

# first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

April 2011

## STEP Up

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Highlights and Recap  
First Illinois  
Chapter Events  
begins on page 17

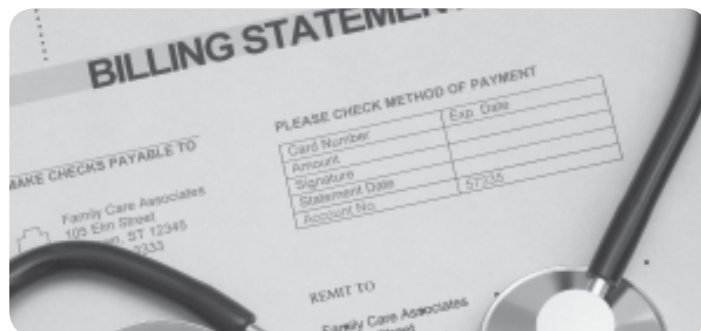
**Founders Merit Awards  
for 2011**

**Treasury Program  
Captured Events**

## Measuring the Effectiveness of Revenue Cycle Operations

BY DAN YUNKER, VP & CFO, METROPOLITAN CHICAGO HEALTHCARE COUNCIL

After my last *Illinois Speaks* article, "Simulating the Impact of Reform on the Region" was published, I received several calls from financial leaders who observed that if the industry does experience a growth in the individual markets as a result of reform, the importance of revenue cycle performance will intensify as



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we will be chasing reimbursements from even more insurers on the exchanges. We don't know how the exchanges will ultimately unfold or how many new entrants will exist in the future but we do know that today we are not anywhere near a utopia state of sending a clean bill out the door and getting paid correctly with no manual intervention.

It is more important now than ever before to start achieving incremental and sustainable improvements that trend towards a targeted utopia state. I have heard some ask why we should focus on improving the revenue cycle when ultimately the payment models are going to transform and the transactional reimbursement as we know it will go away. For a portion of the business this may absolutely be the case, but will it be true for all claims? And even if we are moving away from a transactional reimbursement model, hospitals need to ensure during the transition that processes allow for capturing all the reimbursement that is due. The revenue cycle is a complex process. A revenue cycle leader should take pride in executing a complex process that delivers 99 percent of the reimbursement that is due from third party payers to

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the organization for services rendered. Most CFOs would agree and then immediately ask about the other one percent, because that represents pure growth of current margins. Any fraction of an improvement could be substantial.

So often when leaders talk about their financial performance they reference their days in accounts receivable (AR) metrics. I have to admit that I struggle a bit with this metric because there are so many variables that cause difference, from one organization to the next. My preference of measuring days in AR would have two key metrics:

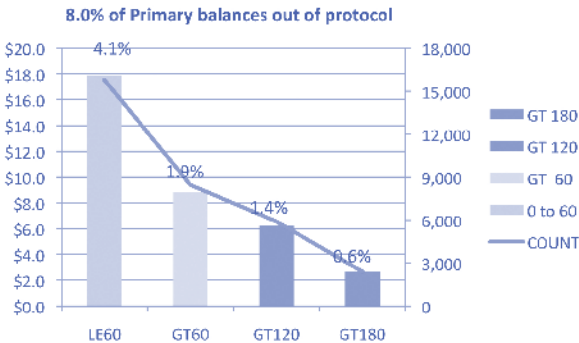
- 1] days of all accounts that were paid within 35 days and
- 2] days of accounts that were paid with rework.

When this is done, suddenly the conversation shifts and examines a group of claims paid in less than 35 days and another group that is paid much more slowly. And in today’s typical revenue cycle, claims that are paid only after manual intervention hold the greater percentage with a small but significant to the bottom line percentage slipping through the cracks. Additionally, the slower paid group is detrimental to the balance sheet, and acceleration of these slow payments could generate additional financial return.

In order to successfully address the one percent or so lost third party reimbursements and your opportunity to accelerate cash, it is important to measure how effectively processes are working compared to what you expect to occur. This process examination starts with how effectively accounts are worked and how many of them simply are falling out of the expected process or have become “out of protocol.” For example, there could be thousands of accounts and millions of dollars in primary insurance AR that are not being processed according to the hospital’s planned follow-up protocols.

Primary	Out of Protocol %
Best Hospital	6.2 %
Poorest Hospital	15.3%

I pulled some data from the Metropolitan Chicago Healthcare Council’s (MCHC) RevSight® database, and the best performing hospital in the database is operating with only 6.2 percent of its primary accounts being out of protocol. The poorest performing hospital is at 15.3 percent. To put this in perspective, for every million dollars of net patient revenues of the lower performing hospital almost an additional \$100,000 is at-risk of not being paid. The data also indicated that some accounts are never paid. Several accounts remain out of protocol on an ongoing basis.



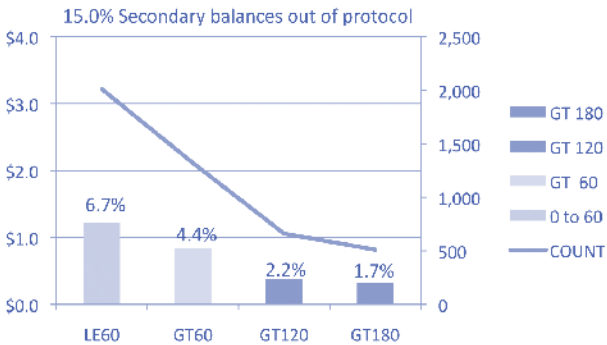
The chart above represents a summary of primary out of protocol accounts along with primary payer balances that are continuously out of protocol. When looking at data this way, the parameters are set to mirror the follow-up targets and protocols established by hospital leadership. As accounts remain continuously out of protocol, they are more and more likely to be lost (in an AR black hole). About half to one percent of the total primary insurance out of protocol accounts are ultimately lost to either a timeliness fatal denial or the staff essentially gives up and pushes the balance to patient responsibility. Therefore some of these out of protocol accounts end up as timely denials and some end up being recorded as self-pay bad debt, but in reality they were due from a third party payer.

When looking at the database, most hospitals do a good job of billing and collecting on secondary insurance. However, when a secondary is not paid on the initial claim, the follow-up is typically not as rigorous as was executed on the primary insurance. The monies collected on the secondaries are still net revenue so the balance represents cash to the hospital and should demand the same rigor.

Primary	Out of Protocol %
Best Hospital	8.2 %
Poorest Hospital	23.6%

As you can see, the best performing hospital in the database is operating with only 8.2% of total accounts out of protocol and the poorest performing hospital is at 23.6%. The performance on secondary accounts even at the highest performing hospital is not as good, and a significant gap grows for the poorer performing hospital.

The chart below represents the secondary payer balances continuously out of protocol.



Measuring and identifying what accounts have been paid and what accounts remain out of protocol allows a revenue cycle leader to direct specific efforts to make sure these bad debts are avoided and that there is direct margin improvement. When an organization measures its expected performance and can identify achievement of targets down to the account level, a clear picture of staff performance also materializes. The data provides a measureable breakdown of how staff members are spending their time relative to the effectiveness of their activity resulting in a new paradigm of performance management in the revenue cycle.

## Letter from the President

This is my final letter as president of the First Illinois Chapter of HFMA. In the past several months, we have had many successes within our chapter including new education programs, more social events and streamlined communication to members.

Earlier this year, members were randomly selected to complete a survey from National to provide feedback to local chapters. Based on our survey, overall First Illinois member satisfaction increased nearly 20%. We saw a significant improvement in member satisfaction in education programs, speakers and chapter communications. This year we made a few changes to our education calendar. As an example, Accounting/Reimbursement and Revenue Cycle programs were offered as separate programs instead of a combined program, allowing a deeper dive into related topics. A new Compliance program was offered to respond to unmet education needs. Our programs continue to host outstanding speakers with representation from providers, business partners and government representatives to give a 360 degree perspective. This year, we offered more social networking events. In addition to our Sox and Cubs outings, First Illinois made a bet on the Arlington Racetrack and membership came out to watch the ponies! This year, a concerted effort was made to improve communications to the chapter through website improvements and fewer yet

more comprehensive email communications. We continue to improve our local website, making it a more robust resource. Although initial improvements to our website have been made, full implementation will continue in the coming year.

We also have opportunities within the chapter. Year over year, we saw our education hours decrease. Education is one of HFMA's core values. With the changing economy, First Illinois saw members pull back on live programs and request more web-based offerings. First Illinois needs to be more responsive to meet the needs of our changing environment. This will be an area of development in the coming year. As I have mentioned in each of my columns, the healthcare environment will be evolving at a faster pace and increasing in complexity. And, HFMA as a group will also evolve to assist our membership to meet these changing needs.

The achievements I described above are due to the tireless work by our volunteers. The successes we have had this year would not have been possible without the tremendous efforts of our volunteers. They have given their precious time, their professional talent and their personal goodwill. Our theme this year has been "Step Up." Like any volunteer organization, the few worked to provide for the many. I would encourage anyone who has enjoyed or benefited from any of our programs to pursue greater involvement with the chapter. There are a variety of opportunities to volunteer. Whether giving your time for an education program, for a support committee or for governance, First Illinois has a wealth of opportunities for volunteerism. As in any community, by taking your turn, everyone benefits. It is a great way to become more involved, expand your network and make great friendships.

Your incoming First Illinois Chapter president is Pat Moran. With his diligent work ethic and attention to detail, I know the projects begun under my tenure will be in good hands. Under his leadership and direction, I am confident the chapter will move forward to meet the changing environment. I would encourage you to give him and his team your support in the coming year.

Through my involvement with HFMA, I have had many great experiences and have made a lot of connections, both personal and professional. As I transition through the end of my presidency, I would like to thank all who have helped me during my officer term. I would particularly like to thank Mike Nichols for his counsel and good humor. ☺

Thank you.

Patricia K. Marlinghaus, CPA, MBA  
2010 – 2011  
Chapter President,  
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# The Power of Mentoring: A Winning Strategy for Developing Leaders

BY VICKI AXFORD AUSTIN

When Odysseus went off to the Trojan War, he couldn't leave his son Telemachus behind without appointing a teacher and guide. Odysseus hired a family friend, Mentor, to be his son's tutor. We now use the term "mentor" to describe a person who guides a younger or less-seasoned professional.

Here's a definition from *Seven Keys to Successful Mentoring* by E. Wayne Hart, published by the Center for Creative Leadership:

**Mentoring is an intentional, developmental relationship in which a more experienced, more knowledgeable person nurtures the professional and personal life of a less experienced, less knowledgeable person.**

Whether the agreement is formal or informal, inside or outside the chain of command, seems less important than whether it's the right "fit." Success is dependent on the generosity of the mentor as well as the willingness of the protégé (sometimes called "mentee") to learn.

## Seeing Your Potential

Tim Manning was lucky enough to have a professor at Northern Illinois University who mentored him. Tim, practice manager of

DuPage Medical Group, learned a mentor is someone who sees your potential and believes you can do great things.

"The Golden Rule of a mentor is that they have no agenda" other than the success of their protégé, Tim said. He also had a formal mentor assigned to him at one of his first jobs, a physician who helped him adjust to an academic faculty physician group.

## The Benefit of Outside Counsel

"I had a formal mentor through work," said Paula Dillon, director of managed care at Rockford Health System. Paula's mentor was the executive director of the foundation, a mix that worked surprisingly well. "Even in a totally unrelated area," Paula said, "having a mentor proved to be very beneficial. You get an outside view of things, skills you need to be successful and make the most of your career."

Paula's boss, the system's CFO, serves as her informal mentor. And she benefits from the mentoring of other professionals through HFMA. She acknowledged Mike Nichols, managing director of McGladrey and a former chapter president, as someone she found to be "very approachable."

Graham McNally's career track was influenced by mentors. He talked to several successful Chicago business people who guided him out of law into healthcare. Since then, he's had informal mentors who've guided his path. He's now a consultant at Merge Healthcare, Inc.

"It's important to follow up [with a mentor], to thank them, keep them informed and be respectful," Graham said. And for anyone who doesn't have a mentor, he enthusiastically recommends finding one. "Start with your friends," he advised. "People know people. You can't expect it to happen overnight, but start an initial discussion and start early."

## Walking the Talk

Sometimes it's the protégée who takes the initiative to forge a relationship. Patt Marlinghaus, corporate director of finance for Riverside Medical Center and First Illinois HFMA chapter president, was approached by a woman in the hospital's marketing department. This ambitious young lady admired Patt's leadership style and asked Patt to mentor her. Patt agreed.

Because of their disparate professions, it's "an odd dynamic" Patt said, but she's learned a lot from her protégée. And Patt was highly complimented by the woman's request. "I didn't think of myself as a role model," Patt said. "Now I stand up a little straighter. I really did take it to heart. A mentor has to lead by example," she added.

To Pat Moran, being a mentor can be challenging because it's a big commitment of time. But when done correctly, mentoring provides great satisfaction, according to Pat, Midwest healthcare market leader of Dell Perot Systems and president-elect of the chapter. Patt had

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## The Power of Mentoring: A Winning Strategy for Developing Leaders

(continued from page 4)

some great mentors himself, including his first boss, Roy Hoff at Eli Lilly. Roy taught him the value of coming to your boss with solutions instead of just problems.

“You learn from people who take the time to explain things, who believe in you and empower you to accomplish things that you wouldn’t have accomplished otherwise. They open a door you wouldn’t have walked through if they weren’t there.” Pat said.

### Parting is Such Sweet Sorrow

Mentors need to know when it’s time to let your protégé “fly,” according to Chip R. Bell, author of *Managers as Mentors: Building Partnerships for Learning* (Second Edition) published by Berrett-Koehler. The author recommends completing the agreement with a celebration and allowing some time to pass before following up with a protégé. Tim Manning agrees: he once was held back by a mentor who didn’t know when to let go.

If you’re on your way up the career ladder, finding a mentor is a powerful strategy for moving your career forward with momentum. And once you’re at the top of that ladder, it’s a privilege to give back. Whether you’re a mentor or protégé, there’s an opportunity to make a difference in someone else’s life—and in your organization. ☘

Vickie Austin, founder of CHOICES Worldwide, is a business and career coach and a professional speaker based in Wheaton, IL. She worked as a marketing communications professional in the healthcare industry for 20 years and was director of marketing for Modern Healthcare magazine. You can reach her at 630-510-1900 or [vaustin@choicesworldwide.com](mailto:vaustin@choicesworldwide.com).

### Sidenote:

From *Seven Keys to Successful Mentoring* by E. Wayne Hart, published by the Center for Creative Leadership

### What mentors do:

- 1 Develop and manage mentoring relationship
- 2 Survey the environment for threats and opportunities
- 3 Sponsor the mentee’s developmental activities
- 4 Guide and counsel
- 5 Teach
- 6 Model effective leadership behavior
- 7 Motivate and inspire



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# The Healthcare Data Storage Challenge

BY NAV RANAJEE

Historically, healthcare has been behind other industries in migrating to the digital age. Automating paper-based processes, digitizing medical records and computerizing patient care processes has long been the mantra of most healthcare pundits and consultants.

The paradigm is quickly changing, however, as technological advances, regulatory policy and stimulus funding is driving exponential growth of digital data over the next few years. A critical success factor in deploying these new technologies will be the data center. Healthcare IT planners will face complex challenges and will need to reassess their current storage and IT infrastructures to meet the needs of the new digital universe.

Not only will finding storage capacity be a challenge, but the sensitive nature of clinical applications required to make life or death decisions heightens the critical need for continuous uptime, large bandwidth, solid security, and established disaster recovery.

## Growth of Digital Data

The ultimate objectives of Healthcare IT are to be more cost efficient and to improve patient care. It was under this concept that the American Recovery and Reinvestment Act (ARRA) included the Health Information Technology for Economic and Clinical Health (HITECH) Act to fund more than \$30 billion in healthcare IT investments.

A large part of this healthcare IT funding will be directed toward

incenting the adoption of Electronic Health Records (EHRs) and there will be penalties (in the form of reduced Medicare reimbursement) for non-compliance. Given that less than half of all providers utilize EHRs today, the industry is poised to experience significant EHR adoption and digital data growth over the next few years.

One telling statistic of this movement toward EHRs was a recent release by the Centers of Medicare and Medicaid Services (CMS) announcing that 21,000 providers had started the registration process in January to qualify for incentives. To illustrate the data digital growth even further, studies show going paperless in a hospital requires 60 gigabytes of data (GB) of data storage per bed per year. For a 100 bed community hospital that would translate into 6 terabytes (TB) of storage per year.

A large part of EHRs is the imaging data commonly referred to as Picture Archiving and Communications Systems (PACS). Imaging such as MRIs, CAT-scans, and X-Rays generate large image files and will cause a significant storage headache for healthcare IT planners. Not only has the use of digital imaging increased significantly over the past decade but advances in scanning technology resulting in the transition from 64 to 256 slice scanners with higher resolution increases data storage needs even more.

Finally, as providers implement EHRs they will need to image and load historical paper records if they are to truly integrate all of a patient's history into one system.

## Compliance Requirements

Another driver of data growth is HIPAA/JCAHO/State compliance requirements to save medical records for a specified period of time. Although state by state regulations may vary a bit, the general protocol has been as follows:

- Records of minors must be kept until they reach the age of 18.
- Images of new births must be kept for at least 21 years.
- HIPAA requires all covered entities to retain records of adults at least 6 years after they were created.
- State laws can vary and mandate longer retention periods but cannot be less than the HIPAA guidelines.
- Surveys have shown nearly half of all providers keep medical records permanently in order to keep history or to protect from malpractice litigation.

Other areas driving digital data growth include administrative document imaging (EOBs/Claims), telemedicine, mobile technologies and digital pharmacy. After decades of paper processing and all of the inefficiencies that come with it, the healthcare industry is now rapidly moving into the digital age.

Healthcare IT planners must carefully assess their IT infrastructures and take the appropriate actions to ensure they can store, process and secure new heavy volumes of data.

*(continued on page 7)*

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## The Healthcare Data Storage Challenge

(continued from page 6)

### Data Center Structures

The reliability of the data center will be of the utmost importance as organizations take on EHRs and other new applications. The successful operation of new healthcare applications will be dependent not only on the software itself but also on the complementary IT infrastructure.

Serious problems can occur if an existing data center is asked to take on more load or be more reliable than its design can handle. Many hospital data centers were designed to support non-clinical data, such as payroll and billing, and may not offer sufficient reliability for mission critical clinical applications. All data centers vary in size and scope. Data centers are differentiated by their power, cooling, connectivity, security and the degree to which they have uninterrupted uptime.

A typical data center will have over 20 major mechanical, electrical, fire protection, security and other systems, each of which has additional subsystems and components. Each of these items must be concurrently maintainable and/or fault tolerant. Over the past 40 years, data centers have evolved into 4 levels. These levels are captured in a tiered classification system defined by the Uptime Institute, a research organization for the data center industry. The classification system reflects the degree of reliability built into its mechanical and electrical infrastructure.

#### Tier I

Single path for power and cooling with no redundancy. Maintenance requires outage. 99.671% availability with annual downtime of 28.8 hours.

#### Tier II

Single path for power and cooling with redundant components. Maintenance requires outage. 99.741% availability with annual downtime of 22 hours.

#### Tier III

Multiple active power and cooling paths but only one active path has redundant components and is concurrently maintainable, providing 99.982% availability. Annual downtime of 1.6 hours.

#### Tier IV

Multiple active power and cooling distribution paths, has redundant components and is fault tolerant, providing 99.995% availability. Annual downtime of 0.4 hours.

Cost will be a key driver of which data center tier a healthcare organization should strive to attain. Obviously, the higher the tier, the more costly it will be to design, build or outsource. It will be a significant investment for a healthcare organization if they decide to upgrade a Tier I or II facility to a Tier III or IV.

Healthcare IT planners will need to assess the applications they plan on implementing and the resulting uptime, security and reliability that will be required. For mission critical clinical applications, design firms are recommending Tier III or IV for the primary data center.

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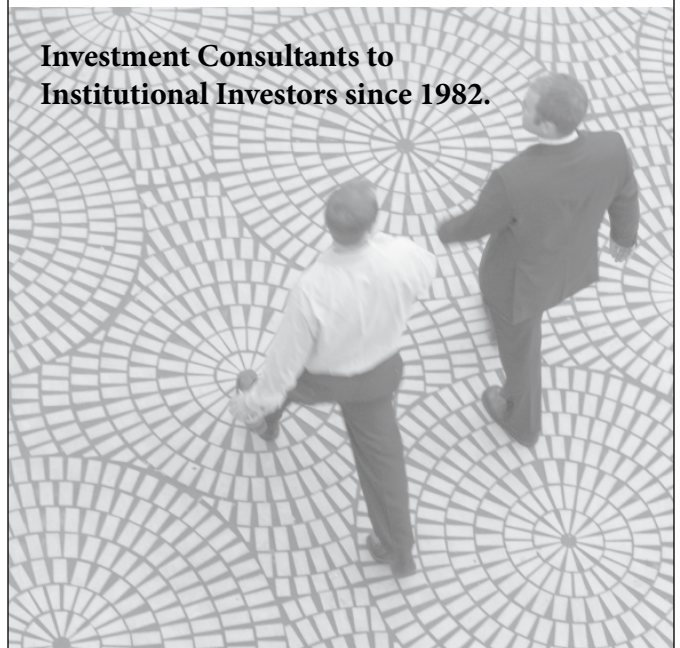
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# The Healthcare Data Storage Challenge

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The level of security will also be a key consideration in data center selection or design. Data breaches of Personal Health Information (PHI) continue to garner the headlines. Healthcare organizations across the country are facing significant fines for unauthorized disclosures in violation of the HIPAA privacy and security acts. Physical security of data and data servers is one of the top priorities of a data center.

Data centers should be equipped with a 24/7 physical and electronic system to ensure your equipment is safe. Monitoring via closed circuit television, on-site support and security teams, biometrics security systems, access key cards and alarms tied to police and fire departments are security measures utilized by the top data centers. Having your data center achieve a SAS 70 Type I or II audit is another recommended method to ensure that operational procedures, security, controls and processes are operating effectively to safeguard and protect your data and equipment.

Another issue that healthcare organizations will grapple with will be scalability. Is the current data center infrastructure able to be easily expanded or upgraded to handle new data loads without any downtime? Healthcare organizations will need to clearly understand their current capabilities, storage options and trade-offs on investments in risk, performance and cost. They will need to balance the competing demands of cost, storage, performance and security.

## Disaster Recovery

Surveys have shown the top priority of healthcare organizations is backup and disaster recovery. The growing amount of data is not only putting a strain on primary storage capacity but on the ability to access critical clinical applications from backup systems in case of unplanned downtime. The criticality of having real time access to a clinical EHR cannot be understated. Even one hour of downtime could affect a life or death situation.

Another factor in having disaster recovery procedures in place is the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA security rule establishes national standards for the protection of Electronic Personal Health Information (EPHI). The major provisions under this act are:

- **Disaster Recovery Plan:** Plan to restore operability of the target system, application or data center facility at an alternate site in case of emergency.
- **Data Backup and Storage:** Procedures to create and maintain exact copies of EPHI .
- **Emergency Mode Operation:** Procedures to ensure business continuity for protections of EPHI in case of emergency.
- **Contingency Operations:** Administrative controls for physical access to backup facilities to continue operations in event of emergency.
- **Applications and Data Criticality Analysis:** Data and application criticality inventory.

A data center equipped to restore critical EPHI is essential to executing a disaster recovery strategy and to be compliant with the HIPAA security rule.

One model that healthcare organizations may follow is to have two data centers. There is the “primary” data center for all clinical and non-clinical applications which is usually located on-site or within a 20 mile radius. A second data center for disaster recovery will typically be in a different location and may be located far away to mitigate a natural disaster striking both centers. Disaster recovery centers are typically lower tiered facilities (Tier I or II) than primary data centers (Tier III or IV).

As disaster recovery plans are developed, key consideration is given to the critical nature of each data element and the level of recovery required. Disaster recovery planners are using the following model to determine recovery levels:


**Level 1:** Critical clinical applications that require synchronous or asynchronous computing such as an Electronic Health Record

**Level 2:** Near critical applications that can be supported with a two- hour downtime

**Level 3:** Non-critical applications that can be supported with an eight-hour downtime such as payroll/billing data

A careful analysis of current and planned applications and their restoration needs must be factored into disaster recovery and infrastructure planning.

## Conclusion

The oncoming digital revolution in healthcare will apply unprecedented data storage challenges for healthcare organizations. The rising volume, cost and complexity of data will force healthcare IT directors to tackle critical decisions in storage design, architecture, operations, performance and security. Not only must healthcare organizations evaluate the cost of an Electronic Health Record (and how to capture the ARRA funding dollars for it) but they must also consider the impact on their current data center and disaster recovery infrastructures. Upgrading current infrastructures to meet scalability needs, security requirements and higher degrees of reliability can be costly, even more so than the clinical applications themselves. How and where the data will be stored must be carefully analyzed prior to committing to the implementation of new digital applications. 

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# Aligning Physicians and Hospitals

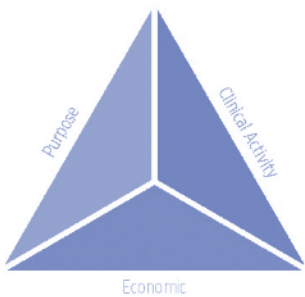
BY KATE LOVRIEN AND LUKE PETERSON

Healthcare and payment reforms, new structural models and myriad market forces have increased the pressure on the physician-hospital relationship, but forging stronger partnerships is a key element of future success.

As illustrated by Exhibit 1, there are three major elements of the Physician-Hospital Alignment Triangle required for full physician-hospital alignment:

- **Clinical Activity Alignment**  
The correlation of the patient care approach, expectations of quality and service, and consolidation of activity in the diagnosis, treatment and rehabilitation of a patient
- **Economic Alignment**  
The correlation of physician and hospital financial returns
- **Alignment of Purpose**  
The correlation of vision, values and energies; creating a shared belief in a single vision/mission, a common culture and an active involvement in the future direction of the organizations

EXHIBIT 1: Physician-Hospital Alignment Triangle



To systematically study alignment, we developed the Physician-Hospital Alignment Diagnostic, a quantitative tool that allows hospitals to test their specific situation and alignment against others across the country.

Taking a sample of 40 hospitals shows some interesting results.

- The total alignment score is measured by adding the scores of the three types of alignment. With a maximum possible full alignment score of 150, the sample scores range from 59 to 106. The mean score is 81.
  - Clinical activity alignment scores range from 19 to 38 of a possible 50 points with a mean score of 27
  - Economic alignment scores range from 12 to 36 of a possible 50 points with a mean score of 27
  - Alignment of purpose scores range from 17 to 36 of a possible 50 points with a mean score of 27
- Urgency of alignment is a factor of the market, hospital, and competitive factors. The measure of Urgency ranges from 22 to 39 of a possible 50 points with a mean score of 30.

These scores, which are similar to other hospitals in the database, show the variability of alignment and that many hospitals have significant opportunity for greater alignment in multiple areas.

## Strategies to Improve Physician-Hospital Alignment

There are 20 distinct strategies in four categories (business services, contracts, structured communications and employment) that hospitals can use to strengthen the three forms of alignment. (See Exhibit 2.) (continued on page 10)

EXHIBIT 2: Physician-Hospital Alignment Strategies

<b>Business Services</b> <ul style="list-style-type: none"><li>&gt; Management services organization</li><li>&gt; Lease and real estate contracts</li><li>&gt; Information infrastructure</li><li>&gt; Payor contracting organizations</li><li>&gt; Clinically integrated physician networks</li></ul>	<b>Contracts</b> <ul style="list-style-type: none"><li>&gt; ER call pay</li><li>&gt; Physician recruiting</li><li>&gt; Medical directorships</li><li>&gt; Clinical co-management and whole program PSAs</li><li>&gt; Joint ventures</li></ul>
<b>Structured Communications</b> <ul style="list-style-type: none"><li>&gt; Blogs/one-way digital communication</li><li>&gt; Two-way digital communication</li><li>&gt; Town hall forums and retreats</li><li>&gt; Physician advisory council</li><li>&gt; Direct physician leadership</li></ul>	<b>Employment</b> <ul style="list-style-type: none"><li>&gt; Individual contract, productivity</li><li>&gt; Standard contract, varied incentives</li><li>&gt; Single-Specialty group</li><li>&gt; Multispecialty group</li><li>&gt; Integrated organization</li></ul>

## Aligning Physicians and Hospitals

(continued from page 9)

Moreover, each of these strategies impacts different parts of the Physician-Hospital Alignment Triangle. As such, the appropriate strategy needs to be used for the each situation. In general, hospitals wanting to align physicians should consider strategies based on the connections outlined in Exhibit 3.

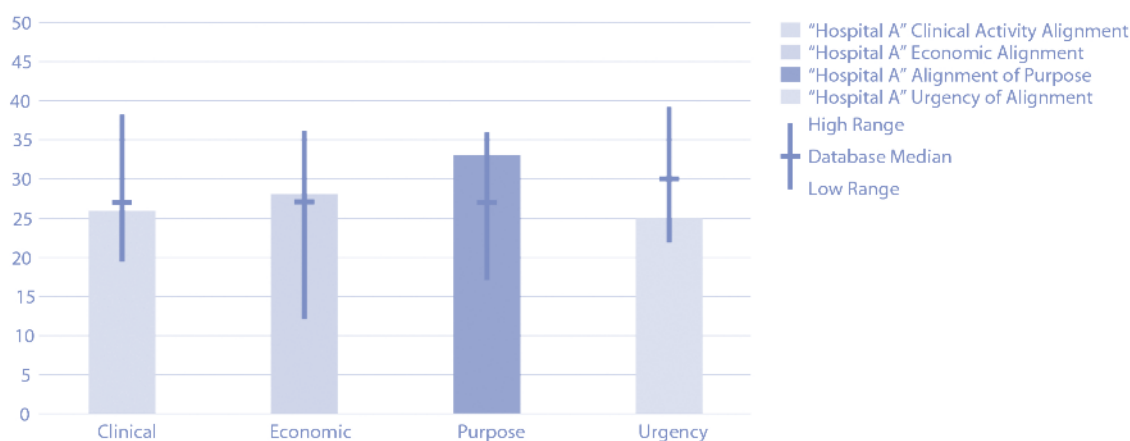
EXHIBIT 3: Categories of Alignment Tools

AREA NEEDING IMPROVEMENT	PRIMARY TOOLS	SECONDARY TOOLS
Economic Alignment	> Business Services	> Contracts > Employment > Structured Communications
Clinical Activity Alignment	> Contracts	> Structured Communications > Employment > Business Services
Alignment of Purpose	> Structured Communications	> Contracts > Employment > Business Services

### Case Study

Evaluating a sample hospital ("Hospital A") shows a typical profile of a hospital in the database. This hospital, a 200-bed hospital, has above-average financial indicators and provides strong community care to a growing, affluent, suburban market. The diagnostic shows that Hospital A has substantially higher-than-average alignment of purpose, but average alignment in clinical activity and economic areas. (See Exhibit 4.) Moreover, market indicators suggest that the urgency of creating stronger physician alignment is lower than average.

EXHIBIT 4: "Hospital A" Physician-Hospital Alignment Score



Further investigation of Hospital A shows that the hospital's administration has been actively working to create a common vision with its physicians. This common vision has led to direct physician leadership in setting the strategic course of Hospital A. However, while Hospital A has kept up with the national trends, it has not been overly aggressive at using the tools that might advance clinical activity or economic alignment. For instance, Hospital A does not employ any physicians, does not pay ER call pay, and has only a very limited number of other contractual and business service activities with its physicians. Given the relatively weaker alignment within clinical activity and economic areas, Hospital A has embarked on investigating the tools that directly impact these two areas of alignment.

### Conclusion

Strengthening physician relationships is a key component of hospital and health system success. With the increasing integration of the physician into the hospital and health system organizations, it is important to create stronger alignment in all three areas. For more information, visit [www.PhysicianHospitalAlignment.com](http://www.PhysicianHospitalAlignment.com).

Kate Lovrien is a senior manager and Luke Peterson a partner with Kurt Salmon's healthcare strategy group, and the two are co-authors of [www.PhysicianHospitalAlignment.com](http://www.PhysicianHospitalAlignment.com). They have focused their careers on advising community and regional referral hospitals and healthcare systems on the strategic positioning including physician-hospital alignment, health system organizational structures, and continuum of care coordination. They can be reached at 612.810.8188 or by emailing [Kate.Lovrien@kurtsalmon.com](mailto:Kate.Lovrien@kurtsalmon.com) and [Luke.Peterson@kurtsalmon.com](mailto:Luke.Peterson@kurtsalmon.com).

## Lesser Known Options for Affordable Capital

BY STEVE KENNEDY, LANCASTER POLLARD

Construction, renovation and acquisition financing options will be different in 2011 than they were in 2010, which saw the expiration of several temporary options created or modified by the American Recovery and Reinvestment Act. While conventional financing may remain difficult for some hospitals to access because of the still-tight credit markets, affordable capital can still be available via lesser-known methods or by combining multiple resources.

Two Illinois hospitals recently closed on lesser-known financing structures that can serve as examples across the state. Marshall Browning Hospital's U.S. Department of Agriculture option is designed for rural hospitals and provides a long-term structure at a low interest rate. Jersey Community Hospital District's financing, while it utilizes two types of bonds that expired in 2010, demonstrates a still-valid strategy of reaching out to multiple banks in order to achieve the necessary financing amount.

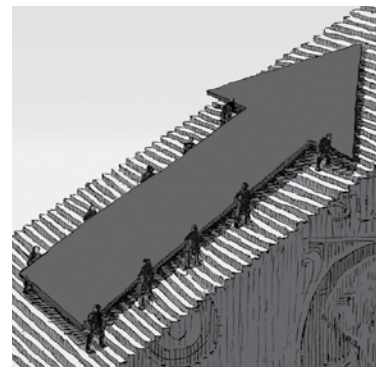
Any questions on these transactions can be directed to Steve Kennedy of Lancaster Pollard at (614) 224-8800 or [skennedy@lancasterpollard.com](mailto:skennedy@lancasterpollard.com).

(continued on page 12)

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# Case Study: Jersey Community Hospital District



## Hospital Type:

Acute Care

## Location:

Jerseyville, Illinois

## Project Objective:

Expansion/Refinance

## Financing Amount:

\$7.05 million [http://www.marshallbrowninghospital.com/photo\\_album/showImage.php?src=/var/www/pictures/photo\\_album/im0023341191512044.jpg&percent=1](http://www.marshallbrowninghospital.com/photo_album/showImage.php?src=/var/www/pictures/photo_album/im0023341191512044.jpg&percent=1)

## Source of Funding:

Alternate Revenue Bonds issued in three series: (i) tax-exempt Bank-Qualified Bonds, (ii) Build America Bonds and (iii) Recovery Zone Economic Development Bonds.

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*~Lawrence P. Bear  
Administrator,  
Jersey Community Hospital*

## Background and Challenges

Jersey Community Hospital District (JCHD) had consistently positive, though modest, operating performance. But the hospital's credit profile took a hit as a result of a negative operating margin at its June 30, 2010, year end. Further, the 67-bed hospital had just 50 days' cash on hand, well below the 174-day median for small hospitals rated BBB by S&P. Throughout latter FY 2010 and into FY 2011, JCHD management took steps that improved operations, but funding its \$4 million expansion and \$3 million refinance would be a challenge.

## Financial Solution

JCHD's organizational structure and debt size made it eligible for numerous funding alternatives: Build America Bonds and Recovery Zone Economic Development Bonds (RZEDB) were options in 2010, as were Illinois Alternate Revenue Bonds, which are conditionally backed by property tax revenue should operating cash flow be inadequate for debt payments. The small project size also made backing a local bank's letter of credit with Federal Home Loan Bank credit support a realistic option.

Lancaster Pollard marketed the financing to local banks and to several regional financial institutions outside the area. Each bank had the ability to lend up to a few million dollars. The firm highlighted JCHD's ability to utilize multiple forms of debt, which appealed both to banks interested in bank-qualified bonds and banks that had appetite only for taxable debt. Meanwhile, JCHD successfully secured \$1 million of RZEDB allocation, which meant it would be reimbursed for 45% of the related interest expense. After Lancaster Pollard put together a team of banks that committed a few million dollars each to the project, one bank suddenly reduced its commitment. Lancaster Pollard immediately worked its contacts to bring in a new bank to close the funding gap.

The transaction timing was tight: It was late November, and Build America and Recovery Zone bonds would expire after December 31. In a time crunch, the hospital still needed a unique financial compilation to qualify it for the Alternate Revenue Bonds. No "Big 5" accounting firm would realistically be able to turn around the request before time ran out. So Lancaster Pollard worked with the hospital's local accountant to complete the report so the deal could close on time.

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# Case Study: Marshall Browning Hospital



**Hospital Type:**  
Critical Access

**Location:**  
DuQuoin, Illinois

**Project Objective:**  
Refinance

**Financing Amount:**  
\$9.9 million

**Source of Funding:**  
Senior debt offering through  
the USDA Business & Industry  
Program

## Background and Challenges

Marshall Browning Hospital's relationship with its letter of credit bank soured when the bank raised the enhancement fee by 300%. Though the hospital was operating consistent with its historic margins, the bank had decided it had violated its annual capital expenditures agreement when it spent \$1 million out of an unexpected \$2 million bequest to build a medical office building.

Marshall Browning sought to end the relationship and hired Lancaster Pollard to refinance its bank-enhanced variable-rate debt.

## Financial Solution

Lancaster Pollard began seeking approval for an FHA-insured mortgage through FHA's new 242/223(f) refinance option, a program for which the hospital qualified with a three-year operating margin comfortably above 1%. Partway through the process, however, FHA could not get comfortable with some of the hospital's historical operating metrics. Lancaster Pollard switched courses to keep the project moving forward, first pursuing Federal Home Loan Bank enhancement and then U.S. Department of Agriculture programs.

Marshall Browning is located in a rural area, making it eligible for several USDA financing programs. The USDA Community Facilities program would require that half of loan proceeds be new debt, but the hospital sought only to refinance. With that factor in mind, Lancaster Pollard pursued the USDA Business & Industry Program, which provides a 70% guarantee for projects up to \$10 million and can be used for straight refinancings.

Lancaster Pollard compiled, authored and submitted a USDA B&I application in cooperation with Marshall Browning's local bank. The local bank lent \$2 million of the nearly \$3 million of the unguaranteed loan portion, and Lancaster Pollard assisted in the search to identify two additional small banks to make up the difference. Lancaster Pollard then structured and sold the guaranteed portion of the loan (nearly \$7 million), keeping the floating-rate structure so the hospital could continue to benefit from an outstanding floating-to-fixed-rate swap and avoid paying mark-to-market swap termination fees.



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# Navigating a New Landscape: The Top 10 IT Focuses for 2011

BY DAVID REITZEL, GRANT THORNTON, LLP

Defining and negotiating major legislation characterized Congress during much of 2009 and 2010. Healthcare reform made great progress and the American Reinvestment and Recovery Act (ARRA) appropriated nearly \$20 billion in federal stimulus funds.

With the structure in place, addressing new healthcare policy in 2011 requires every organization to navigate Health IT regulations that are both challenging and novel, in order to adopt new technologies which meet the requirements. Many of these initiatives appear arduous, but the end result will reduce long-term healthcare costs and improve the quality of patient care.

Here are the 10 trends that will drive the healthcare IT market during the next twelve months:

**1** Electronic Medical Record adoption will gain momentum — Over 16% of Electronic Medical Record (EMR) implementations have reached Stage 4, the starting point for CPOE and CDS use as defined in the HITECH Act. This is an increase of more than 12% during the past two years, according to a Healthcare Information and Management Systems Society (HIMSS) study from the third quarter of 2010.

Only 1% of hospitals have achieved the highest levels of EMR

maturity, which indicates the increasing difficulty of moving up the maturity model.

Hospitals and healthcare systems will continue to install, integrate, and enhance EMR technologies at an accelerated pace in an effort to demonstrate “meaningful use” and capitalize on ARRA incentives.

**2** The use of Personal Health Records accelerates — Through increased use at physician practices, health systems, and employers, personal health records (PHRs), will gain traction in the marketplace as a viable method to transport sensitive patient data. PHR systems complement existing EMR and EHR (electronic health records) configurations by aggregating and structuring additional wellness related personal information.

Employers and Payors see both financial and quality of care advantages to the adoption of PHRs as a tool in promoting wellness programs. A PHR also provides a mechanism for people to aggregate, track, and share information not only with their Primary Care Physician (PCP) but also with other health professionals within their individual care network. Recent security advances in personal storage, smart card, and software technology will help drive this trend.

*(continued on page 15)*

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## Navigating a New Landscape: The Top 10 IT Focuses for 2011

(continued from page 14)

**3** Pressures increase for greater cost containment — The United States spends over \$2.5 trillion on healthcare annually. Projections expect a jump to \$4 trillion annually by 2015 if nothing is done to control escalating costs. The Obama administration will soon scrutinize healthcare spending at every level and reward the most cost-effective hospitals. Healthcare institutions will respond not only by implementing new technologies like EHR and electronic imaging, but also will look to implement systems and processes that maximize their existing IT spend by eliminating waste and providing transparency into the organization.

Spend analysis, workforce and acuity management, and revenue cycle management technologies will all be instrumental in helping hospitals to cut costs, maximize human resources, reduce overtime, and expedite claims resolution to speed payment.

Organizations need to have the right tools to perform the necessary data analytics as well as have appropriate governance and controls in place to verify the completeness and validate the reliability of their enterprise data.

**4** Innovative care delivery options emerge — New technologies will help drive the development and use of innovative healthcare delivery models beyond physicians' offices and hospitals. Individuals can anticipate an increase in the number of worksite and retail health clinics, accompanied by an upgrade in the scope of services provided at these facilities. Home health services will prosper, driven largely by the adoption of tele-health and remote patient monitoring technologies. Adopting these advances will reduce costs because physicians will be able to share information and decrease duplicate tests.

**5** Renewed focus on ROI through technology — Measuring ROI in Healthcare is not an oxymoron. Multiple healthcare organizations and private practices will continue to achieve significant returns on information technology investments. IT healthcare technologies will prove effective tools in delivering high-quality and safe medical management of patients in all settings.

CEOs and Boards will require additional data on metrics, payback periods, and details about how each application contributes to the overall ROI. Metrics and clinical benchmarks will drive all projects. Financial and information officers will be expected to demonstrate valuable process improvements over a baseline measured prior to technology implementations. Continued adherence to financial best practices will destroy the myth that there is no ROI for healthcare technologies.

**6** ICD-10 projects become critical — Every healthcare organization needs to effectively assess and plan for the adoption of both HIPAA 5010 on January 1, 2012 and ICD-10 on October 1, 2013. The level of coordination needed to effectively manage all internal stakeholders, physicians, clinicians, and coders, as well as external vendors requires a significant investment of both time and capital. Transitioning to ICD-10 producer codes will have a

significant and immediate impact on both productivity and resource requirements that organizations need to understand and plan for now!

**7** Patient safety and privacy initiatives intensify — Patient care, patient safety, and patient privacy are a priority to healthcare institutions. In 2010, the adoption of several technologies enabled hospitals, clinics, private practices, nursing facilities, and mental health institutions to keep their patients safer than ever before. These technologies include bedside medication administration systems (to prevent negative drug interactions or dosage errors), diagnosis support software (to prevent missed, incorrect, or delayed diagnosis), patient tracking systems (to prevent wandering patient tragedies) and consent management tools (which identify the improper access of patient information).

Addressing patient safety and privacy across an organization in a thorough manner is a corner stone driving the implementation of these consumer protection technologies.

(continued on page 16)

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## Navigating a New Landscape: The Top 10 IT Focuses for 2011

(continued from page 15)

**8** Renewed demand for skilled Healthcare IT professionals — Demand for healthcare services will outpace the supply of trained healthcare professionals. Hospitals and other healthcare facilities will need to make more effective use of their staff to ensure appropriate coverage on all shifts. Outside help and temporary staffing will not be readily available, and charges will be at a premium for this labor flexibility. Workforce management and advanced scheduling technology can help reduce both labor costs and turnover, while also improving productivity.

**9** Medical information storage and business continuity concerns appear — Nearly 30% of the data stored on the world's computers today are medical images, and this figure continues to increase. Healthcare institutions consistently need to upgrade their storage systems to accommodate an ever-increasing stream of patient data. Furthermore, healthcare facilities must ensure this data is immediately available to provide quality care of the highest level. Finally, this data needs to be both securely backed up and easily restored in the event of a disaster, because patient records can't be replaced. Organizations should look to evaluate Cloud Solutions as a viable and cost effective solution, as they provide flexible, scalable and address disaster recovery capabilities.

**10** Physicians will rejoin healthcare systems — The percentage of hospitals in the US employing physicians has nearly doubled since 1994. Expect this trend to continue in 2011 as physicians actively seek to join forces with healthcare systems. The collaboration allows physicians to quickly enhance their technological capabilities, which can be used as a competitive advantage to attract and expand their customer base. For example, selecting and implementing an EHR is an undertaking many private practices have yet to engage in. By joining a healthcare system with an ambulatory EHR established, the physician group can quickly become eligible for ARRA incentives while avoiding much of the system implementation efforts.

Information Technology will be the foundation for significant advancements in research and care delivery over the next decade. By taking incremental steps today to adopting new technology and address rising costs, information technology can become a strategic asset to drive high quality patient care outcomes instead of a liability or cost center within an organization. ☞



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## HFMA Events

# Founders Merit Awards for 2010

BY BRIAN SINCLAIR, CHAIR, AWARDS COMMITTEE

Congratulations are in order for the recipients of the 2010 Founders Merit Awards. National HFMA recognizes that its strength lies in the volunteers who contribute their time, ideas and energy to serve the healthcare industry and their local chapter. The Founders Merit Award program was established to acknowledge the contributions made by individual HFMA members.

The awards program is a merit plan, which assigns a range of point values to specific chapter activities, such as committee participation, educational presentations, and serving as a chapter officer. The Follmer Bronze Award is awarded when a member has accrued 25 points, the Reeves Silver Award is earned after an additional 25 points are accumulated, and the Muncie Gold Award is presented after a final 50 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the chapter Board of Directors to qualifying members. This award recognizes significant continuous service after completing the medal program.

### The 2010 award recipients are:

#### Follmer Bronze Award

Brian S. Katz  
Kevin R. Cavanaugh  
Michael E. Nugent  
Louis Papoff

#### Reeves Silver Award

Patrick M. Moran  
Patricia K. Marlinghaus

#### Muncie Gold Award

John Brugioni  
Elizabeth Simpkin

Each of these award recipients will receive a personalized inscribed plaque from HFMA to officially recognize their achievements. The First Illinois Chapter officers and directors also extend their congratulations and appreciation for the support and participation of the award recipients.

Please refer to your chapter membership directory for more information regarding the awards series, scoring details and a listing of all former recipients. If you have any questions regarding the awards or your current point status, please call Brian Sinclair, chairperson, Awards Committee, at 630-207-7308. ☎

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## HFMA Events Continued

# Treasury Program

BY PAT MORAN

On Thursday, December 16, First Illinois HFMA conducted its Third Annual Treasury Program at the Chase Tower – Downtown Chicago. This premier event, with a beautiful panoramic view of Chicago, was attended by over 150 Healthcare Financial Professionals, which included over 20 CFOs, 24 treasurers and five board members responsible for Provider's Treasury Function. The morning program began with Bill Foley, CEO of the Cook County Health & Hospital System, discussing the current state of Cook County Health and the impact of healthcare reform on the county health system. Co-chairs of the event were Tony Kazwell, treasurer of Rockford Health System and Pat Moran, Midwest Healthcare Market Leader for Dell, which acknowledged the Treasury Program Committee for its contributions to the program and with Pat presenting Tony with a Yerger Award (HFMA National Award) that the previous year's program had won.

We were then given a Global Market Update by Andrew Goldberg, SVP/Global Market Strategist for JP Morgan Asset Management. This was then followed by Keith Sauter, director of finance for the University of Chicago Medical Center, and Tim Reed, SVP with Bank of America Merrill Lynch who took us through how the University of Chicago has automated its commercial payments and the lessons learned.

After our morning break, Brian Sinclair (chair of the Awards Committee) presented Founder Merit Awards to Carl Pelletieri, President of Next Recovery Source (Gold Award), and Pat Moran (Silver Award). Then there was a three-part presentation by Jeff Friant, Corporate Controller from Edward Hospital & Health Services, Mary Wilson, Partner with SNR Denton, LLP, and Craig Standen, director, Ziegler Capital Markets, to offer the provider, legal and investment banking perspective on providers working with investment advisors. Our last presentation before lunch was conducted by Don O'Callaghan, partner with Deloitte, and Chris Fielding, VP of Healthcare Equipment Financing at Fifth Third Bank, who took us through the projected accounting changes that will affect leasing financing and its impact on a provider's balance sheet.

After lunch, Jim Blake, partner with Kaufman Hall & Associates and Dominic Nakis, SVP and CFO from Advocate Health Care, took us through the current state of the debt market, with Dominic using Advocate as a case study. This was followed by Patty O'Neil, AVP and chief investment officer of Rush University Medical Center with Kyle Patino, managing director of PNC's Derivative Product Group, to give us a better perspective of risk management, especially around derivatives.

After the afternoon break, we had Tony Kazwell, treasurer, Rockford Health System, and Tom Dodd, president of Stratford Advisory Group, walk us through how to improve yields in the current low rate environment. Our final presentations were from the rating agencies, Brian Williamson, associate director of Standard & Poor's, and Jim LeBuhn, senior director, Fitch Ratings, gave us their current perspective on provider bond ratings.

We concluded the event with a wonderful cocktail hour at sunset in downtown Chicago.

Thanks to the speakers, Treasury Committee members, Registration Committee and as always, to Sylvia Sorgel who runs our C-Vent on-line registration.

### Special thanks to our Treasury Meeting sponsors:

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## HFMA Events Continued

# Captured Events

BY AL STADL



MC 2011 Co-Chairs, Denise Cameron & Cathy Peterson



MC 2011 Panel Members, Debra Gold, Tom Wiffler, Karen Atwood, & Sue Podbielski



Physicians 2011, Bronze Award, Kevin Cavanaugh



Physicians 2011, Bronze Award, Louis Papoff



Rev Cycle 2011, Speakers Dave Dyke & Enrique Balaguer

# Reevaluating Credit Scoring in Healthcare

BY CHRISTOPHER THUNDER AND RYAN BREBNER, R&B SOLUTIONS

As comprehensive health care legislation is phased into effect, the healthcare industry continues to be under scrutiny for the cost of services, particularly those incurred by the uninsured and under-insured. This criticism was a large driver in the passing of the Patient Protection and Affordable Care Act (PPACA; Public Law 111-148), which creates insurance exchanges and expands Medicaid to play a major role in covering more uninsured people. With enrollment in these programs expected to cover at least 19 million currently uninsured patients, hospitals are continually looking for new ways to assist patients in qualifying for government programs. In recent years, an ever-increasing number of hospitals began using credit scoring to determine if a patient has a propensity to pay their bill, be eligible for government programs, or charity care. However, with Medicaid expanding and health insurance exchanges forming, does it make sense to continue using credit scores when they are not used in any government program's application process?

Following the backlash of collection practices and criticism of hospital's charity programs, many hospitals sought a review of patient finances to ensure patients without a means to pay would not go to collections, even if they did not provide the necessary documents for a charity application. For credit bureaus, healthcare was seen as one

of the last untapped markets, and, in a rush to sell credit products, many agencies began selling credit reports as a technology solution to screen uninsured self-pay patients for charity and government programs. A credit report replaced what was once a thorough exam of the customer's situation that involved a review of an application, employment verification through pay stubs, tax return information, and other documents provided by the patient to determine eligibility. One needs to only look at the subprime lending practices that contributed to the current mortgage crisis to realize that a simple credit check is not enough to determine a person's ability to pay, and has limits as a verification tool. This is not to say that credit information does not have a purpose in healthcare. Credit information is a valuable tool in checking the accuracy of an address, social security number, reported income, and outstanding loans.

It is important to remember that a credit score is simply showing a propensity to pay, and the income listed in a credit report is usually the income a person provides when trying to obtain a loan. Credit scores were designed to automate the underwriting process for credit data on middle and upper income individuals with extensive transactions. Low income individuals typically don't have enough of a credit history to have anything more than a "thin file" with the major credit bureaus. A person can be an excellent manager of their modest personal finances, and therefore have a high credit score, but be unprepared and ill-equipped financially for a sudden injury or illness. Should these patients receive financial assistance, or conversely be found ineligible for charity care based on the credit information? A patient's credit report will not reveal that a person recently lost their job, or that an injury or illness they are being treated for forced them to leave a job. A credit report does not show a patient's age, or if the person is blind or disabled. For these reasons, credit scoring alone cannot be used to determine a patient's ability to be eligible for financial assistance.

The PPACA requires a streamlined enrollment system that ensures applicants are screened for all available health subsidy programs and enrolled in the appropriate program with minimal collection of information and documentation from the applicant. This puts the onus on the hospital to gather the necessary information. Currently, only a completed application can determine if a patient has the potential to be approved for the current and expanding government programs. To be approved for these programs, the necessary documentation will have to be gathered, which is based largely on information supplied by the patient or someone acting on the patient's behalf. There have been recent advances made in human resources and payroll services that have automated much of the employment and income verifications necessary for approval of patient applications. Along with electronic capture of tax return information, a door has been opened for hospitals to automate and streamline the document gathering process. If hospitals tap into these new resources, they will be able to speed up the completion of an application, which will result in faster submittals and approvals.

*(continued on page 21)*

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## Reevaluating Credit Scoring in Healthcare

(continued from page 20)

Instead of credit information, income verification via electronic pay stubs and tax returns will be more necessary to hospitals in light of healthcare reform. While hospitals can effectively use credit reports to potentially verify the information the patient has submitted, government programs require employment and income verification within their registration applications. With Medicaid expanding and insurance exchanges forming to cover more of the uninsured population, automation necessary to streamline the application process must be focused more on what information will help people apply for the new programs—something a credit score won't do. Automated programs that utilize application information and verifications, such as tax return information and pay stubs, will be of greater assistance to hospitals and their patients as they apply for the new programs. 

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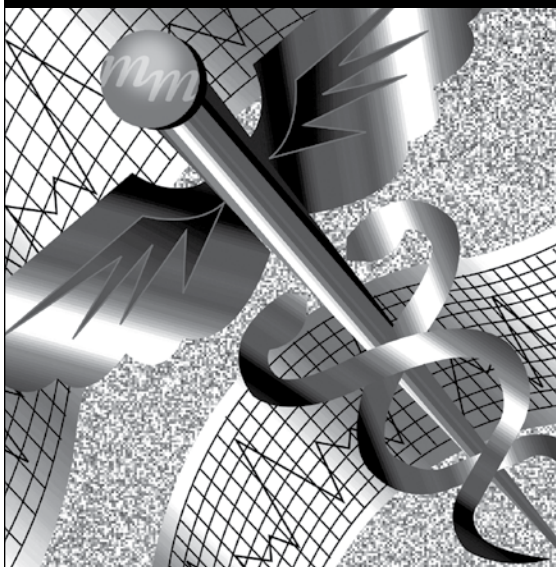
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### The Best Medicine for Kaleida Health

**“This solution has made a huge impact for us, both financially and operationally, with a minimum amount of change.”**

**Patricia Boardway, Kaleida Health**

Buffalo, NY-based Kaleida Health is the largest healthcare provider in Western New York. The non-profit organization serves 8 counties and treats over 1 million patients annually. With revenues in excess of 1 billion dollars, Kaleida's operations continue to grow. Today, Kaleida's business units include 5 major hospital sites, 4 long-term care facilities, 2 foundations, ambulatory centers, and numerous community healthcare centers.

In 2007, the Accounts Payable team at Kaleida set the objective to utilize cutting edge technology to gain new efficiencies. At the time the organization paid vendors primarily via paper checks, a labor-intensive process for both Kaleida and its suppliers. Aware that electronic payments could make her organization more efficient, Patricia Boardway, Accounts Payable Manager for Kaleida Health, began a diligent quest to streamline the organization's payments process. Kaleida's objectives were to reduce paper check processing, continue to strengthen supplier relationships, and impact the bottom line by transforming AP into a revenue-generating department.

#### Making an impact with minimal change

While Kaleida's vision held tremendous potential, they needed to be certain that any process changes would enhance its existing structure. The team managing the initiative reached out across several departments to ensure that the proposed changes to the business process would enhance operational workflow without disrupting the approvals process. Kaleida's IT department involvement had to be minimal in terms of complexity and the amount of time required for testing and implementation.

Kaleida's team set out to find a program that could help them achieve its business objectives and provide support throughout the process. They were looking for a solution that tied in to their existing ERP system and would require limited resource allocation. Kaleida also wanted a provider equipped to help them analyze and re-engineer their payments process to maximize contract-based incentives and enhance operational efficiency.

#### Unlocking potential in Accounts Payable

After reviewing several options, Kaleida Health selected American Express' Buyer Initiated Payment (BIP) as the solution to help streamline their payments process. This web-based platform complements their existing ERP system and offers an easy-to-use means of transitioning to electronic payments for Kaleida and its suppliers. Though the system allows the use of multiple payment methods, Kaleida chose to use an American Express virtual payment account as a primary settlement vehicle. A virtual payment account offers similar payment terms and incentives to a purchasing card program. Unlike a traditional purchasing card program, however, payments are made following invoice approval based on payment terms, and without the exchange of card numbers.

The BIP process is simple and automates several key steps: Once invoices are approved according to standard operating procedures, Kaleida's ERP system outputs a payment instruction file specifying suppliers and payment amounts. The American Express Buyer Initiated Payments solution disburses payments according to those specifications. Suppliers are paid earlier and can reduce their Days Sales Outstanding (DSO), while Kaleida maintains and can extend its Days Payable Outstanding (DPO) by leveraging the American Express billing cycle.

#### A relationship is born and thriving

Kaleida and American Express collaborated to make swift work of the implementation process. The American Express team included dedicated resources for technical support, supplier enrollment, and account management. Kaleida's internal IT team worked unusually fast and was able to complete their tasks within a mere 10 - 15 hours. After only a few weeks\*, Kaleida was up and running on the American Express Buyer Initiated Payment solution. "American Express had a detailed implementation plan with dates and clear action items," noted Boardway. "Overall, it went very smoothly." *(continued on page 23)*



## Why Kaleida Health Chose American Express

### A single, closed-loop network

With banks and other card networks, there are many "layers" and associations. This complicates the process of on-boarding suppliers, who often deal with several teams for implementation. In contrast, American Express is a closed-loop network, so all parties only have to deal with one entity.

### Maximum incentives

American Express allowed Kaleida to include all of its business units in one program, giving Kaleida the opportunity to realize the full benefits of a consolidated program.

### Convenience

American Express' solution complements Kaleida's existing Lawson paycodes as well as its front-end invoicing and payment systems.

### Support and resources

With American Express, Kaleida Health has dedicated resources for merchant acquisition, account management, implementation, and IT/technology support.



"the amount paid to vendors always matches the payment file sent through the BIP solution, unlike traditional purchasing card programs."

**"If you want to be Best in Class, implement BIP"**

When Patricia Boardway discusses BIP with colleagues, she tells them about her experience with American Express: "It is by far the best value-added process you can implement for your company." With its financial incentive firmly in place, Kaleida looks to the future of bringing on more suppliers and continuing to grow the program. Boardway appreciates that the American Express team has stayed engaged beyond the initial phases, meeting with her regularly to discuss strategies for their program and helping Kaleida to resolve any questions that arise. "This is really a long-term partnership," comments Boardway. "American Express has met and even exceeded many of our expectations."

### About Kaleida Health

Kaleida Health is the largest health care provider in Western New York. More than one million patient visits are recorded annually at the Buffalo General Hospital, DeGraff Memorial Hospital, Millard Fillmore Gates Circle Hospital, Millard Fillmore Suburban Hospital, Women and Children's Hospital of Buffalo, plus the health system's 96 clinics and community health care centers. It also includes the Deaconess Center and Waterfront long-term care facilities, plus the nation's oldest – and original – Visiting Nursing Association.

*\*Implementation timelines vary by company. Average implementation time is 10 weeks, but can be as little as 6 weeks.*

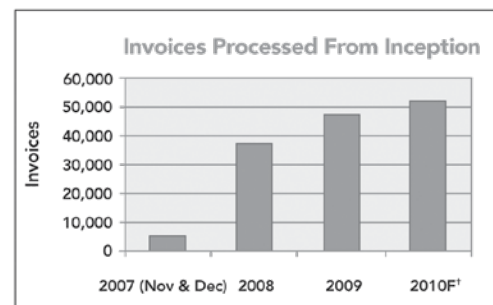
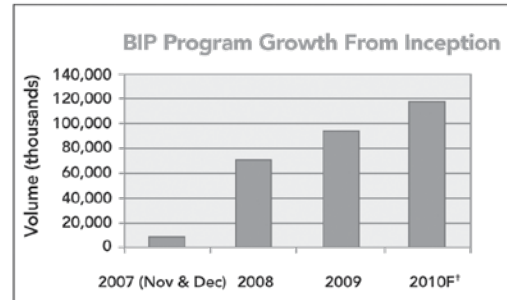
*†2010 statistics based on year end forecast*

Thanks to a highly collaborative process with American Express' supplier enrollment team, in the first ten months alone, Kaleida reached 91% of American Express' estimate for first year volume by putting over \$50M through the BIP process. Since inception in late 2007 Kaleida has placed over \$260M in spend on the program, and now has 320 suppliers enrolled, and an annual volume approaching \$120M. Kaleida's commitment to the program and the team's communications strategy to suppliers helped to ensure success.

One of the reasons that Kaleida turned to American Express was that, unlike other financial institutions, American Express allowed Kaleida to have a single program for all of its business units, giving Kaleida the ability to realize the full benefits of a consolidated program. As a result, the financial incentives that Kaleida receives from American Express have helped Boardway's accounts payable team become a revenue generating part of the organization.

In addition, the AP department has reaped several key benefits. Kaleida Health has unlocked savings opportunities by using the BIP program to strategically manage payment terms and reduce check processing costs. The accounts payable team has been able to leverage American Express' bill payment cycle to more effectively manage cash flow. They have also been able to maintain all custom reports used in their ERP system, including 1099 reporting. Furthermore, suppliers have 24/7 access to the BIP portal and receive full remittance information.

"We're impressed with the impact that BIP has had on our daily operations," said Boardway. Since inception, Kaleida has processed over 130,000 invoices through BIP. Without checks or exchange of card numbers, there is little need for concern around fraud or theft potential. Reconciliation is simple, because



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# first illinois speaks

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Articles for *First Illinois Speaks* should be written in a clear, concise style. Scholarly formats and styles should be avoided. Footnotes may be used when appropriate, but should be used sparingly. Preferred articles present strong examples, case studies, current facts and figures, and problem-solving or "how-to" approaches to issues in healthcare finance. The primary audience is First Illinois HFMA membership: chief financial officers, vice presidents of finance, controllers, patient financial services managers, business office managers, and other individuals responsible for all facets of the financial management of healthcare organizations in the Greater Chicago and Northern Illinois area.

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### **Chapter Educational and Events Calendar 2011**

For a current listing of all upcoming First Illinois HFMA Chapter events, please visit: <http://www.firstillinoisHFMA.org/calendar.htm>

#### **Thursday, April 21, 2011**

Social Event: Healthcare Olympics  
Pinstripes, 100 West Higgins Rd., South Barrington, IL

#### **Friday, April 22, 2011**

CFO Breakfast  
Elmhurst Center for Health, Elmhurst, IL

#### **Tuesday, April 26, 2011**

Webinar  
Online

#### **Thursday, May 5, 2011**

17th Annual CFO Education Symposium and Golf Outing  
Medinah Country Club, Medinah, IL

#### **Tuesday, May 31, 2011**

Webinar  
Online

#### **Thursday, June 9, 2011**

35th Annual Golf Invitational and Dinner  
Gleneagles Golf Club, Lemont, IL

#### **Tuesday, July 21, 2011**

Annual Dinner and Installation of Officers  
TBD

#### **Monday, August 22, 2011**

Cubs Baseball Game  
Wrigley Field, Chicago, IL

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