First Illinois Speaks

HFMA's First Illinois Chapter Newsletter

October 2020

hfma Your Challenge. Our Mission. 20-21

News, Events & Updates of the First Illinois Chapter begin on page 22

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2020 First Illinois Chapter • October 26-30 Virtual Fall Summit: Reflect and Reframe

Like so many plans over the last six months, First Illinois Chapter HFMA needed to make some changes to its premier education event, the Fall Summit. However, with change comes possibilities and this year's Fall Summit is no different. The planning committee has worked tirelessly to bring our members the best speakers and virtual experience this October 26-30.

The theme of this year's Fall Summit, "Reflect and Reframe," is present is every aspect of the conference, down to the way we had to plan and deliver it. Moving from a multi-day in-person event to a multi-day virtual summit has certainly been a reframing experience. We are proud of the event we have been able to craft!

This year's Virtual Fall Summit includes five dynamic keynote sessions, workshop participation by local hospital and system CFOs, and breakout sessions focused on the areas that matter most to you as well as a virtual exhibit hall. This truly exciting summit will be held October 26-30 with a keynote and multiple breakout sessions each day from 8:30 a.m. to 1:30 p.m.

The keynote speakers include:

Monday, October 26

- **Zeev Neuwirth, MD –** Chief of Care Transformation & Strategic Service at Atrium Health

Tuesday, October 27

- **Zeev Neuwirth, MD and Joseph Fifer, FHFMA, CPA –** President and CEO at HFMA

Wednesday, October 28

- **Carol Friesen, FHFMA –** CEO Northern Region at OSF HealthCare, Panelist
- **Catherine Jacobson, FHFMA, CPA –** President & CEO at Froedtert Health, Panelist
- **Nicole Fountain –** VP of Revenue Cycle at UChicago Medicine, Moderator

Thursday, October 29

- **Kim Byas, SR. , PhD, MPH, FACHE –** Regional Executive at the American Hospital Association

Friday, October 30

- **Michael Allen, FHFMA, CPA, MHA –** CFO at OSF Healthcare

Please visit the Virtual Fall Summit website for more details and to register at http://www.hfmasummit.org/. Special 10-person bundled pricing available at only $75 per person. Earn 21 CPEs.

CARES Act Provider Relief Funds:
Much Needed Guidance Released (as of September 21, 2020)

BY BRIAN PAVONA, FHFMA, CPA & DANIELLE SOLOMON, CPA

On September 19, 2020, the U.S. Department of Health & Human Services (HHS) released its Post-Payment Notice of Reporting Requirements. The instructions require Provider Relief Fund (PRF) recipients who have received more than $10,000 in PRF funds to submit the following:

1. Healthcare-related expenses attributable to the coronavirus that another source hasn't reimbursed and isn't obligated to reimburse, which may include general and administrative or healthcare-related operating expenses
2. PRF payment amounts not fully expended on healthcare-related expenses attributable to the coronavirus that are then applied to lost revenues, represented as a negative change in year-over-year net patient care operating income, net of the healthcare-related expenses attributable to the coronavirus

The instructions state that recipients may apply PRF payments toward lost revenue, up to the amount of their 2019 net gain from healthcare-related sources. If a recipient had an operating loss in 2019, it may apply PRF funds to break even in 2020. If recipients don't expend PRF funds in full by the end of calendar-year 2020, they will have an additional six months to use remaining amounts.

The calculation of lost revenue noted above is a significant clarification from the frequently asked questions previously issued related to the PRF. It's important for providers to review these reporting requirements and evaluate the effect on their financial statements. We expect additional comments and clarifications to be issued on the implementation of these reporting requirements.

The instructions define data elements related to demographic information, expenses attributable to COVID-19, lost revenues attributable to COVID-19,
and nonfinancial metrics.

Timing

HHS has updated its website to state the reporting portal won't be available until early 2021 (delayed from October 1, 2020, in its July 2020 notice). However, CMS doesn't appear to have delayed the reporting deadline, so reports for 2020 expenditures and lost revenue related to COVID-19 are still due 45 days from December 31, 2020.

In addition, recipients who don't expend PRF funds in full by the end of calendar-year 2020 will have an additional six months to use remaining amounts toward the expenses or lost revenues defined above.

Next Steps

Provider organizations should carefully track the following:

1. All funds received due to or in response to the National Emergency, including but not limited to PRF, Payroll Protection Program Funds, other federal/state/local grants, and contributions from other sources
2. Terms and conditions for all funds received relative to the National Emergency
3. All costs incurred to prevent, prepare or respond to COVID-19 from January 1, 2020, through the end of the National Emergency (currently extended through at least October 23, 2020)
4. Lost revenues directly related to the National Emergency and the guidance issued by HHS on September 19, 2020
5. Update yourself and your team regarding the requirements of the Uniform Guidance/Single Audit (Formerly A-133)

There are upcoming education opportunities through the Illinois Hospital Association (October 8 and 15) and the First Illinois HFMA chapter (week of October 26) to gain further insights into the ever-changing landscape of PRFs, Single Audit compliance, and overall financial operations in light of the National Emergency.

About the Authors

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Message From Our Chapter President

BY BART RICHARDS, CHFP, PRESIDENT, FHFMA 2020-21

Dear Friends and Colleagues,

Healthcare finance challenges have only been enhanced by COVID 19 and the pandemic. With the reduced outpatient and inpatient volumes that hospitals have had to deal with, many organizations first focused on ensuring that their balance sheets were fortified with enough cash. In addition, many organizations have implemented cost control measures to keep the organization afloat. Lay-offs, furloughs and other measures have had an impact on our members and our members' organizations. Other issues such as revenue recognition of the CARES Act monies are on the minds of executives. This is all on top of the issues that existed before the pandemic, such as ongoing top line revenue pressures, price transparency, merger integration issues, managed care challenges, the list goes on.

Through the first four months of the HFMA fiscal year, your chapter has responded to the unique challenges of the time. First, we have moved our education, planning and social programs to an entirely virtual setting. We have:

- Conducted key events virtually including our Spring Planning Session, the Transition Dinner and Women in Leadership program
- Hosted social networking happy hours via Zoom
- Continued to support the Region 7 webinar program and also added First Illinois specific webinars

We have also performed outreach to our annual partners who support the chapter. We have taken intentional steps to ensure our partners are recognized at our various virtual events.

We continue to support our provider organizations and leaders with their interest of coming together on a quarterly basis to discuss issues of common importance. The Strategic Finance Forum has now met three times over the last 10 months or so.

We held our executive golf outing on September 11. As of this writing, we had 56 golfers registered. This is quite an achievement by all those involved. The golf outing is a primary way we raise money for our scholarship program, which is set up to help pay for the college tuition of our members' children. Each year, our scholarship committee selects five college-bound applicants for scholarships. The golf outing and the scholarship program are part of our chapter's culture and fabric. I am so happy that we've been able to continue these programs during this time.

In October, we are conducting our marquee educational event of the year, the Fall Summit. This year, it will be performed virtually during the week of October 26. Please consider registering for the event. Already several key note speakers have confirmed, and key leaders of our provider community will be attending the event.

Later this year, I am hopeful that you will consider supporting an organization called The Boulevard. The Boulevard of Chicago provides high quality, cost-effective medical respite care, holistic support and housing services to help ill and injured homeless adults break the cycle of homelessness, restore their health and rebuild their lives. Each year, thousands of men and women without homes are discharged from our provider organizations' hospitals with nowhere to complete their medical recovery. That's why The Boulevard exists to help people restore their health and rebuild their lives. Every hospital I know struggles with transitioning patients to post-acute care settings. I can't think of a better organization for the First Illinois Chapter to support during the times we are in.

Finally, I want to encourage all members to give us feedback on how we are doing as a chapter. Feel free to contact me if you have thoughts on how we can improve and what is going well. Please consider giving your chapter a 9 or 10 if you receive a satisfaction survey related to one of our events. These scores make a difference.

In closing, I want to thank everyone who is volunteering their time to support the chapter. I would like to recognize the following volunteer leaders who have made such a difference this chapter year.

- **Lana Dubinsky, Medallia** – Strategic Finance Forum and Fall Summit
- **Rich Franco, Northwestern** – Executive Golf Outing and Partnerships
- **Dominic Nakis, Advocate Aurora** – Host of Fall Strategic Finance Forum
- **Brian Pavona, BKD** – Overall programming
- **Rich Silveria, UChicago Medicine** – Host of the Summer Strategic Finance Forum

Bart Richards, FHFMA
2020-2021 FIHFMA President

To View the Video Message From Our Chapter President **CLICK HERE**

A shift to value

Getting ready for price transparency—getting it right

What drives PRICE TRANSPARENCY?

In an era of rising health care costs and diverse consumer buying preferences, the need for price transparency has taken on increasing importance. There are many factors driving this demand.

7 DRIVERS

1 EXPENDITURES
U.S. health care expenditures and rates of inflation continue to lead the world and dominate federal expenditures.

2 MEDIA EXPOSURE
The media expose irrational pricing strategies and organizations not fully prepared for transparency.

3 CONSUMERISM
Consumers are becoming less loyal and leverage information and technology to spend thoughtfully and seek value.

4 REALIGNMENT
Trade organizations encourage realignment of charges, price and cost data. Comparative clinical outcome information is needed to support informed consumer health care spending decisions.

5 REGULATORY COMPLIANCE
Providers and payers are required to disclose standard charges, negotiated rates and cash prices for all items and services on their websites. This can enable a level competitive environment.

6 VALUE-BASED ECONOMICS
Will provide opportunity to those prepared to compete on value as free market forces are restored.

7 DIGITAL TRANSFORMATION
Technology, analytics and automation enable an enhanced digital relationship, leading to clearer value, reduced clinical/cost variation and better overall experiences.

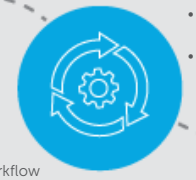
GETTING READY: What can health care systems and hospitals do?

Health care providers effectively managing costs, clinical variations and patient experiences are more likely to thrive in this increasingly transparent environment and launch a comprehensive pricing transparency approach that incorporates the following:

TRANSPARENCY STRATEGY
- Meet regulatory requirements by Jan. 1, 2021
- Rationalize charge descriptionmaster
- Align revenue cycle with transparency objectives
- Embrace risk, value-based prospective and capitated payment arrangements, while de-emphasizing charge-based arrangements
- Identify unjustifiable clinical/cost variation by leveraging analytics, patient-level costing and clinical reporting

REPORTING REQUIREMENTS
- Share CDM in machine-readable format
- Disclose five identified standard changes, including negotiated payments for all payers separately for all items, services and service packages (including commonly bundled items)
- Share standard charges of all hospital and professional items and services in a consumer-friendly format for 300 common procedures
- Consider offering an online estimation tool

CDM RATIONALIZATION
- Build net revenue model
- Review managed care contracts
- Evaluate existing procedure, service type and location variabilities
- Understand cost and develop cost-based algorithms
- Level cost-based market position
- Propose enterprise-wide rational pricing methodology
- Align your chargemaster(s)



REVENUE CYCLE ALIGNMENT
- Develop digital patient relationship improvement strategies
- Embrace automation
- Select/implement patient liability estimation tools
- Optimize scheduling processes
- Evaluate authorization and benefits workflow
- Enhance payment flexibility at the point of estimation

About the Author

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Investing for Enterprise Impact:
A Healthcare Executive's Guide to AI Transformation

BY RACHEL MOONEY

Healthcare executives around the country are turning to Artificial Intelligence (AI) and automation to drive financial performance and efficiency in the face of increasing margin pressures, declining resources and unpredictable change. In fact, according to the OptumIQ Annual Survey on AI in Healthcare, providers' AI adoption doubled from 22% in 2018 to 51% in 2019. Only 6% of healthcare organizations had no intention of adopting AI in the future. But even as AI investment takes off, most providers are struggling to achieve their desired results. According to Forrester Research's Barriers and Best Practices for Scaling RPA:

- Robotic Process Automation (RPA) projects have a 50% failure rate and fewer deliver expected ROI
- 87% of organizations have failed to scale AI, stalling at niche and point solutions

The root cause? Underestimating the resources needed to ensure the technology can operate in a dynamic environment and scale across an evolving enterprise.

Beyond technology: Laying the foundation for your AI workforce success

Like traditional software implementation, successful automation depends on the support of resources and talent. For "non-invasive" RPA software, defined as "technology that does not alter existing systems in any way," Forrester found that **for every $1 invested in the technology, $3.41 was spent on services to make it work.** Building bots is only a small fraction of the work required.

The services required to stand up and scale AI and automation may be performed by external partners with core expertise, or organizations may elect to hire and train specialists who perform these tasks within their organization. Critical services required to drive AI workforce productivity and payoff include:

- Developing a roadmap that draws on process expertise and maximizes business impact
- Establishing governance and operating standards to build, test and launch automations
- Maintaining continuity of AI workforce operations to prevent costly downtime, resolve issues and manage system changes
- Ingesting and analyzing system intelligence to optimize efficiency and performance while identifying and activating new work

In short, achieving meaningful outcomes and business value with AI relies on selecting the right implementation model—**one that supports sustainable, scalable automation across the**

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healthcare enterprise.

Avoiding common pitfalls of AI adoption

Implementing a sub-optimal AI model can lead to:

- Failure to scale beyond a point solution
- Static automations that fail to adapt to evolving business needs
- Lack of preparedness for future challenges and emergent events

Ultimately, healthcare leaders are faced with a deployment model decision: to achieve business goals should they build, partner or buy their AI workforce? Given the ever-present need to do more with less, it's imperative to prioritize a model that delivers accelerating value over time. The most common options include:

1. **Build:** Internal Center of Excellence (COE)

This model draws heavily on internal resources who are dedicated to mobilizing and scaling your AI workforce. Hiring and training talent may hinder initial progress, and scaling workflows requires investing in incremental staff to support AI workforce operations and performance. A complex vendor ecosystem is required to support multiple technology purchases. Allowing internal staff to scope and build new workflows elevates risk of shadow IT. Common areas to be mindful of include:

- **Platform extensibility:** Typically requires multiple add-on purchases and partnerships to realize full potential of machine learning and advanced AI capabilities.
- **Resources and responsibilities for execution:** Internal resources such as process optimization experts, engineers, data scientists and business analysts must be dedicated to scope, build, support, optimize and scale. This may require repurposing existing resources or hiring and training new talent. As workflows expand, so too do the internal resources and thus staffing costs needed to support them.
- **Network effects:** Few opportunities to leverage external intelligence across a provider's network as automations are built in-house using internal knowledge and metrics.
- **Workflow production:** Friction in acquiring technology and talent to mobilize an AI workforce limits the speed and capacity of workflow creation.

2. **Partner:** Consulting-led COE

This partnership requires fewer internal resources at the outset, but initial investment in consultants is significant. Over time, ownership and costs transfer to the hospital as consulting fees decline, and both staffing costs and output scale in relation to the capacity of internal resources. Common areas to be mindful of include:

- **Platform extensibility:** Typically requires multiple add-on purchases and partnerships to realize full potential of machine learning and advanced AI capabilities. Consultants may play a significant role in selecting and implementing additional technologies, resulting in higher fees.
- **Resources and responsibilities for execution:** Establishing a COE and building initial workflows is supported by external partners, but internal stress and resource costs increase over time as consulting involvement wanes and internal teams are responsible for scoping, building, supporting, optimizing and scaling. As workflows expand, so do the internal resources and thus staffing costs needed to support them.
- **Network effects:** Intelligence is siloed between the hospital and a limited number of partners.
- **Workflow production:** Increased efficiency in workflow builds, thanks to external support, but friction still present in maintaining, optimizing and scaling the AI workforce.

3. **Buy:** AI-as-a-Service

AI-as-a-Service (AIaaS) takes advantage of external expertise and data intelligence across a network of providers. A comprehensive subscription allows for a simplified vendor relationship, minimized impact on internal resources, and fixed cost structure while accelerating scale and impact across the enterprise ~~-s~~ecured by a performance-based contract.

- **Platform extensibility:** Single purchase that includes automation, machine learning, and advanced AI capabilities, supporting ongoing innovation and enterprise-wide scalability while reducing the need for a complex vendor ecosystem.
- **Resources and responsibilities for execution:** Minimal impact on internal resources, as AIaaS subscription includes a dedicated team of experts who are responsible for scoping, building, supporting, optimizing and scaling AI workforce across the enterprise and held to performance targets. Spend is predictable across the entire AI workforce maturation process, from scoping initial workflows to identifying and mobilizing new automations and increasing their value over time.
- **Network effects:** High: Extensive access to ongoing intelligence gleaned from a large and diverse network of connected providers used to identify and resolve common issues, drive continuous improvement and take on new and extended work based on insight and analysis.
- **Workflow production:** Accelerated: Responsibilities for mobilizing, supporting and scaling AI workforce are performed by a dedicated team of experts, speeding annual workflow production.

Investing in an AI workforce improves your financial position while driving elevated efficiency and insight across your organization, so you can lower the cost of care while delivering a better patient experience. Choosing a model that accelerates your results without straining your resources is key to capturing value and leading the next wave of innovation.

About the Author

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How Orlando Health Improved its Bottom Line by Optimizing **Observation Services**

Reprinted from the June 2020 edition of HFMA's **Financial Sustainability Report**

BY RICHARD BASALY, MD, Director of Physician Advisors, Orlando Health | LARRY VOLKMAR, Managing Director, Claro Healthcare | KRIS SZEWCZYK, Manager, Claro Healthcare | BARTON RICHARDS, Managing Director, Claro Healthcare | POONAM PATEL, Manager, Claro Healthcare

Bringing together clinician "huddles" for quick reviews of the status of patients under observation was just one step that enabled the Florida health system to substantially reduce length of stay among observation patients, thereby reducing costs and increasing revenues by tens of millions of dollars.

Effective management of patients in observation status is important for ensuring a health system's profitability. By optimizing length of stay (LOS) among patients in observation, a health system can free up capacity for care of patients with higher-acuity conditions. These benefits will remain elusive, however, if the organization lacks a clear strategy and approach for addressing observation management inefficiencies.

Orlando Health in central Florida offers a case example of how one health system has successfully pursued such an effort. As a private, not-for-profit healthcare system comprising eight community and specialty hospitals with over 1,800 beds, Orlando Health was struggling with rising observation rates and associated capacity constraints. The executive team was challenged to reduce observation rates by optimizing the process for determining patient status and shortening LOS for these patients.

To achieve these goals, they designed and launched a multifaceted initiative aimed at improving management of their observation patient population at each of its hospitals.

7 WAYS TO ENSURE OPTIMAL OBSERVATION RATES ARE ESTABLISHED AND OBSERVED

Broadly, the initiative encompassed the following seven areas of focus deemed essential to the health system's efforts to establish and maintain optimal observation rates.

1 Create dedicated observation units. A lack of bed availability to move patients from the emergency department (ED) created throughput issues for observation patients, with the result that they ended up scattered throughout the hospital. By developing dedicated observation units, a hospital could create cohorts of observation patients while opening up inpatient beds for higher-acuity patients.

The specifics of each observation unit vary by hospital, depending on the space available. Dedicated units range from 15 to 25 beds. Some facilities use clinical decision units that interacted closely with ED staff to help patient placement or the decision to discharge.

Initially, only patients who met selective criteria were placed in observation units. Such criteria applied, in particular, to patients experiencing cardiac-related symptoms. This approach allowed hospitals to pilot the functioning of the observation units and address common barriers before expanding to the entire observation patient population.

With dedicated units, the system achieved synergies in treating patients. The units helped create a culture where it was understood that observation patients had relatively low acuity and should have a short LOS. As such, the care teams were better able to prioritize observation patients for ancillary testing, thereby contributing to a decrease in the LOS. Hospitals were also able to vacate beds on higher level of care units, including intensive care units.

2 Implement observation huddles. A Observation patients who were not placed in the dedicated observation units also required attention. Taking a lesson from its success in managing inpatients through multidisciplinary rounds, the organization implemented daily observation huddles in an effort to achieve similar results with the lower-acuity population.

The huddles are 15-minute calls in which the care management leader, the utilization review team and physician advisors discuss each observation patient. The huddles have two goals:

- Assign and communicate follow-up tasks.
- Convert or discharge observation patients.

Participation of physician advisors in the huddles was key to their success. (The role of physician advisors is discussed in greater detail at step six below.) A physician advisor can directly indicate whether to convert a patient or schedule follow-ups with physicians who might have disagreed with the outcome of the secondary level review.

To be effective, huddles also require a strong facilitator, who can bring clarity around assignment of follow-ups and reiterate the plan of care for the patient.

Orlando Health saw the observation rate decline immediately after it implemented the huddles, with a 15% decline in the number of observation patients staying greater than 48 hours, and a 25% decline in Medicare patients with long LOS.

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3 Educate staff on effective observation patient management. To sustain results achieved, Orlando Health needed to ensure all members of the care team were knowledgeable of observation patient management. The health system developed and delivered specific education to the care management team and bedside nursing in particular, because these departments were identified as critical to the success of the process changes.

Bedside nurses typically have the most frequent interaction with patients and often are most attuned to when patients are ready for discharge. These staff members were presented with an overview of:

- The meaning of *observation* status
- Documentation requirements for billing
- Circumstances when inpatient status may be appropriate
- The role of care management
- The need for collaboration to improve patient satisfaction, achieve the correct admission status, and reduce LOS

In addition to these topics, education for the care management team focused on:

- Application of the Two-Midnight Rule
- Observation billing rules
- When observation is appropriate after a procedure
- Status implications for the patient

4 Redesign the care management function. A review of the organization's care management department disclosed an opportunity to combine the role of care managers and utilization review nurses and establish care management teams to manage caseloads of similar units. Shifting to an integrated dyad model improved collaboration across the continuum of care while serving patient needs in a quality and timely manner.

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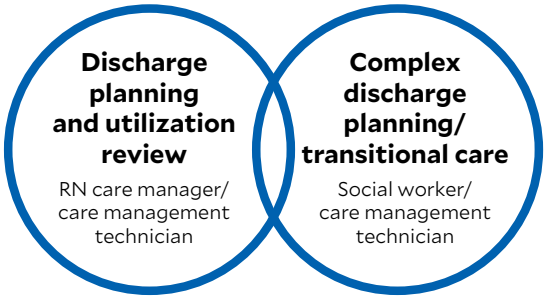
Orlando Health: Integrated dyad model for care management



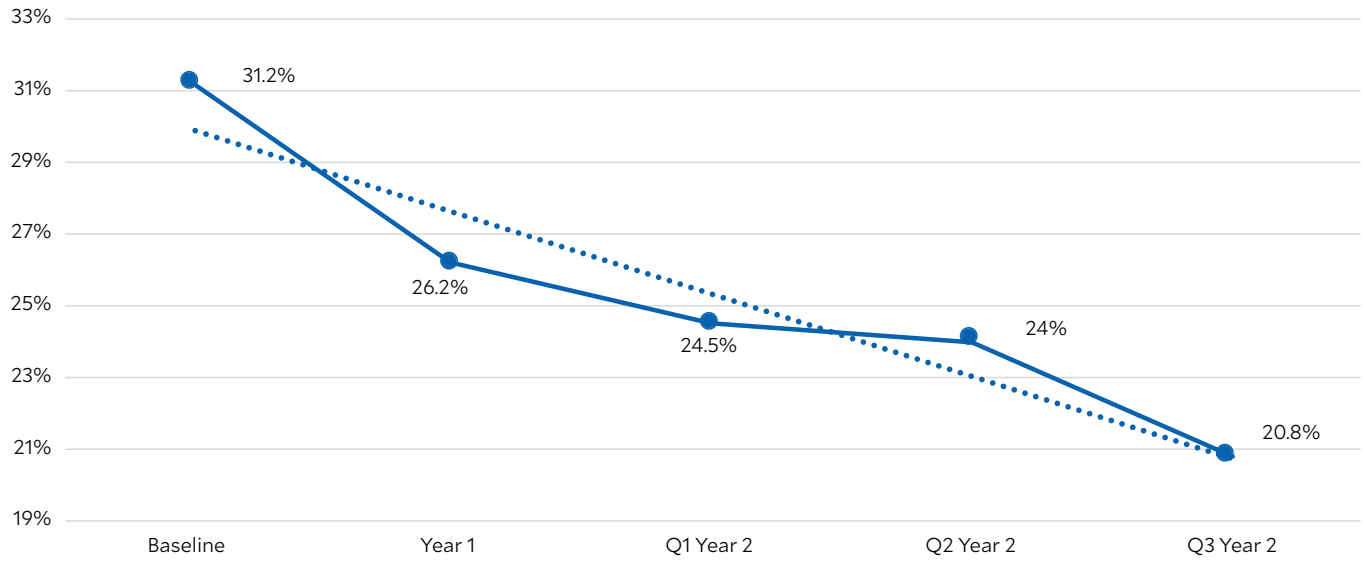
Discharge needs support
Care management technician

Denial prevention and compliance assurance
Utilization review liaison

Secondary clinical review
Physician advisor and utilization management committee

Source: Claro Healthcare, 2020

Orlando Health: Trend in observation-to-inpatient ratio for traditional Medicare



Source: Claro Healthcare, 2020

Orlando Health implemented the integrated dyad model, which combines the roles of care managers and utilization review, to improve collaboration across the continuum of care.

This redesign reduced silos and redundancy of efforts while improving patient flow by centralizing teams responsible for cohorts of patient populations. Care management teams consisting of registered nurses (RNs), social workers and technicians now cover similar units. Staffing for each team is determined based on projected daily census by unit.

A new role, the utilization review liaison, was created to manage denial prevention and ensure timely compliance. Freed of these responsibilities, RN care managers can focus on utilization review and simple discharge planning. Social workers focus on complex discharge planning and coordination of care. The team leverages technicians to support clerical and post-acute care coordination efforts.

Education and hands-on cross-training also were required to clarify new roles and responsibilities.

5 Optimize the ED care manager role. Orlando Health already had care managers located in the ED, but it wanted to improve collaboration between physicians and care managers in the admissions process. To accomplish this objective, the health system identified workspaces within the ED where care management would be visible and could interact with physicians as status decisions were being made. Care management coverage in the ED was altered to focus on times with historically high volumes, resulting in increased coverage hours of up to 24 hours a day at the largest facility. This change helped bring about the desired collaboration and improved documentation of medical necessity for admissions.

6 Revamp the physician advisor program. Physician advisors are instrumental in promoting a health system's financial health. The stringent financial constraints under which health systems must operate in today's complex regulatory and compliance landscape can leave physicians confused, with patients often caught in the middle. Physician advisors bridge the gap between physician partners and the care management team while supporting the revenue cycle.

To fulfill this role, Orlando Health hired dedicated physician advisors to support these demands. The health system's initial goal was to have one physician advisor per site, to be available to provide care management for all secondary reviews during business hours. An additional physician advisor was made available on call for the entire system after 5 p.m. to support portal-of-entry care managers. For weekends, the health system instituted a rotating call schedule where one physician advisor would provide coverage remotely systemwide.

Because the physician advisors possess not only leadership skills, but also people skills, they have been well received by medical staff, nursing staff, executives and revenue colleagues. Essential characteristics included:

- Ability to educate colleagues in a non-confrontational fashion
- Strong communication skills to explain complex medical issues to physicians, medical directors of health plans, nursing and executives
- Strong written skills to appeal denials with payers

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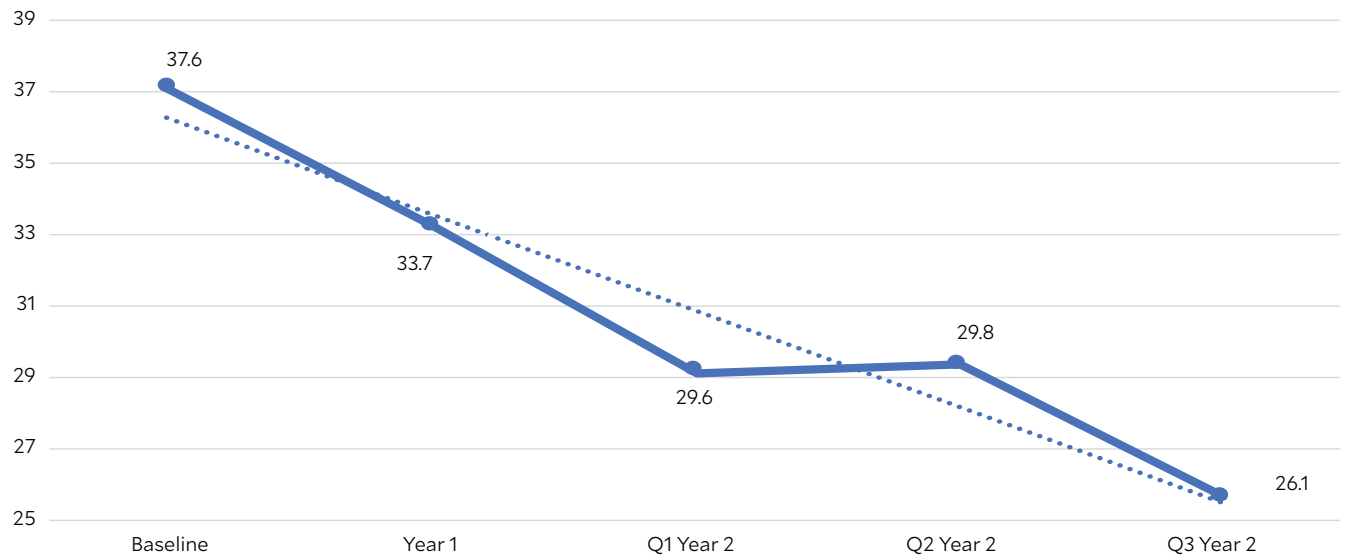
Orlando Health: Trend in observation-to-inpatient ratio for traditional Medicare



Source: Claro Healthcare, 2020

- Strong clinical skills, preferably boarded in their specialty, with the ability to formulate strong rebuttals to support medical necessity for hospital care

4 LESSONS LEARNED FROM ORLANDO HEALTH'S OBSERVATION IMPROVEMENT INITIATIVES

Any time organizations undertake initiatives impacting the existing culture, there are lessons that can be applied for future change management ventures. Four takeaways from Orlando Health's experience in seeking to optimize observation services are applicable to almost any hospital change management endeavor:

1 Communication is key. Change in hospitals touch many stakeholders and coordination needs to begin with communicating why the change is needed.

2 Strong leadership and messaging to staff will have a profound impact. In times of change, staff will look to their direct leader for guidance and observe their actions. Management's reaction to changes is the first impression team members see and the basis for attitudes that develop.

3 Data tells your story. Sharing data is to your advantage when trying to attain buy-in or show progress.

4 Physician leadership via a physician advisor program can bridge the gap between clinical and financial departments. A physician advisor can be an invaluable resource through established relationships with both the care team and the business office.

7 Institute metrics and reporting to monitor LOS and observation rates. Orlando Health recognized the need for metrics and reporting to advance and sustain the initiative. The key purposes for reporting are to:

- Aid in completion of daily duties
- Provide visibility into performance metrics

Targeted reporting for observation huddles and utilization reviews at the point of entry has been particularly beneficial for these areas. An observation scorecard dedicated to care management also was developed to enable the team to monitor performance of the new processes.

Observation huddles. Although the observation units helped create cohorts of patients in a single space, observation patients could still be found on other units within the hospital at times of high census. Therefore, participants in the observation huddles needed a synchronized worklist to be successful. The health system therefore needed to create an observation census report, listing observation patients within the hospital and additional detail such as current LOS, initial diagnosis and payer source to aid discussion during huddles. The report is automatically created every morning to support care managers' efforts to prioritize assigned observation patients at the start of the workday.

Portal-of-entry reviews. The portal-of-entry team reviews cases in the ED for timely and appropriate status determination at the beginning of the patient stay. An indicator of the team's performance is the rate of admissions for observation. To reduce this metric, a system-generated report is sent to portal-of-entry in the morning and afternoon. The information identifies which patients require an admission review, providing the team with a process to perform a concurrent review process that can have a real-time impact on the status determination process, instead of having to work a backlog of retroactive reviews.

The report alone does not ensure patients receive timely reviews. Incorporating it into the daily workflow, however, has resulted in an increase in patients whose utilization reviews are completed in a

THE IMPORTANCE OF IMPROVED OBSERVATION AFTER COVID-19

Healthcare systems are under pressure from numerous external forces including COVID-19 and increased regulatory burdens, creating substantial financial challenges for leaders across the United States. A recent Fitch Ratings report finds that the median hospital operating margin had improved year over year, largely attributed to clinical and operational improvements from prior years.a Now, in the face of a sudden economic crisis, the need for effective operations management to organize, plan and execute strategies to ensure the stability of healthcare systems has never been higher.

Sustainable financial transformations in healthcare organizations, particularly in the face of a crisis such as the COVID-19 pandemic, require both revenue enhancement and cost management. In clinical operations, revenue enhancements can be realized by managing medical necessity and increasing hospital capacity through length of stay improvements. Effective cost management strategies in clinical operations are often achieved by applying evidence based protocols to reduce variation, reducing excessive testing, and streamlining patient discharge processes. For organizations struggling with capacity management or looking to improve their financial standing through clinical operations, focusing on improving care in a lower acuity population such as observation patients can prove to have an immediate impact for the financial health of the organization. Lessons learned from standardizing care for a lower acuity population, such as observation patients, can then be applied to expanded patient populations.

a. Holloran, K., "Smaller U.S. NFP Hospitals Lead Turnaround in Margins," Fitch Ratings, Sept. 3, 2019.

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timely manner. The observation rate at admission decreased by nearly 10% over the course of four months.

Scorecards. Each facility also has a scorecard for its own metrics for the current month's performance and trends over time. The most prominent indicators of performance in the scorecards are observation rates and observation LOS, viewed from both a hospital-wide and payer class perspective. Additional metrics included inpatient LOS and patient satisfaction scores.

RESULTS

By improving its process for determining patient status and reducing LOS, Orlando Health has achieved a total benefit exceeding $40 million. The initial 12-month period yielded additional revenue of $13 million from status determination improvements and $4 million from LOS improvements. At this level of performance, Orlando Health expects to continue achieving $27 million in annual benefit relative to the baseline period. Looking at observation rates, the observation-to-inpatient ratio has decreased by 7% for all payer classes. Medicare observation rates decreased by over 10% at most facilities. Observation LOS decreased by nearly 10 hours across the system. Reduced LOS created additional bed capacity, enabling Orlando Health to backfill the newly available beds with additional patients and realize an increase in incremental revenue.

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For Cash-Strapped Providers, a Known but Insufficiently Used Strategy: Zero-Balance Reviews

BY FRANK MASSI

Despite the return of elective procedures at most hospitals and outpatient centers, not nearly enough patients have been showing up, fearful of what they perceive as high-risk environments. As a result, healthcare's COVID-19-fed economic downturn has reached epidemic proportions, leaving organizations of all types and sizes scrambling to identify any new or accelerated sources of cash.

Instead of mass layoffs or furloughs, some forward-looking health systems are seeking cash-yielding solutions that are non-disruptive to current operations. They are even looking beyond COVID-19's impact for lasting positive effects on cash and efficiency. Here are four tactical and strategic priorities that should be pursued simultaneously (and immediately):

- Take advantage of the opening presented by the dramatic and sudden reductions in volumes and shifts in account mix due to the COVID-19 crisis to design and implement a new business office operating model that effectively "future-proofs" cash.
- Use reviews of past and prospective payments analysis to discover and recover significant new cash.
- Take the low-risk approach of choosing projects completely unaffected by the crisis so staff can stay focused on their own related urgencies.
- Short-list only those vendor partners who will perform the work completely at-risk and with no upfront fees.

When zero means quick cash

At a time when many institutions are in the midst of a severe revenue downturn, seeing a cash recovery in the millions of dollars brings much-needed relief.

This process, known as zero-balance reviews, involves both a retrospective and prospectively modeled look at paid and/or written-off claims. These reviews of closed accounts use a process of reimbursement analysis followed by the grouping and analyzing of like claims to find out why some are underpaid and where there may be significant trends that convert to large sums of recovered cash immediately. As importantly, it identifies the underlying issue(s) and corrective actions to take. As a result, tens of millions of dollars in future revenues have been protected from leaking away into rivers of red ink.

Zero balance reviews will pay even larger dividends when normal volumes return. Much revenue leakage is caused by providers failing to code and bill according to payer rules. Analysis of payment to charges catches accounts paid properly per payer contracts but underpaid as they were coded incorrectly.

Automating denial management

If you are a health system with a robust denial management system, many of your claims look right. If you are a health system with a high-quality reimbursement analysis program, many of your claims will be paid according to how they were billed. Working with a partner with a strong coding team and an AR team that understands the payer market across the spectrum will show you why and how those claims were underpaid. Working with a partner that can also detect errors across the full spectrum of your revenue cycle operation will show you why and how to lift performance across the board.

Using advanced automation in the review process means that thousands of claims can be reviewed instead of a few dozen per day through manual processes, which removes the only viable objection to zero balance reviews that they involve many small balances not seen as worth a lookback by staff straining to handle new claims.

Audits find root causes of underpayment

One way is to expand the net by finding underpayments as a result of many other breaks in the process, like coding and billing. In addition, analyses of reimbursement-to-charge ratios can be opportunities to ensure all services provided are coded correctly and completely.

This work is made practicable through technology-enabled workflow, intricate knowledge of national and local payer practices, and data mining and analysis tools.

The fact that zero balance reviews are non-disruptive even amid the pandemic is a huge bonus. They are unaffected by the huge shift in AR to non-elective procedures due to massive procedure cancellations as well as labor shifts and reductions in business office staff or coding.

Regular audits of the business office through this program provides well-articulated root causes of underpayment. Processes and systems are calibrated to address the inevitable challenges brought by the interdependencies and continually evolving roles of business office people, processes and technology, thus protecting future revenue streams.

The time to deliver cash for current operations is now, with an even bigger payoff to come.

About the Author

Frank Massi *is executive vice president of Business Development & Sales, Salud Revenue Partners, Lafayette, Indiana. You can reach Frank at fmassi@saludrevenue.com.*

A Silver Lining

The pandemic has turned many things upside down – but it may have created an opportunity to reorganize and modernize patient collections

BY HEATHER GROVER

The continued increase in patients' direct responsibility for their healthcare payments and the financial stress created by pandemic-related job losses make this a good time to evaluate both the patient payment experience and the tools and approaches used in collections.

Patient access is ground zero for the mood of a consumer's experience in seeking, receiving and eventually paying for medical care. Friction in access has been a drag on positive patient reviews for as long as patients have tried to see a doctor, but the overnight flip to digital front door capabilities like appointment scheduling, tele-medicine, improved patient portals and mobile communication have ironically turned a global disaster into the start of medical services finally being influenced by the same consumerism dictating the online shopping experience.

In fact, patient-focused technology can benefit a collections strategy, too. It would be a wasted opportunity to dilute a patient's satisfaction with their front-end experience by not trying to replicate the convenience and efficiency of digital engagement to improve collections. The payment experience is influential: If poor, collections are likely to be a challenge. If clear, convenient, compassionate and accurate, collections start to look like transactions in other categories (think retail and travel).

Mobile is a big part of that convenience. Combine mobile payments and accurate estimates (which is consumer-speak for "price transparency") and you start to have the tools that can alter a collections strategy to include things like pre-payment, personalized payment plans and open conversations about ability to pay, which is of increasing importance in these days of high unemployment. To a hospital's finance department, collections is typically a numbers exercise, but to the patient it is highly emotional, being connected to two very important things: health and money. Creating additional stress around those won't help collections success rates.

Additionally, the consumer financial stress of 2020 makes a case for reviewing how to better identify and work with the accounts most likely to yield results. This can be done by:

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A Silver Lining (continued from page 16)

1. Segmenting patients by likelihood of recovery with data-driven insights
2. Directing patients to the appropriate personnel
3. Keeping updated data on payment benchmarks

Data can determine which accounts should be managed inhouse vs. delivered to a collections agency, illuminating potential charity cases or write-offs. Analyzing patient populations helps reduce the cost of collections by showing you which type of personnel can best help each patient and how to prioritize the working of accounts.

It's best to use a dynamic system that continuously monitors each patient's successful or missed payments, ensuring a real-time picture of a patient's financial situation.

For example, one Midwest provider identified 4,000 accounts that were eligible for nearly $2.7 million in assistance, helping customers in need. Additionally, the provider was able to boost successful rate of collections 114% by identifying accounts with a high propensity to pay. According to the provider, within 10 months of implementing a solution to help with this, they were able to completely revamp their internal collections strategy to more effectively provide financial solutions for their patients in an "ethical and compassionate manner."

The pandemic forced the front-end patient experience to modernize; it's a great chance to upgrade and optimize the patient's financial experience, too. Some of the same "high-touch, touchless" engagement solutions can help, as can getting smarter about which accounts to give [compassionate and caring] attention. Old solutions and tactics didn't perform well before and will perform worse now, which is not a good strategy following the economic blows from COVID-19. Sometimes a crisis creates the change we need to design a better future.

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Data Readiness Assessments in Patient Advocacy

BY PETER K. ELIAS AND REBECCA M.S. BUSCH, RN, MBA, CCM, CFE, CPC, CHPA-IV, CRMA, CICA, FIALCP, FHFMA

The end goal of any patient advocate should be to educate their client in such a way that they are capable of effectively self-advocating. While there are various tools available to help patients actively manage their own healthcare data, they can prove ineffective for patients who are not yet fully ready and capable of taking on the task.

In the July 2019 "First Illinois Speaks" newsletter, we introduced one of these tools called the Patient Healthcare Portfolio[1], which can help patients better organize their own healthcare data in the pursuit of self-advocacy. However, for the patient to acquire this data efficiently, their providers need to have a program in place that will facilitate its collection, as well as provide valuable benefits to the organization itself. This was the topic of the June 2020 "First Illinois Speaks" newsletter, where we discussed how any healthcare organization can effectuate a *Data Management Program* by borrowing insights from the DCAM (Data Management Capability Assessment Model).

In this final article of our three-part series, we will discuss how a patient can get to the point of self-advocacy by using a *Data Readiness Assessment*. The idea behind the Data Readiness Assessment began with the DCAM. Originally created by members of the Enterprise Data Management Council (EDM) for use in the banking industry, the concept of assessing a firm's capacity to effectuate a data management plan can apply in a wide variety of contexts and industries. Instead of applying the concept to a firm or organization, however, we are applying it to the *individual*. For the purposes of patient advocacy, these concepts serve as a reference point in developing a tool to assess a patient's capability and sustainability in managing their own healthcare data.

A *Data Readiness Assessment* builds the foundation for an action plan designed to get the patient to the point of self-sufficiency. It assesses an individual's knowledge, skills, ability and readiness to receive, manage and assimilate their personal health information. In other terms, a *Data Readiness Assessment* can be understood as a Gap Analysis. A Gap Analysis is "the means by which a company can recognize its current state […] and compare it to its target state." There are many different areas where gaps in patient engagement can be assessed, from their understanding of their current treatment regimens to their collection of health plan documentation. The level of detail they possess regarding these areas is also pertinent. Do they possess formal documentation? Supporting documentation? What is their level of interaction with their payors and providers? Are they capable of mediating problems? Or know where they can seek assistance if they come across a road block?

Assessable areas of engagement include, but are not limited to:

- Whether the patient possesses a listing of their healthcare providers – Do they possess a formal list? Does it contain demographic information?
- Their knowledge of their current health and wellness status/history – Are they aware of or have documents concerning past, current and ongoing treatment regimens? Do they have any supporting documentation?
- The current status of their healthcare data collection – Are they in possession of medical records? Do they have a collection of healthcare payment data?
- Their understanding of their health plan provisions – Are they reactive to their health plan provisions? Do they know where to get information about them or approval for particular services? Are they tracking their coverage activity? Do they understand how to select health plans based on coverage options? Or what to do if there are resource gaps in their current plan? Do they have a collection of supporting documentation? Can they mediate denials of service?

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Data Readiness Assessments in Patient Advocacy (continued from page 18)

- Their knowledge of whether or when to seek healthcare assistance or wellness support – Do they seek services within their health plan? Do they understand the financial implications of particular healthcare decisions?
- Whether they have a process or any tools to help them manage their healthcare data – Do they have a way of managing updates to their treatment regimens, health plan coverage, etc.? Do they utilize a perpetual methodology of any kind? How is their information organized? Do they know where to seek assistance when encumbered by their process?

The patient's collective level of engagement in these areas determines their "score" on a data readiness continuum. Remember: Patient readiness cannot be classified dichotomously. A patient cannot be considered either "engaged" or "unengaged." They tend to fall into a particular category of engagement, again based on their knowledge, interactions and formal data collection procedures, etc. These categories can be summarized as follows:

1. Uninitiated – When the patient is not clear on how to use the health plan provisions and does not have a knowledge of health and wellness status.

2. Conceptual – The patient is in initial planning stages with a basic knowledge of their current providers and history of care. They are reactive to their current healthcare plan provisions and do not necessarily seek services outside their health plan.

3. Developmental – Patient engagement is underway; the patient has fair knowledge of their current providers and has a documented history of care and ongoing treatments. They are aware of their plan's provisions and know where to seek approval for services.

4. Defined – The patient maintains their known medical history, history of payment and coverage activities, and understands the healthcare plan-based offerings in relation to their personal needs. Patients at this stage have begun to develop more formalized procedures and documentation strategies.

5. Achieved – The patient has a comprehensive understanding of demographic information and has often demonstrated the capacity to manage the process of maintaining a PHR in addition to being aware of available management tools. They possess comprehensive supporting documentation regarding treatment regimens and health plan provisions.

6. Enhanced – The patient demonstrates behaviors consistent with being a healthcare data-driven consumer with an understanding of how to successfully navigate an episode of care. They possess the means to mediate denials of service and know where to seek assistance when encumbered with the process.

Once the patient's data management readiness has been assessed, the patient advocate should have all the information they need to construct objectives centered on bridging patient knowledge and practice gaps. From here, consequent plans, strategies and programs can be formulated, such as a Health Data Management Strategy, a Health Data Quality Program, a Health Data Governance structure, etc.

Patients simply cannot begin to advocate on their own behalf if they are not engaged. By properly assessing their level of data readiness, the patient advocate can act in a way that suits the appropriate level at which the patient is currently operating and avoid overwhelming the patient or wasting time rehashing what the patient already knows. By being aware of patient engagement gaps, the patient advocate can more effectively lead individuals towards self-advocacy and data-driven healthcare consumption.

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Resources

[1]Busch, R.M.S. 2017. Patient's Healthcare Portfolio: A Practitioner's Guide to Providing Tools for Patients. Taylor and Francis Group: Boca Raton, FL.

[2]https://www.investopedia.com/terms/g/gap-analysis.asp

Zero-balance Account Review:
Boost Revenue Integrity and Lower Cost-to-collect

BY CHRIS MOSHIER | DUANE J. FITCH | SOREN PAL | MARY ANNE RANDICK, PLANTE MORAN

Are you getting paid everything you deserve? Applying an analytics lens to your zero-balance accounts helps you uncover more opportunities to increase collections and strengthen revenue integrity.

The twin goals of revenue integrity — improving coding and charge capture while lowering compliance risk — are increasingly important in times of uncertainty. With healthcare organizations feeling heightened financial pressure from all directions, now is not the time to miss out on revenue you've already earned.

Healthcare payers are using increasingly complex algorithms and a myriad of other tools to reduce your payment levels — often erroneously. Continued high unemployment makes it even harder to collect from patients who are saddled with everincreasing levels of responsibility for their healthcare bills. Add in the significant decrease in volume for profitable service lines as a result of COVID-19, and it all adds up to tremendous pressure to cut costs and simultaneously increase cash collections.

By not fully charging or by not fighting claims that may have been underpaid or denied, you're leaving money on the table. **Up to 1% of net patient service revenue is lost due to charge integrity leakage** — not to mention revenue lost to underpayments and improper denials. Finding and correcting these errors and oversights through zero-balance account reviews can have a dramatic and immediate impact to your bottom line.

Zero-balance account reviews: A booster shot for financial health

How do you know if you're getting paid everything you deserve? Are there denials that you wrote off too quickly? Charges that you could have billed, or billed at a higher rate? Were there instances where the payer downgraded or underpaid what they should have based on your contracts? Once accounts are closed and given a zero-balance status, these all-too-common issues oftentimes go unseen, and the revenue attached to them sits untouched.

> By not fully charging or by not fighting claims that may have been underpaid or denied, you're leaving money on the table.

As we approach fiscal year-end for many organizations, financial executives understandably focus on lowering the cost-to-collect ratio. While many margin improvement activities act like preventive medicine to improve long-term financial health, a zero-balance account review is like a booster shot. It infuses quick cash to boost your health system's financial immunity right when you need it, while also arming you with the analytics you need to improve revenue cycle operations on a go-forward basis.

Practical tips to stop revenue leaks, mitigate compliance risk, and lower cost-to-collect

When you're searching for needles in a haystack, how do you distinguish the needles from the hay? With the amount of data most health systems have to sift through, the answer generally entails an analytic rules engine. Using sophisticated analytics to quickly and thoroughly identify anomalies in the data allows experienced revenue cycle team members to dig deeper to determine whether those "exceptions" are actually missing charges, preventable denials, underpayments, or even overpayments that open up the organization to compliance risk.

Consider the following tips to maximize the effectiveness and efficiency of your zero-balance account reviews.

1 Focus your search.

When you're looking for needles in a haystack, it helps to know which area of the haystack to look in. Isolating accounts that have been closed out within a given period (such as the past year) allows you to focus on a manageable population.

2 Apply analytics to quickly highlight problem areas.

A healthcare reimbursement rules engine consists of thousands of rules — or even tens of thousands in the case of large health systems — that indicate which codes tend to go together. For example, if a patient had a hip replacement surgery, you would expect to see a charge for an implant. Similarly, if a patient received a dose of a drug in the hospital setting, you would expect to see an administration charge for that same drug.

> A zero-balance account review infuses quick cash to boost your health system's financial immunity right when you need it.

By taking the population of accounts that was isolated in the previous step and running it through this engine, you quickly highlight accounts where something looks fishy: The encounter has a charge for a high-cost drug, but not for the administration of it. The hip replacement patient wasn't charged for the cost of the implantable device. Highlighting these anomalies, or "exceptions," allows you to take the next step of verifying that they really are reimbursement opportunities.

3 Identify accounts with dollars attached.

Just because an exception exists, it doesn't necessarily mean there are dollars attached to it. There's no point in rebilling for a missed charge if the encounter was part of a bundled payment or per-diem arrangement, for example.

At this stage, it's important to take the time to review every encounter manually, rather than automatically applying each rule across the board. A sophisticated reimbursement engine will factor in each payer's reimbursement practices and rules, but healthcare organizations must also invest in the right level of billing and collections expertise to process the data appropriately.

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With the regulatory landscape shifting faster than ever, and with new codes for telehealth and for testing and treatment of COVID-19, staying up to date with coding updates is more important and more challenging than ever. Ensuring staff members are properly educated on the most up-to-date coding guidelines and billing practices, and that they have processes in place for cross-team collaboration, will improve your bottom line and staff satisfaction.

4 Find the golden needles.

Once you have a list of encounters with reimbursement tied to them, how do you know where you should spend your limited resources to capture the most revenue? Essentially, for each of the zero-balance accounts that have revenue-capture potential, you must answer the question: Is this the right thing to do?

We recommend creating a risk stratification profile to zero in on the accounts with the greatest compliance risk or revenue opportunity. For example, you might want to start with your most profitable service lines, or with the payers that have the tightest deadlines for timely filing.

> Just because an exception exists, it doesn't necessarily mean there are dollars attached to it.

At a big-picture level, you'll need to weigh short-term financial gain against the long-term relationship with the payer. For example, in cases where claims are being audited or litigated, you will have to make a judgment call about the tradeoff between potential financial gain and the possibility of exacerbating an already strained relationship.

5 Take action to recover and prevent.

The beauty of the zero-balance account review is that it delivers financial benefit today and tomorrow. By running closed accounts through an analytics engine to identify exceptions, and then taking the appropriate resolution action (appeal, rebill, etc.) for each type of exception, you improve your collection rate and lower your cost-to-collect promptly. And by creating rules in your electronic health record system to flag exceptions as they occur, you can prevent those revenue leaks before the charge goes out the door.

Improve charge assurance, patient and physician satisfaction, and mission achievement

The benefits of zero-balance account reviews go beyond improving charge capture.

- **Charge assurance:** One of the core objectives of revenue integrity is protecting your organization from compliance risk. In addition to leaving cash on the table, erroneous coding also opens up the organization to "over-coding" scenarios, which may lead to costly audits by both commercial and government payers.
- **Patient satisfaction:** Patients are hesitant to come back to the hospital because of the fear of contracting COVID-19. Improving revenue integrity has an impact on patient satisfaction by decreasing the time it takes the claim to go out to the payer and patient. Limiting rebills due to late charges and unexpected patient balances from payer denials helps improve the patient's financial experience.
- **Provider satisfaction:** Coding and billing accurately the first time means that patients aren't bringing up financial conversations with their providers. When providers can focus on clinical conversations instead of answering billing questions due to a late charge or a denial, their satisfaction is greatly improved.
- **Mission preservation:** Ensuring that your revenue cycle is operating at maximum efficiency allows your organization to allocate resources to serving your community.

Recover revenue you've earned while improving cost-to-collect

Collecting more of the revenue that you have earned — in many cases at least 1% of NPSR — can help close the gap on the budgetary shortfalls stemming from COVID-19 while improving your cost-to-collect ratio. For every $1 of cost invested in the technology and human resources to perform zero-balance account reviews, we generally see an additional $4 or $5 of revenue collected.

How do you know you're not getting underpaid? In today's challenging environment, you can't afford to leave money on the table. Use these steps to improve revenue integrity and your cost-to-collect ratio.

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HFMA Event Summary

First Illinois Chapter Executive Golf and Scholarship Event 2020

This year's First Illinois Chapter Executive Golf and Scholarship Event took place on September 11 at the Willow Crest Golf Club in Oak Brook. Over 52 golfers attended the chapter's premier fundraising event that raised nearly $6,000 in scholarship funds to support the chapter's annual scholarship program. The First Illinois Chapter Scholarship Program annually awards $15,000 in scholarships to college-bound children of chapter members. Winners of the longest drive and closest to the pin received golf gift cards, and raffle winners received a variety of gift cards, including a free golf foursome with lunch and dinner and a hotel stay at the Hilton Oak Brook Hills and Conference Center. Look for 2021 golf dates and details in the coming months.

Post Golf Dinner on the Grill

Louis Papoff and Bart Richards

First Illinois logoed golf balls - a gift to all participants

Jori Brink, a golfing contest recipeint &
Rich Franco Golf Committee Chair

Women In Leadership Committee and Mentoring Program Launch

The First Illinois Chapter's Women in Leadership Committee held its first virtual event on August 20 with over 80 registered participants. Committee goals include formalizing the committee, promoting awareness of the committee, and recruiting additional committee members and event volunteers. Committee members include co-chairs Nicole Fountain, VP of Revenue Cycle at UChicago Medicine, and Sue Marr, principal at Healthcare Management Consulting, Plante Moran; Lauren Gorski, senior manager, Claro Healthcare; Katherine Molony, assurance senior at EY.

During the virtual event, participants learned about the chapter's newly launched Mentorship Program. The program connects experienced healthcare professionals with healthcare careerists seeking advice and direction and serves as an additional membership benefit (for both mentor and mentee). The overall framework/structure of the program allows flexibility in developing the mentor/mentee relationship. During this inaugural year, for each mentor and mentee pairing, the chapter will provide $100 for networking activities.

Later in the program, Sue Marr, committee co-chair, moderated a dynamic panel discussion on "Leading and Striving Through Crises." Panel members included Kelly Blair, senior vice president, GM Change Healthcare; Nicole Fountain, VP of Revenue Cycle at UChicago Medicine; Staci Kucharsk, VP of Revenue Cycle, Cancer Center of America; and Brenda VanWythe, CFO, Rush Copley Medical Center.

Participant Comments

- *I enjoyed hearing about women leaders at different institutions and our common challenges and tips for how to overcome them.*
- *I really loved and appreciated the honesty from the panel. It's comforting in a way to hear the validation from my peers on the current climate of the world and to know that we are on track/in line with what others are also doing.*
- *The speakers were honest and thoughtful with their panel discussion. It is refreshing to have speakers "be authentic" in their messaging and environment.*
- *As usual, the experiences of other HFMA members contributes greatly and validates what a lot of us see and feel in our work and in our organizations.*
- *Connecting with my fellow community members and sharing information on how to better connect during this pandemic. It was great to see so many female HFMA members attend and participate.*
- *It was excellent to see strong, female leaders talking about how they mobilized and supported their teams.*

Mark Your Calendars

- Mark your calendars now for the not-to-be missed **Women in Leadership in Healthcare Panel** during the First Illinois Chapter's October 28 at 8:30 am during the Virtual Fall Summit. (http://www.HFMASummit.org/) Panel members will include Cathy Jacobson, FHFMA, CPA, president and CEO, Froedert Health, and Carol Friesen, FHFMA, chief executive officer, Northern Region, OSF, with moderator Nicole Fountain, VP of Revenue Cycle, UChicago Medicine.

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Welcome New Members (continued from page 25)

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Guidehouse

Vivian Pascal
Reimbursement Analyst
University of Chicago

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Welcome New Members (continued from page 26)

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HFMA's First Illinois Chapter Newsletter

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First Illinois Chapter HFMA Editorial Guidelines

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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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Publication Scheduling

Publication Date	Articles Received By
February 2021	January 1, 2021
June 2021	May 1, 2021
October 2021	September 1, 2021