninth Circuit's jurisdiction—Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, and Washington—and one for all others.

According to the CR, SSI ratios for hospitals in the Ninth Circuit jurisdiction "include only 'covered days' in order to reflect the decision of the Ninth Circuit in *Empire Health Foundation v. Azar* (currently pending before the Supreme Court), in order to preliminarily settle cost reports.

For all other hospitals, the methodology for calculating FY 2019 SSI ratios uses total Medicare days, consistent with our existing regulations."

Considerations for Hospitals

Hospitals should keep a few factors in mind based on their classification.

IPPS Hospitals

FY 2019 SSI ratios will generally apply to Medicare cost reports beginning on or after October 1, 2018 and prior to October 1, 2019 for settlement purposes.

For IPPS hospitals, this updated data will be used to determine their Medicare Disproportionate Share (DSH) adjustment. For those hospitals that don't share the same

fiscal year-end as the federal government—October 1 through September 30—we recommend a review to evaluate if the hospital would benefit from a recalculation.

Current CMS regulations allow a hospital to request a recalculation of its Medicare fraction or SSI ratio based on the hospital's cost-reporting period if it's different from the federal fiscal year. Learn more about how to recalculate an SSI percentage here.

IRF Hospitals

IRF hospitals will incorporate the updated percentages into their low-income patient adjustment.

LTCHs

LTCH discharges paid under the short-stay outlier payment adjustment will use updated SSI data.

Protecting SSI Fraction Appeal Rights

We recommend that hospitals not in the Ninth Circuit jurisdiction consult with counsel or their external partner to evaluate the necessity of a protest item for the SSI Fraction to protect the hospital's appeal rights pertaining to this issue.

When protesting items, it's important to:

- Remember to follow Medicare rules regarding the identification of an issue. Pursuant to Medicare rules, hospitals must claim an item if the MAC can pay it or protest it if in controversy.
- Provide a calculation detailing the amount in controversy including the accumulation of all applicable supporting documentation.
- Consult appeals counsel to ensure that you properly preserve your rights to reimbursement on this issue.

About the Author

Jonathan Mason is a healthcare consultant with Moss Adams. He has worked in health care finance since 2004. He can be reached at jonathan.mason@mossadams.com.

---

continued from page 23

bulletin. The bulletin, titled *Healthcare Employers in Dire Need of an Expanded Workforce Pipeline*, was released in February with the goal of drawing attention to this crisis situation and to compel interested sectors to work collaboratively to build a more robust pipeline of clinicians for the future.

The importance of building a sustainable healthcare workforce is essential to alleviating these expense pressures and to alleviate the potential for more pronounced labor shortages going forward. The bottom line is that hospitals exist to provide healthcare services to those in need, within the communities they reside. New Jersey healthcare employers must continue to collect and use critical data not only to gauge the depth and impact of staffing shortages but also to generate solutions to retain and augment existing staffing and build a pipeline of future staff going forward.

About the author

Sean Hopkins is Senior Vice President Center for Health Analytics, Research & Transformation at NJHA. He can be reached at SHopkins@NJHA.com.

Your Path to Program Success: Expert Advice

How Can We Get More Efficient at Delivering Care That Benefits Everyone?

Anne Beekman

Dan Halverson

by Anne Beekman and Dan Halverson

*In this month's article, I have asked **Anne Beekman, Director of Care Pathway Solutions, Terumo Health Outcomes**, along with **Dan Halverson, CEO of Sightline**, a healthcare process improvement and project management company, to address the issues that we have seen in many programs and continue to see as ongoing challenges. Their collective work has demonstrated the existence of a common, recurring issue that can and needs to be addressed if cardiovascular programs, their staff, and patients are to benefit in a meaningful way. I hope you will take the time to not only read their article, but consider how our unique solutions and team at Terumo Health Outcomes can help your program.*

— Gary Clifton, Vice President, Care Pathways Consulting

If you have been a healthcare leader or have worked in a hospital over the last 20 years, you may be desensitized to the constant message of impending staffing shortages. Adjusting compensation is the most common response and may be a quick solution for short-term retention, but not the innovation healthcare needs to be competitive and retain talent. At the same time, cardiovascular teams are being called on to improve patient satisfaction, employee satisfaction, and patient throughput, as well as patient outcomes. To continue to serve patients, some form of change is required.

Staffing shortages are predicted by the average age of nurses and physicians, the number of physicians and nurses graduating, and a ratio of healthcare workers to the overall population.[1] Cardiovascular teams are forced to be increasingly selective as to where they allocate their resources. COVID-19 also appears to have upended traditional models of predicting the healthcare workforce. We can no longer expect direct caregivers to complete 30-plus years in their traditional roles. Physicians, nurses, and technologists are looking for the same post-COVID workplace benefits as other occupations: flexible schedules, workload reduction, support for childcare or elder care, and opportunities to advance and grow. These are difficult demands for current hospital staff models to support.

The necessary change has been prescribed by multiple sources: we need to lean more heavily on available technology, but in reality, we are already struggling with technology fatigue.[2] The idea of more change can feel overwhelming. As the adage goes, "if we can't work harder, we must work smarter." We can start working smarter by identifying and removing tasks from our workload that provide little value. Applying this lens to healthcare, we find a common category of low-value work; namely, redundant and duplicative work. The top benefits of driving change through technology are improved patient outcomes with risk models, reduced costs through quality and operational improvements, and elimination of redundant documentation in the electronic medical record (EMR), all of which contribute to reduced staffing turnover and improved patient satisfaction.

A 2017 survey of physicians published by *PLOS ONE*[3] noted that 20% of the medical care provided to patients was unnecessary, including 25% of all tests administered. A 2010 report identified an average of 78% of all progress notes were redundant, with 54% of the content already documented in the chart by another party.[4]

There is a growing body of evidence suggesting we have not learned how to collaborate with each other, nor have we learned to leverage the power of existing documentation within our EMR.[5] Healthcare is not alone in this quandary. Humankind at large endures this problem every time our ability to communicate becomes more efficient. The heart of the problem is captured well by the Spanish playwright, Lope de Vega, who lived about 100 years after the advent of the printing press: "So many books! So much confusion! All around us an ocean of print. And most of it covered in froth."[6] Today, with the quantity of information at our fingertips via the EMR, we experience the same problem. We don't know where to find previously documented information, to an extent we distrust it, and we experience quantity fatigue.[7]

Contributing to this problem is the fact that healthcare in the United States has been in a mode of financial crisis for half a century, acknowledged by presidents from both parties, starting as far back as 1969, when Nixon warned, "We face a massive crisis in this area. Without prompt administrative and legislative action," he added, "we will have a breakdown in our medical care system."[8] Yet despite continuous calls for action, our system has hobbled on, carried on the shoulders of staff who work longer and/or harder. This has led us to a phenomenon of burnout, first identified in 1972 by American psychologist Herbert Freudenberger. A 2016 Advisory Board white paper encapsulated burnout symptoms with the term "loss of efficacy."[9] When we lose our efficacy, or ability to care about anything but the essentials, we stop looking for opportunities to improve. This leads us into a cycle of putting out fire after fire, leaving little to no time to think about how to prevent fires in the first place.

There is both a call to action and a possible silver lining to this cloud of financial crisis, burnout, and staffing shortages. It is possible, and perhaps even necessary, to reduce work bloat and improve outcomes at the same time.

The amount of excessive and redundant documentation has not escaped the cardiovascular procedure space. Below are some basic examples that create rework, cost, and frustration:

- Duplication of patient education
- Med reconciliation performed multiple times
- Labs and testing repeated due to lack of access to reports
- Information in the History and Physical is reentered to multiple platforms
- Appropriate use criteria (AUC) reentered into the procedure log
- Data to identify individual patient risk pre procedure is not available (e-PRISM)
- Excessive documentation in the procedural log
- Manual registry abstraction
- Physician post-procedural note does not adequately pull from EMR/hemodynamics

Continuing with these historical workflow practices and lack of data utilization for prospective patient risk management has an impact that can be measured and is significant. Taking the average "costs" for common patient events, it is easy to see the financial benefit of removing redundancy, improving the workflow, and achieving top decile in quality care (Table 1).

We are staring at an inflection point brought on by a host of challenges, including a COVID-19 pandemic and a national nursing shortage. These challenges have placed heightened financial burden on hospital systems and stress on staff. Despite these challenges, we are in the midst of a necessary migration to value-based care that requires us to navigate an evolving payor landscape, all while serving the needs of our patients. Is the value equation shifting to prioritizing recruitment and retention in order to drive low-cost and high-quality performance? Protecting and growing the healthcare team is quickly becoming the cornerstone to achieving value.

The solutions that have helped us in the past are no longer working. Technological solutions are both available and able to help us thrive in this environment. We must learn to leverage these solutions, but many programs feel stretched too thin. Something must give. We can and must find solutions that allow us to focus on value for our patients and improve outcomes while reducing clutter that clogs our pipelines. In the cardiovascular profession, our workflows and documentation practices provide us abundant opportunity for time savings and cost savings while also improving outcomes. Teams that learn to leverage these opportunities will not only improve patient outcomes, but also their employee, provider, and patient experience.

References

[1]Zhang X, Tai D, Pforsich H, Lin VW. United States registered nurse workforce report card and shortage forecast: a revisit. *Am J Med Qual.* 2018; 33(3): 229-236. doi: 10.1177/1062860617738328

[2]Ash JS, Sittig DF, Campbell EM, et al. Some unintended consequences of clinical decision support systems. *AMIA Annu Symp Proc.* 2007; 2007: 26-30.

[3]Lyu H, Xu T, Brotman D, et al. Overtreatment in the United States. *PLOS ONE.* 2017 Sept 6. Accessed October 6, 2021. Available online at https://doi.org/10.1371/journal.pone.0181970

continued on page 28

continued from page 27

Table 1. Quantifying financial benefits from removing redundancies, improving workflow, and achieving top-decile status in quality care.

Activity	Current state resource	Future state resource	Cost saving per event
Education	30 min x 2 FTE	30 min x 1 FTE	$40 per patient For 4,000 patients $160,000
Use of risk models per procedure – PCI example based on 500 PCIs total	Prospective individual risk models are rarely run	Run individualized prospective risk models on 100% of elective procedures (e-PRISM)	$8,000 per bleeding event Average occurrence 5% 25 pts = $200,000 $12,000 per AKI event Average occurrence 6% 30 pts = $360,000
LOS reduction and same-day discharge (SDD) Based on 300 elective PCI	U.S. average of SDD for elective PCI patients = 38%	Top-decile programs achieve SDD for 75% of outpatients	$2,600 per overnight stay Increase for 38% to 75% or 111 patients $288,600 per year
Retention[10] Focused on workflow redesign and documentation	25% RN turnover or 5 RNs out of 20 RNs	10% RN turnover or 2.5 RNs out of 20 RNs	$50,000 per RN or $125,000 total
Costs are based on a program performing 4,000 cath lab procedures with 500 PCIs, 300 of which are elective			**Annual cost avoidance by addressing redundant roles, use of risk models, LOS, and workflow redesign = $1,133,600**

Min = minutes; FTE = full-time employee; PCI = percutaneous coronary intervention; AKI = acute kidney injury; LOS = length of stay; SDD = same-day discharge; RN = registered nurse

[4]Wrenn JO, Stein DM, Bakken S, et al. Quantifying clinical narrative redun-dancy in an electronic health record. *J Am Med Inform Assoc*. 2010; 17(1): 49-53. doi: 10.1197/jamia.M3390

[5]O'Malley AS, Grossman JM, Cohen GR, et al. Are electronic medical records helpful for care coordination? Experiences of physician practices. *J Gen Intern Med*. 2010; 25(3): 177-185. doi: 10.1007/s11606-009-1195-2

[6]Carr N. *The Shallows: What the Internet is Doing to Our Brains*. New York, NY; W. W. Norton & Co, Inc.; 2010. Accessed Oct 8, 2021. Available online at https://archive.org/stream/the-shallows/The%20Shallows_djvu.txt

[7]Wyatt J, Spiegelhalter D. Field trials of medical decision-aids: potential problems and solutions. *Proc Annu Symp Comput Appl Med Care*. 1991: 3-7.

[8]Millenson ML. Half a century of the health care crisis (and still going strong). Sept 12, 2018. HealthAffairs. Accessed Oct 8, 2021. Available at https://www.healthaffairs.org/do/10.1377/hblog20180904.457305/full/

[9]Hasan H. Combating physician burnout. The Advisory Board. Aug 5, 2019. Accessed Oct 6, 2021. Available online at https://www.advisory.com/topics/physician-engagement-and-burnout/2019/08/combating- physician-burnout

[10]Jones CB, Gates M. The costs and benefits of nurse turnover: a business case for nurse retention. *OJIN: The Online Journal of Issues in Nursing*. 2007;12(3). Accessed Oct 13, 2021. doi: 10.3912/OJIN.Vol12No03Man04

The Rise of Smart Data: 8 Top Themes from HIT Leaders on Advanced Analytics

Steve Lefar

by Steve Lefar

More electrons and pixels have been posted on the arena of analytics among CIOs in healthcare than almost any other topic.

Billion-dollar buzzwords like AI, Big Data and robotic process automation are postulated as the new grail to healing healthcare. But beyond the hype, venture funding and trends lies the hard, messy, arduous and tedious work of making sense of the information — aggregating, normalizing and visualizing the data to address important use cases, like improving performance and understanding the actual costs of care.

On the week of The HIMSS Global Health Conference & Exhibition (one of the largest, longest running global conferences for health information and technology professionals), Strata met with senior leaders to continue the conversation on data analytics. What follows here are their thoughts and my perspective, informed by the almost 30 years I've spent in healthcare.

Smart data and advanced analytics will be the picks and shovels that we use to improve health system performance. But what do those words, "smart data" and "advanced analytics" mean in practice? We delved into these concepts and eight key themes emerged, which are fundamentally critical to developing smarter, more advanced analytics strategies.

1. **Don't boil the ocean with your analytics strategy**
   Health systems struggle with demands to do it all, to present every data element together. (Even if we can, we must always have the wisdom to ask if we *should*.) Success in our industry means getting the right data to the right people at the right time. Eric Lee, medical director of clinical informatics at Los Angeles-based AltaMed, echoed this when talking about the difficulty of bringing data together for insights. "How do you provide the right info at the right time for the right patient?" he asks.

   To create truly "smarter" analytics, our organizations need to be able to produce accurate, activity- and time-driven costing, the way every other industry can today. We should be chasing that, determining which clinical and operational data is key to help us get there. Don't boil the ocean. Focus on the key pieces of data that tell the story.

2. **Make data consumable for end users**
   We need to bring together cost and financial data with key (not all!) clinical and operational data. We need to link it, normalize it and make it consumable in tools that meet end users where they are. We must make it easier for the user, e.g. use advanced machine learning and visualization tools to elevate findings, such as auto filtering, anomaly detection, hot-spotting and heatmapping to help users draw informed conclusions. "You name it, we have it: Cloud, Edge, Python, visualization tools, etc." says Dr. Shafiq Rab, chief digital officer and CIO at Burlington, Mass.-based Wellforce. "That's not the big issue. It's getting all the data together."

   Advanced technology paired with our human experts can make us all bionic professionals of sorts, even when we don't have as much funding as we might desire. On this topic, Scott MacLean, CIO of Columbia, Md.-based Medstar, says, "It's important and valuable — and our biggest challenge — to organize our data well and make it useful. We don't have a team of data scientists, but I advocate for investing in technology to get ahead of the curve."

   Don't make end users search for insights and answers and instead use the tools and the data you have today

continued on page 30

continued from page 29

to help them make the right decisions. Consider how you can make the data consumable for your end users.

3. **Get going! Tier your data into basic, essential, advanced and value-based for better analysis**
   Let's take an example of analyzing surgical costs. Leaders need to consider how their organization will access and use basic, essential, advanced and value-based information.

   For starters, basic and essential data includes OR data, such as charge level (basic) or actual minutes (essential), actual labor cost averages (basic) or person-level wages (essential), standard or true supply costs, anesthesia costs, PACU time and procedural coding to examine case types and basic acuity.

   Advanced data, which helps stratify risk, includes things like basic biometric data (BMI), social circumstances to cohort patients and claims data or details on clinical history.

   Value-based data includes linking pre- and post-procedure information from claims or registry to tie cost and longer-term outcomes. Steven Lane, MD, clinical informatics director at Sacramento, Calif.-based Sutter Health states that it is important to know what was done to enhance clinical quality outcomes. "We need to know what has been done so that we can target our follow up appropriately." For example, he suggests taking the claims data to see who has had a bi-lateral mastectomy and use that to inform the clinical chart. "You do not need to do outreach for mammograms once this has been documented," he says.

4. **Avoid the atomic baloney slicer**
   While new technologies such as cloud-based data lakes (and data marts), Python and commercial machine learning platforms have made it even more feasible, usable and more affordable to integrate retrospective and real-time data within tools, we need to avoid the atomic baloney slicer (a term I'm borrowing from an old friend). In analytics, one atomic baloney slicer is an overly complex, singular, monolithic enterprise database.

   To avoid building these unnecessarily complex systems within our healthcare analytics strategies, it's important that hospitals leverage their data for end users. Think of it like oceans of data (from source systems) flowing into lakes (data lakes) that flow into ponds (data marts) for smarter data sets for end users. To get the right data to the right people, you need to understand the problem that is trying to be solved. For Ben Petro, informatics analyst at the University of Chicago Medicine, this means thinking about the end user of data and how they will use it. In his case, senior leadership, executives and management level need access to this data weekly and need to be able to drill into volumes by service line.

   Focus your data efforts on that problem with the least amount of data needed. Don't let perfect get in the way of good enough. Do you really need real time data to make your projection? (Sometimes yes, but often no.) What are the tradeoffs from using more data? It's about separating the signals from the noise. More data is not always better data. Do you need an atomic baloney slicer or will a butter knife work?

5. **Build bridges between finance, IT, analytics and operations**
   All this work requires cooperation between finance, IT, clinical, analytics and operations to get to the right solutions. Mitchell Fong, director of telehealth at Reno, Nev.-based Renown Health, is working to create new Telehealth programs or "Health at home" programs to help patients return to their normal lives faster after hospitalization through intermittent monitoring and interventions at home.

   But the challenge is tying telehealth data to hospitals visits. "It's hard to match up survey data to encounter data," says Mr. Fong. "… And then we have to figure out how to get the telehealth visit back into the clinical record." We know our teams can make better, more informed decisions with the right data at their disposal. That means connecting all the data points.

6. **Learn from the clinical side**
   Normalization of data is critical to credibility. Health systems often struggle with combing through and normalizing data. Of the healthcare IT leaders we talked to at HIMSS21, all described challenges linking clinical and financial data.

   Dr. Lane (Sutter Health) told us that "usually clinical data is seen of a higher value." Clinical data is ahead of financial and operational data in simplifying and

normalizing. There have long been standards put into place such as procedure codes, LOINC, taxonomies, etc., already developed and in the market. Other than how we count dollars, basic accounting principles and a few standards for charts of accounts, Finance teams have had no way of normalizing their data prior to advancements made by data sharing consortiums like the StrataSphere® platform and network.

7. **Use cross-industry data and standards**
   Organizations are looking to others across the industry to better understand and standardize data for stronger insights. Healthcare IT leaders consider not only their internal performance, but also how to understand it more deeply with alternative data (like social or claims) and to compare apples-to-apples externally. Healthcare is changing. Regulations around site of care payment differentials, what is allowed inpatient versus outpatient and the very nature of healthcare providers are also changing (e.g. the creation of venture and private equity backed groups with financial wherewithal).

   Make sure your lens is not only focused on your traditional competitors in healthcare but also emerging providers and technologies. This creates a need for access to alternative kinds of data and cross-industry standards that don't exist today for finance.

8. **Understand the goals and objectives of data sharing**
   Data is considered the "new oil" and is being aggregated in many ways across industries and within healthcare. There have been many historical efforts to do this in healthcare and there are several new ones emerging. Some have failed, causing large financial losses, some don't leverage modern technology to make it far easier (and less expensive) to share and participate and still others try to serve too many masters. One of the keys for leaders will be to understand the goals and objectives of each of those that they join and whether they appropriately solve challenges for their organizations.

   B.J. Moore, executive vice president and CIO of Renton, Wash.-based Providence suggests that bringing data together requires 3 strategic pillars: "simplify, modernize and innovate." To get the most out of your data, an organization needs to be able to consolidate to a cloud solution and centralizing systems. "Truly integrated reporting needs to be done at scale, which needs to be done in the cloud," Mr. Moore says.
   StrataSphere is one such collaborative that has enabled healthcare organizations to share and leverage deep, normalized, consistent, current financial and operational data. Participants can access this data directly, from over 400 health systems representing more than half of all spending in the U.S. attributable to hospitals and health systems (over $1 trillion).

Our discussions with healthcare IT leaders only solidified my view about what healthcare organizations need to be successful with their data strategies. To be successful, healthcare organizations need to plan for scale and scope, and to carefully consider the use cases and goals of their data before making huge "build it and they will use it bets." Focusing on how it will help end users make better, smarter decisions should be a north star and will drive improved investment priorities.

Leaders should look across our industry and at the standards and data use of others, to collaborate with other organizations and make improvements. Smart data and advanced analytics will be the backbone of healthcare analytics strategy moving forward. It's tough, messy work, but with collaboration and the right tools, we can make it happen. With these tools and networks at our fingertips, healthcare leaders can empower teams with the right data at the right time to make the right decisions and drive success.

About the author

Steve is a three-time CEO with nearly 30 years of experience in healthcare with expertise in strategy, analytics and software. In June of 2018, Steve joined Strata Decision Technology as Executive Director of StrataDataScience (SDS) and StrataSphere®, Strata's collaborative cross client data initiative. StrataSphere leverages the nearly $600B per year of healthcare costs from 200+ health systems that work with Strata. He is a member of Strata's senior leadership team and drives analytics strategy. He is also a board member of several venture backed companies. These include Evive and Wildflower Health. Previously, Steve was CEO of Applied Pathways (acquired August 2017 by AIM Healthcare which is part of Anthem). Prior to Applied, he was CEO of healthcare market intelligence, consulting and analytics firm Sg2 (acquired by MedAssets in 2015) and President of MediRegs (acquired by WoltersKluwer in 2007). He was also head of Corporate Development at Allscripts and worked in consulting with both Accenture and APM early in his career. Steve earned a BA in economics from the University of Michigan in 1988. Steve can be reached at slefar@stratadecision.com.