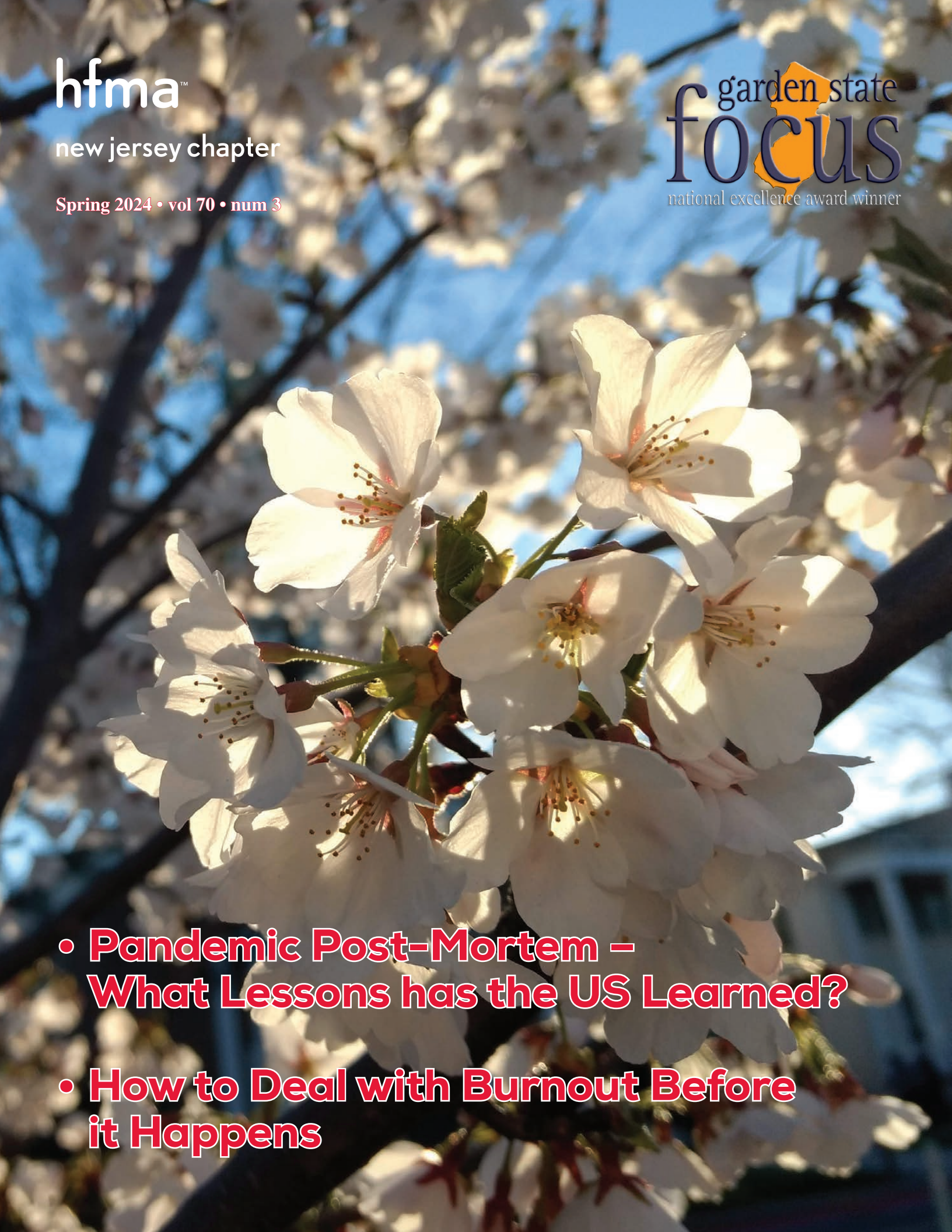
hfma™
new jersey chapter

Spring 2024 • vol 70 • num 3

garden state focus

national excellence award winner



- Pandemic Post-Mortem – What Lessons has the US Learned?
- How to Deal with Burnout Before it Happens

Do You Want to Get More Involved with New Jersey HFMA?

HERE'S HOW!

Participate in our committee meetings. All are virtual and easy to access from anywhere!

Volunteer on a committee. Our chapter welcomes your help!

VOLUNTEERS NEEDED

Attend a live education session or networking event to learn and make new connections.

VISIT OUR WEBSITE FOR MORE DETAILS

WWW.HFMA.ORG/CHAPTERS/REGION-3/NEW-JERSEY

focus •advertisers•

CBIZ KA Consulting Services, LLC

Withum Smith+Brown

focus •cover•

Cover Courtesy of
Jennifer Lenahan

focus •points•

Who's Who in the Chapter 2

The President's View
by Heather Stanisci 3

From the Editors
by James Robertson 4

New Members 16

Who's Who in NJ Chapter Committees 17

Job Bank Summary 21

Save The Date 29

Certification Corner 37

Focus on Finance 38

focus •features•

Pandemic Post-Mortem – What Lessons has the US Learned?
by John J. Dalton, FHFMA **5**

Beyond the Bottom Line: Insights from a Healthcare CFO on Revenue Strategies
by Fatimah Muhammad and Martin Herry **11**

Apply for the Executive of Healthcare Revenue Cycle Designation **18-19**

How to Deal with Burnout Before it Happens
by Lisa Hammett **20**

HIPAA Hot Topics and Headaches
by Elizabeth G. Litten, Esq. **22**

How Are Those New Year's Resolutions Going? **24**

Natasha Schlinkert: Shaping the Future of Healthcare Revenue Cycle Management by Incorporating Artificial Intelligence
by Fatimah Muhammad **25**

HHS OIG Seeks To Re-Focus And Re-Educate The Healthcare Industry On The Importance Of Effective Voluntary Compliance Programs
by John W. Kaveney **30**

Photos from the Laundromat Joint Social with ACHE **34-35**

Spotlight on the Compliance, Audit, Risk and Ethics Forum
by Fatimah Muhammad and Ryan Peoples **40**

Spotlight on the Payer and Provider Collaboration Committee
by Tracy Davison-DiCanto **42**

Superbowl Virtual Cooking Class **44-46**

Annual NJ HFMA Golf Outing **47-48**

Check Out Our New Website **49**

Who's Who in the Chapter 2023-2024

Chapter Website ....www.njhfma.org

Communications Committee

Brian Herdman, Director ..... CBIZ KA Consulting
James A. Robertson, Esq., Editor ..... Greenbaum, Rowe, Smith & Davis LLP
Rachel Gisser ..... WithumSmith + Brown, P.C.
Laura Hess, FHFMA ..... NJHFMA
Elizabeth Litten, Esq. ..... Fox Rothschild, LLP
Fatimah Muhammad ..... Saint Peter's University Hospital
Amina Razanica, CHFP ..... New Jersey Hospital Association
Lisa Weinstein ..... Bancroft
Michael McKeever ..... Retired
Stacey Medeiros ..... Penn Medicine
Jill Squiers ..... AmeriHealth NJ

NJ HFMA Chapter Officers

President, Heather Stanisci ..... Annuity Health
President-Elect, Maria Facciponti ..... Affiliated Healthcare Management Group
Treasurer, Jonathan Besler ..... BESLER
Secretary, Lisa Maltese-Schaaf ..... Children's Specialized Hospital
Assistant Treasurer, Hanna Hartnett ..... AtlantiCare Regional Medical Center

NJ HFMA Board Members

Teresa Bailey – Associate Board Member ..... Penn Medicine
Chris Czvornyek ..... Hospital Alliance
Michael Costa – Ex-Officio ..... DocGo
Danny Demetrops – Associate Board Member ..... Medix
Alex Filipiak ..... RWJ Barnabas
Jason Friedman ..... Elevance Health
Christine Gordon ..... Virtua Health System
Kim Keenoy ..... Bank of America
Fatimah Muhammad ..... Saint Peter's University Hospital
John Nettuno – Associate Board Member ..... St. Joseph's Regional Medical Center
Josette Portalatin ..... Valley Health System
Amina Razanica, CHFP ..... New Jersey Hospital Association
Roger Sarao, CHFP – Ex-Officio ..... New Jersey Hospital Association
John Smith ..... WithmSmith + Brown, P.C.
Lisa Weinstein ..... Bancroft

NJ HFMA Advisory Council

Brian Herdman ..... CBIZ KA Consulting
Stacey Medeiros ..... Penn Medicine
Michael McKeever ..... Retired
Jill Squiers ..... AmeriHealth NJ

Advertising Policy/Annual Rates

The Garden State "FOCUS" reaches over 1,000 healthcare professionals in various fields. If you have a product or service you would like the healthcare financial industry to know about, please take advantage of this great opportunity!

Contact Laura Hess at 888-652-4362 to place your ad or receive a copy of the Chapter's advertising policy. The Publications Committee reserves the right to refuse any ad not consistent with the overall mission of the Chapter. Inclusion of an ad in this Newsmagazine does not infer endorsement of the product or service by the Healthcare Financial Management Association or the Publications Committee. Neither the Healthcare Financial Management Association nor the Publications Committee shall be responsible for slight variations in production quality of published advertisements. Effective July 2015 Rates for 4 quarterly issues are as follows:

	Per issue/Total	Per issue/Total	Per issue/Total	Per issue/Total
Black & White	**1x**	**2x (10% off)**	**3x (15% off)**	**Full Run (20% off)**
Full Page	$ 675	$ 607 / $ 1,214	$ 573 / $ 1,719	$ 540 / $ 2,160
Half Page	$ 450	$ 405 / $ 810	$ 382 / $ 1,146	$ 360 / $ 1,440
Quarter Page	$ 275	$ 247 / $ 494	$ 233 / $ 699	$ 220 / $ 880
Color				
Back Cover – Full Page	$ 1,450	$ 1,305 / $ 2,610	$ 1,232 / $ 3,696	$ 1,160 / $ 4,640
Inside Front Cover – Full Page	$ 1,350	$ 1,215 / $ 2,430	$ 1,147 / $ 3,441	$ 1,080 / $ 4,320
Inside Back Cover – Full Page	$ 1,350	$ 1,215 / $ 2,430	$ 1,147 / $ 3,441	$ 1,080 / $ 4,320
First Inside Ad – Full Page	$ 1,300	$ 1,170 / $ 2,340	$ 1,105 / $ 3,315	$ 1,040 / $ 4,160
Full Page	$ 1,100	$ 990 / $ 1,980	$ 935 / $ 2,805	$ 880 / $ 3,520
Half Page	$ 800	$ 720 / $ 1,440	$ 680 / $ 2,040	$ 640 / $ 2,560

Ads should be submitted as print ready (CMYK) PDF files along with hard copy. Payment must accompany the ad. Deadline dates are published for the News magazine. Checks must be payable to the New Jersey Chapter - Healthcare Financial Management Association.

DEADLINE FOR SUBMISSION OF MATERIAL

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

IDENTIFICATION STATEMENT

Garden State "FOCUS" is published 4 times a year by the New Jersey Chapter of the Healthcare Financial Management Association c/o Laura A. Hess, FHFMA, Chapter Administrator, Healthcare Financial Management Association, NJ Chapter, P.O. Box 6422, Bridgewater, NJ 08807.

OBJECTIVE

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

EDITORIAL POLICY

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

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

REPRINT POLICY

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

The President's View . . .

Heather Stanisci

It's hard to believe that Spring has arrived, and with it my last column for the Garden State Focus as Chapter President. While my Presidential year seems to have flown by, I'm already missing those great events that the NJ Chapter has provided this year, as well as the wonderful people from our Chapter, Region and the Association that It's been such a pleasure to work with to make it all happen. But don't despair, I've heard a rumor that Maria Facciponti, the President-Elect, has already started the planning process for her Chapter year, which begins on June 1. The biggest news has to be the new venue for the Annual Institute, that will take place on October 9 - 11 at the Hard Rock Hotel and Casino in Atlantic City.

Besides the upcoming change of venue for the Annual Institute, you may have also noticed our new look website. As an essential element of the One HFMA initiative the Association has required all Chapters and Regions to migrate to a single web platform, so that the look and feel is the same across the universe of HFMA. The same information is still there, but with a different look. The Association's content is accessed from the buttons on the top of the page, whereas the Chapter specific content is listed down the left side. If you haven't been to the new site yet, check it out. Also included is a link to the Region 3 website, special thanks due to Anne DelPizzo from Metro Philadelphia who created the site, which includes a calendar for all Region 3 events as well as links to the other Chapters' sites.

There's still a lot going on before the current year ends, including our always successful Women's Leadership and Development Session on May 1 at the Double Tree by Hilton in Tinton Falls. This year's event is titled 2024 Positive Thinking – How to Unleash It and Use It! On May 9 we have our Annual Golf Outing, which is being held once again at Mercer Oaks Golf Course in West Windsor. We've brought back the Golf Clinic this year, for those of you who are beginners and those seasoned pros who may need a quick tune-up. Even if you're not available to join us on the course, you're still welcome at the cocktail hour and dinner. Hope to see you all there.

As this is my last column, I wanted to take this opportunity to thank the Officers, Board Members, Committee Chairs and Co-Chairs, and especially the members for all of the support you gave me throughout the year. It's been both a pleasure and an honor to serve as President of the NJ Chapter. And a special thanks has to go to Laura Hess, our Chapter Administrator. And best of luck to Maria in the upcoming Chapter year. See you at the Hard Rock!

Sincerely,
Heather Stanisci
President, NJ HFMA

From The Editor . . .

James Robertson

Spring is in the air. With the same excitement and anticipation that the warmer weather and awakening of the spring foliage bring to New Jersey and the greater Northeastern seaboard, we bring you this Spring Edition of *FOCUS* Magazine.

This edition opens with John Dalton's piece on lessons learned during the pandemic, followed by Fatimah Muhammed and Martin Herry's insightful interview of one of the legends of New Jersey healthcare finance, Garrick Stoldt, CFO of St. Peter's University Hospital.

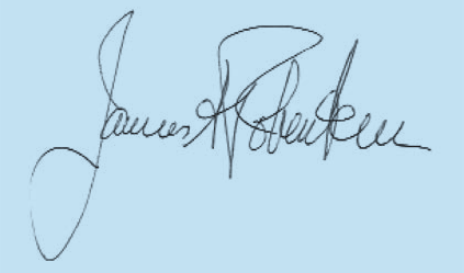
Lisa Hammett provides thoughtful suggestions on how to avoid burnout before it happens, and our former Editor, Elizabeth Litten, gives us a insightful survey on HIPAA hot topics and headaches.

Fatimah Muhammed provides an additional interview of Natasha Schlinkert, CEO of Innobot, who discusses how healthcare revenue cycle management will be revolutionized by advent of artificial intelligence, followed by John Kaveney's analysis of the OIG's latest pronouncements on voluntary compliance programs.

Ana Costa provides the Focus on Finance piece on understanding your organization's financial statements, followed by Spotlights of the NJ HFMA's Compliance, audit, Risk and Ethics (CARE) Forum, and the Payer and Provider Collaboration Committees.

As always, we thank all of our authors for their contributions and encourage you all to similarly share your talents and volunteer to write or edit articles for our award-winning FOCUS Magazine.

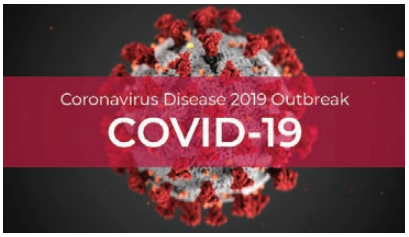
We on the Communications Committee wish you and your families a joyous spring season and look forward to seeing you at any of a number of upcoming events.



Pandemic Post-Mortem – What Lessons has the US Learned?

John J. Dalton

by John J. Dalton, FHFMA



Four years after the World Health Organization was informed that a *"pneumonia of unknown cause"* had been detected in Wuhan City, Hubei Province of China, the US has endured the worst pandemic in its history. More than 1.1 million Americans perished during the Public Health Emergency, and Covid still causes about 20,000 hospitalizations and 2,000 deaths each week[1].

When the pandemic lockdown was imminent in March 2020, I began editing a twice-monthly curated newsletter, The Three Minute Read™, to provide overwhelmed colleagues with five or six article summaries on key recent healthcare developments affecting them. Four years later, the Healing American Healthcare Coalition has published 112 issues with nearly 700 article summaries from about 100 different sources.

The Covid-19 pandemic's death toll reached 675,000 on September 21, 2021, matching the number of American fatalities during the 1918-19 "Spanish Flu" pandemic (that actually originated at a farm in Kansas). When the pandemic reached that milestone, my publisher Ed Eichhorn and I coauthored "Healing American Healthcare: Lessons from the Pandemic." It recapped the trauma and stress of the prior 20 months in nine chapters.

Each chapter began with our analysis of the topic followed by article summaries from The Three Minute Read™ that completed the chapter's content. The final chapter discussed seven lessons from the pandemic:

- From curing disease to promoting health;
- Telehealth must be here to stay;
- China is not America's friend;
- Critical supplies should be on shored;
- Clinician shortages and burnout must be addressed;
- Committed compassionate leadership is the key; and America should emulate the Scandinavians.

This article briefly discusses the current status of each of the seven lessons.

Moving from Curing Disease to Promoting Health

Sadly, American healthcare remains the worst value in the developed world[2]. I've written and spoken extensively on the American paradox. Despite having the world's best equipped hospitals and most thoroughly trained physicians, the US has consistently ranked last in the Commonwealth Fund's ranking of 13 high-income countries (Australia, Canada, France, Germany, Japan, Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, UK and US)[3].

US per capita health spending ($11,912) is 2.5 times Japan's and Japanese life expectancy (84.7 years) is 7.7 years longer than the US. At 17.8% of GDP, the US spends nearly double the Organization for Economic Cooperation and Development (OECD) average of 9.6% of GDP. The US has obesity rates (42.6%) that are 71% higher than the OECD average (25.0%), the highest maternal and infant mortality rates and among the highest suicide rates. Deaths from assault (including gun violence) are nearly triple the OECD average.

The US also has the highest death rates for avoidable or treatable conditions. Preventable deaths can be avoided through effective public health measures and through primary prevention, such as nutritional diet and exercise. Treatable mortality can be avoided mainly through timely and effective health care interventions, including regular exams, screenings, and treatment.

On a positive note, US screening rates for breast and colorectal cancer and flu vaccination rates are among the highest in the 13 countries.

The US has excelled in treating disease once diagnosed, but not in preventing them. Under the leadership of Dr. Donald Berwick, the Institute for Healthcare Improvement first articu-

lated the "Triple Aim" in 2008 as the "ultimate destination for the high-performing health systems of the future." Simply stated, it serves as the foundation for optimizing health for individuals and populations by simultaneously improving the patient experience of care (including quality and satisfaction), improving the health of the population, and reducing per capita cost of care for the benefit of communities.

Has the US progressed in moving from healthcare (curing disease) to health (preventing disease)? One could argue that the minimal increase in healthcare's percentage of gross domestic product from 2009 (17.2%) to 2022 (17.3%) represents progress[4]. However, the per capita cost of care is essentially unchanged despite the population health efforts devoted to achieving the Triple Aim. As Modern Healthcare's Editor Emeritus Merrill Goozner has pointed out, "We will not achieve that lofty goal until total health care spending grows at about the rate of inflation. When that occurs, its share of the total economy will begin to shrink and move closer to international norms[5]."

The Covid-19 pandemic heightened America's awareness of the formidable obstacles to be overcome to attain the objective. About 15% of the US population live in rural areas where access to care is a major problem. Recent research found that the US had more geography-based health disparities than 10 other high-income countries.[6] Rural Americans have higher rates of chronic disease, suicide, worse maternal health, and limited access to care when compared to city dwellers. They also have more difficulty paying for care than residents of rural areas in the other countries included in the analysis.

Telehealth must be here to stay

If the Covid-19 pandemic had a silver lining, it was the accelerated adoption of telehealth as a safe, effective care delivery mechanism. For example, from March-July 2020, telehealth consultations successfully diverted millions of dollars of nursing home transfers. Instead of calling 911 and shipping an ailing resident off to a hospital emergency room, frail elderly were diagnosed and treated without the disruption of an ambulance ride to the nearest hospital.

Parents wary about bringing a sick child to a pediatrician's office crowded with other sick children found that an on-line visit was just what the doctor ordered.

Seniors who were reliant on public transportation to travel to their doctor's office found telehealth to be a real blessing as clinicians became adept at diagnosing from afar.

For America's 4,000 rural areas with a shortage of primary care, access to telehealth also has proven to be a blessing.

In the April 2021 Senate confirmation hearing for CMS Administrator, Finance Committee Chair Senator Ron Wyden said: "As a result of the pandemic, we've removed some of the roadblocks for people to actually get a telehealth provider. We're going to have to make these kinds of changes permanent in addition to working on the critical reimbursement issue[7]."

Is telehealth here to stay? "Yes, but only if we stick the landing," says Dr. Josh Umbehr, M.D., a Family Medicine Specialist in Wichita, KS.[8] As part of the Public Health Emergency, "the federal government eased restrictions for telehealth and the market exploded."

Telehealth is used for more than just talking on the phone or a webcam. It includes remote patient monitoring as well as transmission of digital medical details such as pre-recorded video or images (X-rays, MRIs, etc.) for consultations with specialists.

Going forward, telehealth access across state lines must be allowed to continue. Without congressional action to extend them, the waivers that provided telehealth reimbursement flexibilities will expire Dec. 31, 2024.[9] They include not requiring providers be licensed in the same state as the patient receiving care, allowing more types of practitioners to provide telehealth services, permitting audio-only telehealth services, and delaying the in-person requirement for mental health patients seeking treatment through telehealth.

The HHS Secretary has been directed to study how telehealth has affected Medicare beneficiaries' overall health outcomes and whether there are geographic differences in use. This information, along with a review of medical claims data related to telehealth, is due by Oct. 1, 2024.

As a safe, cost-effective and patient-centric care delivery method, telehealth ***must*** be here to stay.

China is not America's friend

The *"pneumonia of unknown cause"* had been circulating in Wuhan for weeks before the World Health Organization (WHO) was notified on December 31, 2019. China was not fully cooperative with WHO in investigating SARS-CoV-2's origin. Was it a zoonotic disease transmission from a Wuhan "wildlife wet market" or a "lab leak" from the Wuhan Institute of Virology?

Today, the preponderance of the evidence appears to indicate that the first to contract Covid-19 were three scientists at the Wuhan Institute of Virology (WIV) who were engaged in "gain-of-function" research on SARS-like coronaviruses when they fell ill.[10] The first people infected by the virus, "patients zero," included Ben Hu, a researcher who led the WIV's "gain-of-function" research on SARS-like coronaviruses, which increases the infectiousness of viruses.

President Barack Obama banned federal funding for gain-of-

function research in 2014 because experts had come to the consensus that it was too dangerous. The WIV "lab mishap" that produced SARS-CoV-2 confirms the wisdom of the US ban.

Prior to the pandemic, China's economy was among the world's fastest growing. It is now facing headwinds as its population declines, the result of its now abandoned one-child policy. Although growth will likely meet the government's 5% target for 2023, the Chinese economy remains troubled, plagued by flat private investment, flagging consumer confidence, and high youth unemployment**.** Falling prices and depressed business and consumer confidence are flashing warning signs about the year ahead. Policymakers are struggling to stabilize the country's main stock indexes after a plunge to five-year lows.

Two years ago, US and European hedge funds piled on to what looked like a highly profitable distressed debt trade for the China Evergrande Group. They envisioned big payouts to juice their returns given the Chinese government's stated intent to prop up the country's faltering property market. Instead, what they got was a harsh lesson in the dangers of trying to bargain with the Communist Party. A Hong Kong court has ordered Evergrande's liquidation, and the bonds are trading in secondary markets at 1 cent on the dollar.[11]

Caveat emptor – buyer beware!

Critical supplies should be on shored

"Supply chain" was a little-known term prior to the Covid-19 pandemic. However, critical shortages of personal protective equipment (PPE), reagents and other materials critical to battling the pandemic quickly brought it into the vernacular.

Why the shortages? In most instances, these items were being manufactured offshore to take advantage of lower labor costs in third world countries. Orders went unfulfilled as needed supplies went to higher bidders or were retained for local use.

In February 2021, President Biden established a task force across more than a dozen departments and agencies to figure out where supply chains were vulnerable. Their recommendations, along with investments in key industries such as semiconductors and in infrastructure, helped to untangle the supply chains that remained snarled throughout 2021. The Federal Reserve Bank of New York tracks supply chain pressure. From October 2021 to October 2023, supply chain pressure fell from near-record highs to a record low.[12]

The White House Council on Supply Chain Resilience's charge is to make sure that those supply chains stay strong. The 1950 Defense Production Act requires companies to make certain products deemed necessary to national defense in exchange for guarantees that the products will have a buyer. The Biden Administration will use it to make more essential medicines in the United States and to increase production of new clean energy technologies.

The U.S. Commerce Department reported in February that the value of goods imported from Mexico rose nearly 5% from 2022 to 2023, to more than $475 billion while the value of Chinese imports tumbled 20% to $427 billion.[13] The last time that Mexican goods imported by the United States exceeded the value of China's imports was in 2002. Mexico has been among the beneficiaries of the growing shift away from reliance on Chinese factories. The biggest drops in Chinese imports were in computers, electronics, chemicals, and pharmaceuticals.

Challenges remain, but the progress made to date is encouraging.

Clinician Shortages and Burnout must be addressed

Clinician shortages and burnout were concerns pre-pandemic, but Covid-19 pushed the issue to new heights, exacerbating the supply/demand imbalance. Federal data indicate that about 82 million Americans live in primary care "health professional shortage areas." And it's not just an American problem. Last year, the Commonwealth Fund reported that more than 80% of primary care physicians in the other ten high-income countries reported struggling with workload.[14]

Doximity's 2023 Physician Compensation Report found two out of three physicians are thinking about leaving their current positions because they continue to be overworked; 36% are considering early retirement and 16% are looking for a new career.[15] Average pay declined 2.4% in 2022. The gender pay gap is still an issue with male physicians earning almost $110,000 (26%) more than their female counterparts.

Burnout has long been part of nursing, largely due to long working hours in difficult situations. The Covid-19 pandemic made these factors worse. A November 2022 survey of more than 12,000 nurses by the American Nurses Foundation found that 57% said they felt exhausted; 43% said they felt burned out. Only 20% said they felt valued and 43% said they were thinking about leaving their jobs.[16] Interest in entering the nursing field continues to be positive, but more than 60,000 qualified applicants were turned away from nursing schools last year due to a lack of clinical rotation slots to provide the hands-on training they need.

Last August, the Department of Health and Human Services (HHS) announced that it will invest $100 million toward addressing the nursing shortage. The HHS funding will be directed towards increasing the number of nursing school

faculty and supporting the career ladders for licensed practical nurses and vocational nurses to become registered nurses. Funding also will be used to train more nurses to become primary care providers to address mental health and substance use disorder issues and maternal health needs.[17]

Some experts believe that virtual nursing, combining the best elements of primary and team nursing, may be a practical pathway to alleviating stress and burnout.[18] Virtual nursing provides a multifaceted solution to a range of pressing challenges. It enables experienced nurses to take on mentorship roles, fostering the professional growth of younger, less-experienced nurses. Patients, including the elderly, benefit from the personalized one-on-one attention provided by virtual nurses.

Lack of full interoperability and clunky electronic health records also are other reasons cited by clinicians that add stress to their daily workload. Modern Healthcare's Editor Emeritus Merrill Goozner tackled the issue head-on in a recent issue of GoozNews.[19] The 2009 HITECH Act added a new set of requirements - use of standardized data protocols so that patient records could be easily exchanged between providers.

The law's architects believed health record interoperability was key to overcoming the fragmentation that plagues America's healthcare delivery system. Instead of eliminating duplicative testing and reducing medication and treatment errors, things did not turn out as planned. What we see today is a failure to achieve HITECH's ambitious goals.

While nearly all hospitals and 4/5ths of physician offices have installed electronic health record systems (EHRs), frustrated patients still have to fill out pages of information when their specialist practice's computer system's HER is unable to accept the primary care physician's EHR because they use different vendors.

Goozner asks "What's behind this systemic refusal to use digitized medical records to reduce fragmentation, lower costs, improve quality, and get better outcomes?" In his opinion, it's "the financialization of health care. Every player in the healthcare ecosystem has a proprietary interest in maintaining a stranglehold over what they consider to be their data." He also delves into the speed bumps imposed by EHR vendors, where four firms control over 80% of the market.

It's different in countries with universal healthcare. France figured out interoperability 25 years ago, achieving interoperability and eliminating paper medical records with the Carte Vitale.[20] This green plastic credit card with an embedded memory chip is the central administrative tool of French medicine. Issued to all of France's 66.7 million citizens and legal residents, the encrypted card contains the owner's complete medical history (a child's medical record is maintained on the mother's card until age 15). The Germans followed ten years later.

Meanwhile, the US has turned physicians and nurses into data entry clerks. I had my annual wellness visit with my primary care physician last week (it went well, thank God). He went through the required questions, and I readily recalled the three words while he stood at his terminal typing away. I asked him about clinician burnout. He said that he felt less stressed once he gave up his hospital coverage, leaving it to night-shift hospitalists. When he got late night calls from the nursing station, it often took up to 45 minutes to boot up his computer, get on the system and transmit his order (oral orders are not allowed). He doesn't miss the "pajama time."

As we concluded the visit, I asked him if the use of the EHR made him feel like a data entry clerk. His response, "Yes, when you leave it will take 12 more clicks to complete your visit record."

Teladoc Health and Microsoft have teamed up to use the latter's artificial intelligence services to automate clinical documentation on the telehealth platform, so relief may be on the way.[21]

It's too soon to tell, but innovative approaches like virtual nursing and the use of artificial intelligence to aid clinicians should be encouraged.

Committed Compassionate Leadership is the Key

Long term, the most important issue to address in combating future pandemics is leadership. The Covid-19 pandemic caught most countries unprepared to deal with the threat. Scholars will spend the next generation debating the types of governance structures, level of preparedness and other variables that best protected the nation's residents. In my opinion, one of the key factors separating success from failure in dealing with SARS-CoV-2 was the compassionate commitment of the head of state to protect the country's residents. Countries whose leaders placed public health above political considerations had lower fatality rates than those that ignored science.

Early in the pandemic, Pulitzer Prize winning columnist Nicholas Kristof posed a question: "Are female leaders better at fighting a pandemic?"[22] Kristof compiled data from 21 countries, 13 led by men and 8 led by women. At that point in the pandemic, the fatality rate in male-led countries was six times higher than in countries with female leaders, Kristof attributed the difference to "male ego and bluster" and contrasted it with the low-key, evidence-based leadership in countries led by women.

Germany and New Zealand were two examples of countries led by women that outperformed their peers in getting ahead of the pandemic. German Chancellor Angela Merkel, a scientist by training, communicated clearly, calmly and regularly during the crisis. New Zealand Prime Minister Jacinta Ardern

recognized that, with fewer ICU beds per capita than hard-hit Italy, drastic action was needed. After imposing border restrictions and a lockdown, by June 2020, only 1,500 Kiwis had contracted Covid-19 with 22 deaths. As of June 30, 2022, only male-led Japan had a lower fatality rate.

Did their approaches work? I've been monitoring the 38 OECD member nations since the onset of the pandemic through June 30, 2022. At that point, New Zealand's Covid-19 fatality rate/100,000 at 30.1 was second only to Japan at 24.9.

Germany's fatality rate/100,000 at 167.6 was significantly lower than its peers: France was at 229.9, the United Kingdom at 264.5 and the US at 304.7. Sadly, the US ranked 31st, trailed only by seven former Soviet satellite states.[20] Except for a six-month period beginning in April 2021, America's per capita fatality rate has consistently ranked in the bottom quartile of the OECD. Experts cite vaccine hesitancy and rampant misinformation as reasons why the US did a poorer job of protecting its residents than its global peers.

America should emulate the Scandinavians

What European country has the shortest growing season and an 830-mile border with Russia?

What European country's residents consistently rank as the happiest in the world?

The correct answer to both questions – Finland.[23]

What global leader has never ranked in the top ten?

That's right – the United States of America.

What accounts for the Finns upbeat attitude? Among other factors, Finland sees housing and health as inextricably linked.[24] Of its 5.5 million residents, only 3,700 are homeless, or about 7 of every 10,000 Finns. In the US last year, an estimated 653,104 were homeless, or about 20 of every 10,000 Americans.

The health consequences of homelessness in the US are profound:

- People who experience homelessness have higher rates of illness and die an average of 12 years earlier than other Americans;
- Unhoused people are more likely to have behavioral health needs;
- Low-income and unhoused people are the top 5% of hospital users and account for 50% of health care costs; and
- People experiencing homelessness account for 1/3 of ED visits, and nearly 80% are for concerns that could have been preempted with preventive care.

Finland implemented its "Housing First" initiative in 2008, moving homeless people into stable housing right away — with no conditions — and then providing additional social services as needed. People receive a rental unit and access to support staff to help them navigate their finances, find jobs, and address any other needs. To build community, tenants are invited to participate in group activities and undertake charity work. To foster financial independence, they pay a percentage of the overall rent with the help of financial subsidies, if needed.

The Housing First approach has resulted in fewer emergency room visits and hospitalizations and less time spent in the hospital. ED visits are estimated to cost $18,500 annually for each unhoused person, so a 2/3 reduction in US ED visits by the homeless could save over $800M/year.

The other four Scandinavian countries, Denmark, Iceland, Norway and Sweden, have consistently ranked in the top ten happiest countries. During the Covid-19 pandemic, the only OECD member nations that collectively did a more effective job of protecting their residents were the four Pacific Rim countries (Australia, Japan, South Korea and New Zealand).[25]

While the other four countries took strong measures early in the pandemic, Sweden got off to a halting start and had been critical of other countries' strict lockdowns.[26] Anders Tegnell, the country's chief epidemiologist, admitted in a radio interview the there was "quite obviously a potential for improvement in what we have done." Sweden closed schools for over 16s and banned gatherings of more than 50, but shops, restaurants and gyms remained open. Prime Minister Stefan Lovfen defended Sweden's approach but noted that it had failed to protect the care home where half of the deaths had occurred.

So, what else are the Scandinavian countries doing right? Among other factors, in Scandinavia, "socialism" is not a four-letter word. In its 2018 report "The Opportunity Costs of Socialism," President Trump's advisers trashed the Nordic economic model saying it reduced living standards. To the contrary, the World Economic Forum credits the region's societal model as *"the most promising"* in charting a sustainable path out of the crisis.[26] Bloomberg Economics Johanna Jeansson pointed out that these small export-oriented nations had certain advantages including "deep public coffers, a tight social security net, and a larger reliance on sectors that have been able to work from home and sell online."

With low levels of debt as a percent of GDP (Denmark and Sweden – 40%; Finland – 70%; EU average – 90%), the countries had more leeway to spend their way out of the coronavirus recession. HSBC Economist James Pomeroy said: "If you have a very digitally savvy population, that sets you up very well going forward in terms of productivity."

Given the Scandinavians success in protecting their residents from the Covid-19 pandemic, America would be well advised to emulate their approach.

References

[1]The Centers for Disease Control and Prevention Covid Data Tracker, 2/12/24

[2]"American Healthcare – Worst Value in the Developed World," by John J. Dalton, ***garden state focus***, Summer 2016, Vol 62 Num 4, Fall 2016 Vol 63 Num 1, Winter 2017 Vol 63 Num 2.

[3]"U.S. Health Care from a Global Perspective: Accelerating Spending, Worsening Outcomes," The Commonwealth Fund, 1/31/23

[4]Statista, U.S. national health expenditure as percent of GDP from 1960 to 2022

[5]Merrill Goozner, GoozNews, 2/2/24

[6]"Rural Americans Struggle with Medical Bills and Health Care Affordability," by Munira Z. Gunja, The Commonwealth Fund, 7/24/23

[7]"Prospective CMS Administrators confirmation hearing highlights Congress's desire to expand telehealth coverage," by Nick Hut, HFMA, 4/21/21

[8]"Is Telehealth Here to Stay? Yes, But Only if We Stick the Landing," by Dr. Josh Umbehr, RealClear Health, 3/3/22

[9]"Why 2024 is the 'Super Bowl' for telehealth legislation" by Brock E. W. Turner, Modern Healthcare, 1/3/24

[10]"Covid-19 Patients Zero In Wuhan Identified, Boosting Lab Leak Theory," by Eric Mack, Forbes, 6/15/23

[11]Bloomberg Evening Briefing, 2/8/24

[12]Heather Cox Richardson, "Letters from an American," 11/27/23

[13]"Mexico overtakes China as the leading source of goods imported by US," by Paul Wiseman, Associated Press, 2/7/24

[14]"Overworked and Undervalued: Unmasking Primary Care Physicians; Dissatisfaction in 10 High-Income Countries," The Commonwealth Fund, 8/16/23

[15]"Overworked physicians consider exiting roles as pay rates drop," by Alan Condon, Becker's Hospital Review, 3/24/22

[16]"Nurses are Burned Out. Can Hospitals Change in Time to Keep Them?" by Bradford Pearson, New York Times, 2/20/23

[17]"HHS to invest $100M to train nurses, bolster clinician workforce, " by Heather Landi, Fierce Healthcare, 8/10/23

[18]"Transforming Healthcare with Virtual Nursing: Considerations for Nurse Leaders," by Karie Ryan, MedCity News, 2/5/24

[19]"Who owns your medical records?" Merrill Goozner, GoozNews, 2/12/24

[20]"Pandemic Year 3: How is the US Doing?" by John J. Dalton, FHFMA, ***Garden State Focus,*** Institute 2022, Vol 69, Num 1

[21]**"**Teladoc Expands Microsoft Tie-Up to Document Patient Visits With AI," Reuters, 7/18/23

[22]"What the Pandemic Reveals About the Male Ego," by Nicholas Kristof, New York Times, 6/13/20

[23]"The world's happiest countries for 2023", by Marnie Hunter, CNN, 3/20/23

[24]"Finland Sees Health and Housing as Inextricably Linked," by Munira Z. Gunja, The Commonwealth Fund, 2/12/24.

[25]"American Healthcare – Worst Value in the Developed World, part 2" by John J. Dalton, ***Garden State Focus***, Fall 2016 Vol 63 Num 1

[26]"We should have done more, admits architect of Sweden's Covid-19 strategy," by Jon Henley, The Guardian, 6/3/20

[27]"Crisis Showcases Corner of Europe Derided by Trump Advisors," by Nicholas Rolander and Ott Rumelas, Bloomberg Business Week, 1/11/21

About the Author

John J. Dalton, FHFMA, is Senior Advisor Emeritus at BESLER, cofounder of the Healing American Healthcare Coalition and Editor of its newsletter, the Three Minute Read™. John received HFMA's 2001 Morgan Award for lifetime achievement in healthcare financial management and was named 2017 Hospital Trustee of the Year by NJHA.

Beyond the Bottom Line: Insights from a Healthcare CFO on Revenue Strategies

Fatimah Muhammad

Martin Herry

by Fatimah Muhammed and Martin Herry

Garrick Stoldt

In the fast-evolving landscape of healthcare finance, the role of the Chief Financial Officer (CFO) has never been more critical. Garrick Stoldt, a seasoned CFO, brings a unique perspective to the table blending financial acumen with a forward-looking vision for the future. As we delve into his insights on the revenue cycle, climate considerations, and the outlook for the healthcare industry, particularly in hospital settings, we uncover a tapestry of challenges and opportunities shaping the path ahead.

Muhammad & Herry: Today we have the pleasure of speaking with the Chief Financial Officer (CFO) of Saint Peter's University Hospital (SPUH), Garrick Stoldt. This discussion will dive into his perspective of what the future of the revenue cycle is and the challenges that healthcare institutions may face. There are many current and foreseen challenges within the healthcare industry, considering there have been a lot of modifications in healthcare over the past few years since the pandemic and that this is an election year. So, Garrick, would you kindly just give us a little intro of what you have seen within the revenue cycle during your career, but also as a CFO of the hospital?

Stoldt: Well, the revenue cycle is always evolving and changing. New challenges and regulations are always creating opportunities and obstacles at the same time.

In the most recent two years, as we emerge from the pandemic, it is clear that payers are upping their game on denials and DRG downgrades to a doubling, in some cases almost tripling the number of denials that are happening. And this is not just in New Jersey, not just here at Saint Peter's, but around the country. So, we have to retool our operations to deal with this onslaught. We have to deal with it from a practical standpoint of staffing to deal with the challenges of changing the operational flow of activity.

Even good revenue cycle operations are in an awkward position and have to change their operations because of this onslaught. Nobody thinks that the internal resources of two years ago are going to be adequate to handle the challenges created by the payers and denials today. You have to retool and readjust the operations to address it.

And this has gone on since I've been in healthcare. There are always regulatory issues or payer issues that come up and then the industry comes up with ways to address and mitigate it. And then the payers come up with something else or the government comes up with something else and then we come up with some other ways to address it and modify it. It's like a ping-pong game that goes on and never stops. If you're not evolving, then you're falling behind. So, there's no such thing as a static workforce when it comes to more static job positions and titles and responsibilities. They have to continue to evolve and change because of the market dynamics.

The industry is hurting right now. I think a lot of the revenue compression that's taking place because of denials is affecting the margins. You can see it in New Jersey, from the New Jersey Hospital Association's FAST Report, disseminating information on operating margins and other financial performance. You can see financial indicators have been dropping, available cash and investments are dropping. The margins are much tighter than they were, with more hospitals losing money. It's a function of three issues: the payer downgrades and denials, the cost of labor along with the agency costs, and

the rising inflation costs. Those three things are driving down margins.

The major rating agencies, Moody's and S&P Global, both have negative outlooks on the healthcare industry right now because of these issues. Although the salary issue and the workforce problems have been mitigated to a large degree, certain segments are still very much costing healthcare institutions quite a bit of money, specifically respiratory therapy, because there's no quick solution to that. There's only one school that produces respiratory therapists, and we're losing respiratory therapists faster than they can produce new students. Same thing with nursing -- we need more nurses.

I know that schools have turned away hundreds, if not a thousand applicants, qualified applicants. Why? Not enough faculty to teach. If you don't have the faculty to teach, you can't have the students that will graduate and then go into the profession. The pipeline has been damaged until we can get more educators to create more nurses, and then that will right-size itself to a degree. But it's not going to be overnight. So, we have to deal with these challenges until it does.

It's like any other challenge or problem. Some good outcomes come from this. What did the healthcare industry spend a lot of time on now? Their workers and their work-life balance and engaging them to have a highly engaged workforce.

The employer-employee relationship is getting better because it has to. You have to retain your nurses. You have to retain your staff. To do that, you have to be more engaged with them. That's a good byproduct, although it's a hard lesson to learn if you're not doing it already or improving your employee engagement. But employee engagement is everything now.

You can see in all the literature that's out there how you engage your workforce better because you want them to stay with you. There are so many opportunities to work elsewhere that you have to make yourself a place where people want to work. Easier said than done.

Muhammad & Herry: I'm glad you mentioned that when it comes to dealing with employee retention, as well as talent and development in the finance departments for healthcare institutions. And these are at a higher peak now since COVID-19. What other ways would you recommend that hospitals address these challenges when dealing with recruitment, retention, and talent development, especially within our finance department? As you mentioned, there are not enough educators to push out these nurses and we're having a shortage of respiratory therapists. We see that when it comes to the disease state, these areas are increasing to where the demand is for people such as respiratory therapists. So, what is your recommendation?

Stoldt: Well, one of the things I'm proud of is that we're rolling out an education program, and a process to allow unskilled workers the opportunity to pay for their education to get skills. We have a decent amount of unskilled labor in certain departments, such as environmental services and dietary. There are a few other areas where you can get a job and have no skills, not even a high school education in some cases. But that being said, because they come from a low economic area, they'll take those jobs, but there's no real career path.

We're going to try and provide the education free for those employees who want to move up to get educated, to get a high school degree, pay for a high school supplemental degree, pay for college, pay for graduate school, or pay for trade school. The goal is to have people come on and be employed. They're at the entry level position, so they're relatively low paid and they have no money for education. They have barely enough money for housing and feeding themselves. Those are the things they worry about first, everything else is secondary.

They have no thoughts of moving up or getting educated. But if we can take that burden away and allow employees to be able to then get trained for a position that pays better and give them the opportunity, it becomes a question of how much they want to move up. We have the people. We just need to move them up higher in the education scale so they can now take on skilled trades and services, become, for example, medical assistants, and to come and to be in areas where now they can move up. Now they'll have a career ladder.

Muhammad & Herry: Well said. And it's funny that you say this, and you mentioned two things. You talked about their economic status. So, now you are changing the narrative for people who are a byproduct of their social determinants of health, which is a very serious issue right now. And something that's being talked about and addressed in some areas of organizations that has really been ignored for quite some time. So, I really appreciate you bringing that to the forefront. And this sounds like something that used to be done but has been totally forgotten about -- where people could be a part of an organization and build on a trade and be able to grow within their organization. SPUH is a place where people stay for years and years, this becomes their family and their designated workplace because of the culture.

Stoldt: There are a lot of people who move up at SPUH and change jobs, but they don't change the organization. That's absolutely correct. But what they do is they start out in one department, and then they evolve. They see something where it's one level up in some other department. They move and do something totally different in the organization. And you see a number of people have been here 20, 30 years. They've been in five different departments, and they've moved up in terms of their education and their scope of their skill sets because they've been able to evolve and move in different areas because they had that first jump to do something better than what they're currently doing.

Muhammad & Herry: So, you're a different kind of leader

because you lead with the belief that you must invest in the people. Invest in their education because it's taking care of the home base of an organization. Why do you think that other CFOs and other organizations do not do that? What are the challenges of why other organizations don't do it when this would increase their bottom line because you're investing in the people?

Stoldt: I think the simple answer is it's a long-term view. There is no quick payback. Most people want to see you implement a new program or service. You want to see a payback for that right away. The payback happens over time. And the real value comes as someone gets more skills and they become far more valuable to the organization. And that investment pays off. It doesn't happen overnight, it takes years. Our society is based on quick return for a reward, a quick reward for some sort of risk or investment. This is not a quick return. This is a long-term return. But it's the right thing to do.

Just like we do a lot for the underserved population, we've been expanding our Family Health Center. And when you take care of the underserved population, not everybody stays in the underserved population – they move up. And they realize that 10 years out, when they had been really down, they had a place to go. And now they realize they've become loyal to your organization because of that effort.

We just had a celebration for Black History Month, which I thought was very nice. And we had a guest speaker who was really, really good and talked about the experiences here, about how people are being treated, whether they're unemployed or they're president of a company. They're treated with respect up and down the organization.

And that, just being respected, carries a value that's indescribable and has long-term effects, positive effects. You may not see that person coming in for health service for five years or six years, but they'll remember that experience. They will remember how you treated them. And that's where they'll want to go.

Muhammad & Herry: So, let's dive into balancing the need for cost containment and providing quality patient care and maintaining the high patient satisfaction, which goes with what you just said about being respected and maintaining the continuation of wanting to receive your care from that facility. St. Peter's is in the forefront of alot of these things that I just mentioned, which impacts the bottom line. But being a hospital that provides a lot of charity care to patients and Medicaid patients, how do you maintain that balance and the need for cost containment with providing quality patient care and maintaining high patient satisfaction? What do you do here that other competitors do not do to maintain that?

Stoldt: Well, I think everybody does it to a degree. The difference with us is the fact that it's universal, meaning it's everywhere in the organization. You go to a clinical department, and they have compassion for their patients and their families. It's the whole family. It's not just the patients that are here.

When you go to another service department, like patient accounting, you go to dietary, the same feeling, the same compassion. It's throughout the entire organization. It's our culture, and it's the culture that I believe makes that difference. I've been to many organizations in the state and the cultures are not the same.

Culture change is the hardest thing to change because many things are embedded that follow the people who worked here before. Your whole management structure has to be buying into it in order to get all of your rank-and-file frontline people to get into it. So, it has to be universally accepted. It's very hard to have universal acceptance in anything today. But this is an effort that's been going on for generations, it's embedded in the organization.

Muhammad & Herry: Let's switch a little bit from culture to this financial aspect. How would you say that you and your hospital collaborate with other healthcare stakeholders, such as physicians and administrators, to try to drive the financial and operational alignment?

Stoldt: Well, physicians are feeling the same pain that we are. You know, they're in the same boat with the issue of denials right now. As a matter of fact, I met with a bunch of senior physicians representing the state society and others about how we can align together both the hospital and physicians to attack the problem and start putting some regulatory controls in place to restrain the managed care companies. We're all feeling the pain.

So, you become good bedfellows when you're all feeling the same problem and then can address it as a bigger class of not just hospitals, but physicians trying to address the same problem. One of the things I find interesting is we had some research done that shows that it's affecting the consumer, that a lot of consumers are now having their care delayed or denied because of some of the practices by the payers. It's affecting everybody. But when we're aligned, when our incentives are aligned between physicians and hospitals, great things can happen.

Muhammad & Herry: We are living in a time where technology is at an all-time high. When you look at when your career started up until now, I don't know if you could have imagined a time of artificial intelligence and automation, which is expected to revolutionize the revenue cycle for hospitals and healthcare. What's your take on it? What is the impact on the shortage of employees? What is your take and where you see AI impacting the healthcare industry and the revenue cycle?

Stoldt: Well, I'm not into predictions, but I will say this. I would expect that over the next five to seven years, you could see as much as 20 to 25 percent of the revenue cycle workforce, and that's just the revenue cycle, it's happening in other areas

as well, being taken over by robotic learning. As a matter of necessity, you know, if you can get a robot or machine learning to do what an employee does for 90 percent of their work, and working 24-7 without having to pay benefits, you think about the return on that over time. It may not be a quick return, but again, once it's up and running and proven its value, you can do many functions now robotically using machine learning.

I don't expect to lose a single employee. The reason for that is the fact that we always are in need of employees, and that the skill set, someone who's in revenue cycle, they have a lot of knowledge that you can't afford to lose, and there are always positions open. A lot of employees may be doing something different than they did before, but they still have a job, and now they'll take that knowledge they have and do other duties within the revenue cycle. Therefore, we can keep a higher level employed in terms of all the positions we have, because right now we've had periods of time in the last two, three years where we've had a 25 percent turnover rate because of the disruption in the workforce.

That's not sustainable. You've got to have a stable workforce, so if you can start taking some positions out by having robotic learning take their place and redeploy your staff in other areas, now you should have a much higher filled position rate than you did before, which adds stability in the operations.

In many years we've had the lowest turnover rates in the state for employees, but the disruption went everywhere. It wasn't just nursing, and there were many other departments, and different departments now are feeling the pinch that weren't felt a year or two ago.

It's going to continue. It's like a ripple effect in the economy. It happens at different times in different departments. The need to find ways to stabilize the workforce and get the work done, leads to robotic learning as the clear the way to go. There's enough turnover in most organizations that can handle redeploying staff as opposed to letting people go, so I don't expect job loss. I expect redeployment of people or positions.

Muhammad & Herry: When you look at key performance indicators over the last decade, how has SPUH used these indicators to measure revenue cycle management efficiency, and also how do we address the challenges of ensuring precise medical coding and accurate billing? I know you oversee Susan Klein, who really is responsible for that. In addition, what initiatives has SPUH started for aiming towards prioritizing patient access that you think will help impact our bottom line?

Stoldt: I'll do the last question first -- the access issue. We implemented software about a year and a half ago to allow patients when they come in, who don't have Medicaid or charity care, in fact, they don't have anything but a smartphone, to download an app that we add to their phone. In order to get on Medicaid or charity care or some sort of government assistance program, there's a lot of documentation needed which would require patients to come back, and there will be a delay in care at the Family Health Center until they provide the documentation. Now, given the app, they go home, and all they have to do is image those documents from home through the app, and it gets filed directly for Medicaid or charity care, so it provides a huge convenience factor for patients.

Most patients, you know, if they're in an uncertain population and they have a job where if they don't work, they don't get paid, and it's very, very difficult for someone to come in. If we can make their job easier so they don't have to come back to do paperwork in order to get enrolled in programs, and they can do it from their home and don't have to take extra time off, that convenience shortens the timeline and is less effort for them and they don't have to lose hours of pay. And at the same time it's a convenience for us too. It's quicker for us to get the work done, to get the applications in. The program has been a huge success and very few places have this program, and it's one of the things that I think makes us stand out compared to other organizations.

And as for the previous question, well, the way you really know? How is your cash? It all comes down to cash. How much cash have you been able to collect on services? And there are always things that are changing and evolving.

We have committee meetings regularly on revenue cycle and issues because new rule sets come out, whether it's government or it's payers, and we have to constantly be moving and changing and seeing how our cash collections are and saying, we got paid X amount for something, now we're getting paid something less than that. Why does that happen? Is it a change of practice? We looked a while back, for instance, at radiation therapy and said, how come we're collecting less on radiation therapy? Well, the protocols changed. You know, it used to be for prostate cancer, and you're getting 40 fractions of procedures for radiation therapy, and now they do them in a much lower number, and they realize those extra doses of radiation weren't really benefiting.

After so many, you've gotten the benefit from the radiation, you're not going to get much more. Those extra shots of radiation weren't really having a positive clinical impact. So now they use less radiation on a cancer patient than they did in the past, on average.

There are other changes where payers create new obstructions or obstacles to getting care, and we have to react to that as well. Government changes their protocol on how often people get screened for certain conditions, or add new pieces of information that have to be included. The government's always looking for more information, so in order to get paid, you need more information in the record so it's available.

So, we constantly have to evolve our financial and clini-

cal practice at the same time. You know, when I first got into health care, it used to be the clinical people did clinical work, and the finance and operations people did the operations, and that was the 20-20. Now they're so intertwined.

Almost every payer contract we have has paid for performance in some way. That clinical performance drives how much revenue you'll be able to earn from a payer for services being rendered. Now we're totally integrated in the sense that everyone has to be working from the same page for clinical outcomes, because it has direct financial impact.

Muhammad & Herry: What would be the two or three recommendations you would give anyone stepping into a revenue cycle role tomorrow? What would you tell them in order to have a long successful career? Because you are very well known in the state, and people always have great things to say about you and your leadership, your perspective is invaluable.

Stoldt: Number one, your obligation is to understand your operation in detail, meaning you need to know your clinical people. You need to know the operations because with that knowledge, it puts everything in perspective. If you just have clinical people doing their operations and not knowing what they're doing, you can't adapt finance to make sure we're addressing everyone's needs.

And with the clinical integration of financials and how we are paid, you need to know clinical operations as much as you can and the different service lines that you provide.

Number two, you never stop learning. You have to constantly go and get educated, go out to places, go to conferences, see what other people are doing, and always bring back at least one idea that you can implement in your organization. You have to be the agent of change. The CFO has to be a change agent. You can't just accept things as they are.

And if you're not a change agent, then you're not going to be successful.

Muhammad & Herry: Thank you so much. Very well said.

Exploring the healthcare revenue cycle landscape through the lens of a CFO like Garrick Stoldt, one thing becomes abundantly clear: the significance of having knowledgeable CFOs who grasp the intricacies of the entire operation and anticipate the evolution of revenue cycles cannot be overstated. In an era teeming with technological advancements and shifting trends, CFOs who are equipped to navigate these complexities will be pivotal in steering healthcare organizations towards financial success and sustainable growth. By embracing the insights shared by visionary CFOs like Garrick Stoldt and staying attuned to the future trends and technologies on the horizon, healthcare entities can position themselves at the forefront of innovation and resilience in the years to come. When healthcare leaders think of the discourse on the interconnected realms of healthcare finance and clinical operations, we underscore the paramount significance of CFOs possessing an intimate understanding of both domains. By marrying financial expertise with a deep comprehension of clinical processes, CFOs can offer invaluable insights that put the entire operational landscape into perspective. The seamless integration of clinical knowledge with financial acumen not only optimizes revenue cycles but also fosters a holistic approach to organizational decision-making. In a dynamic environment where healthcare reimbursement models and service lines are continually evolving, the imperative for CFOs to continuously expand their understanding of clinical operations remains ever-present. By embracing this ethos of ongoing learning and aligning financial strategies with the clinical intricacies of service provision, CFOs can chart a course towards sustainable financial health and operational excellence in the face of tomorrow's challenges and opportunities.

About the authors:

Fatimah Muhammed has extensive experience in pharmacy, public health, and professional research while possessing an eclectic blend of interpersonal skills. She serves as the 340B Pharmaceutical Services Director at Saint Peter's University Hospital where she presides over all projects related to 340B. Her current endeavors focus on Health Disparities, Health Equity, Patient-Reported Outcomes, Community Health Promotion, and Disease Prevention and Health Services Research. She can be reached at fmuhammad@saintpetersuh.com.

Martin Herry is a future healthcare leader, HFMA member, 340B Pharmaceutical Service Intern, and a recent Rutgers University graduate, holding a degree in Health Administration and a minor in Sociology. His passion for promoting health equity and advocating for underserved populations shines through his dedication to driving positive change and raising awareness about healthcare challenges. With a deep understanding of healthcare systems and the impact of social determinants of health, Martin is on a mission to make a difference in the lives of others. Martin can be reached at martinherry@icloud.com.

New Members

Tonita Coachman
tonita.coachman@student.uagc.edu

Glorivee Otero
Atlanticare
Patient Access Supervisor
glorivee.otero@atlanticare.org

Fedner Joseph
Hackensack
Meridian Health
f.joseph5939@o365.ncu.edu

Andrew Nealy
RSM US LLP
Assurance Supervisor
andrew.nealy@rsmus.com

William Koczan
CBIZ KA Consulting Services
Sr. Manager
wkoczan@cbiz.com

Brian Holman
Grant Thornton LLP
Manager
Health Care Advisory Services
(347) 658-2741
brian.holman@us.gt.com

Valerie Aiello
HQSI
Chief Executive Officer
vaiello@hqsi.org

Ashley Kressler
Revco Solutions
Director - Insurance Operations
ashleykressler1@gmail.com

Bakir Shabazz
Hackensack University Medical Center
Billing Analyst
shabazzbakir@yahoo.com

Arielle Restrepo
Robert Wood Johnson University Hospital
Epic Application Analyst
arielle.restrepo@student.uagc.edu

Daniel Sestak
CSBI
daniel.sestak@student.uagc.edu

Mansi Parikh
Penn Medicine
Director
mparikhm@gmail.com

Jignesh Ray
CSPR
Evolent Health
Product Manager
jignesh.ray@gmail.com

Candy Batista
candy.batista@student.uagc.edu

Dominique Becerra
Hackensack University Medical Center
Project Manager
dominique.becerra@student.uagc.edu

Rachel Migliaccio
rachel.migliaccio@student.uagc.edu

Johnny Ervin
john.ervin@students.jefferson.edu

Michael Cajuste
Atlanticare
Patient Access
michael.cajuste@atlanticare.org

Kelsey Aikens
Senior Associate
Billing and Collections
kaikens1@bayada.com

Ghazanfar Bashir
CRCR CSPPM medSR
Director Operations
ghazanfarbashir@carecloud.com

Marilyn Blaustein
Bayada Home Health Care
Senior Authorizations Associate
mblaustein@bayada.com

Rita Francis
Associate II
Billing & Collection (SR)
rfrancis@bayada.com

Debra Melhorn
Bayada Home Health Care
Manager
dmelhorn@bayada.com

Elyce Litts
Bayada Home Health Care
Sr. Associate Authorization
Management Managed Care Pediatrics
elitts@bayada.com

Jenna Morris
Bayada
Reimbursement Associate
jmorris2@bayada.com

Casey Murdock
casey.murdock@sanofi.com

Stephanie Gardner
Revenue Cycle Billing manager
stephsteph018@yahoo.com

Andrew Kissinger
Hackensack University Medical Center
Patient Access Manager
andrew.kissinger@hmhn.org

DeAnna Rivera
Bayada Home Health Care
Manager Eligibility
drivera@bayada.com

Holly Bentrup
CRCR
Associate Eligibility
hbentrup@bayada.com

Theresa Corrigan
Sierra Health Group LLC
VP
Client Services
tcorrigan@sierrahealth.net

Christina Espinoza
Bayada Home Health Care
Insurance Verification
cespinoza@bayada.com

Zina Kalmus
Bayada Home Health Care
Associate
zkalmus@bayada.com

Sean Sim
sean.sim@student.uagc.edu

Paul Croce
Greenbaum Rowe Smith & Davis LLP
Counsel
pcroce@greenbaumlaw.com

Dawn Cicchetti
Princeton HealthCare System
Director of Care Coordination
dawn.cicchetti@pennmedicine.upenn.edu

Lynn Desbiens
Bayada Home Health Care
Senior Associate

Brooke Lawson
Bayada Home Health Care
blawson@bayada.com

Jamie Nerney
jnerney@bayada.com

Theresa Palestino
Bayada Home Health Care
Associate
(856) 793-2414

Daniel Palma
palmada@kean.edu

Joseph Callahan
Penn Medicine
Preregistration Specialist 3
joseph.callahan@pennmedicine.upenn.edu

Megan Ridpath
Coding Educator
megan.s.ridpath@medstar.net

Marlena Rizzo
Bayada Home Health Care
Reimbursement Associate
mrizzo@bayada.com

Sara Bennett
Bayada Home Health Care
Associate
sbennett4@bayada.com

Amanda Carlson
Bayada Home Health Care
Senior Associate of Authorizations
acarlson@bayada.com

Llz Oberer
Bayada Home Health Care
Supervisor
lizoberer1@comcast.net

Justin D'Andrea
Senior Associate
jdandrea@bayada.com

Patricia Gorgol
Bayada Home Health Care
Collections
pgorgol@bayada.com

Amanda Hess
Bayada Home Health Care
Associate
ahess3@bayada.com

Christopher Kim
chris.han.kim1@gmail.com

Ryan Smith
Bayada
Director, Treasury
rsmith1@bayada.com

Ilham Atir
Bergen New Bridge Medical Center
Laboratory Director
iatir@newbridgehealth.org

Ashley Jones
CRCR
Null Credit
Resolution Specialist
mariyasmom@gmail.com

Janet Boessman
Bayada Home Health Care
Associate
jboessman@bayada.com

Soyon Bongiovanni
University Hospital New Jersey
Manager
Financial Planning and DecisionSupport
bongiose@uhnj.org

Diane Juliano
Thomas Jefferson University Hospital
Associate Chief Nursing Officer
diane.juliano@jefferson.edu

Valerie Nerenberg
Thomas Jefferson University Hospital
Associate Chief Nursing Officer
valerie.nerenberg@jefferson.edu

Frank Rocco
Thomas Jefferson University
Hospital VP Operations
frank.rocco@jefferson.edu

Emily Votta Atlanticare Accountant II
evotta@atlanticare.org

Matthew Pierre
CRCR CSBI
Montefiore Health System Clinical
Informatics Manager
mpierre@montefiore.org

Colleen Patton
Brighton Healthplan Solutions
Vice President Network Management
732-667-8947
cpatton@brightonhps.com

Amber Rogers
Healthcare System Director
Clinical Appeals
amrogers@montefiore.org

•Who's Who in NJ Chapter Committees•

2023-2024 Chapter Committees and Scheduled Meeting Dates

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

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

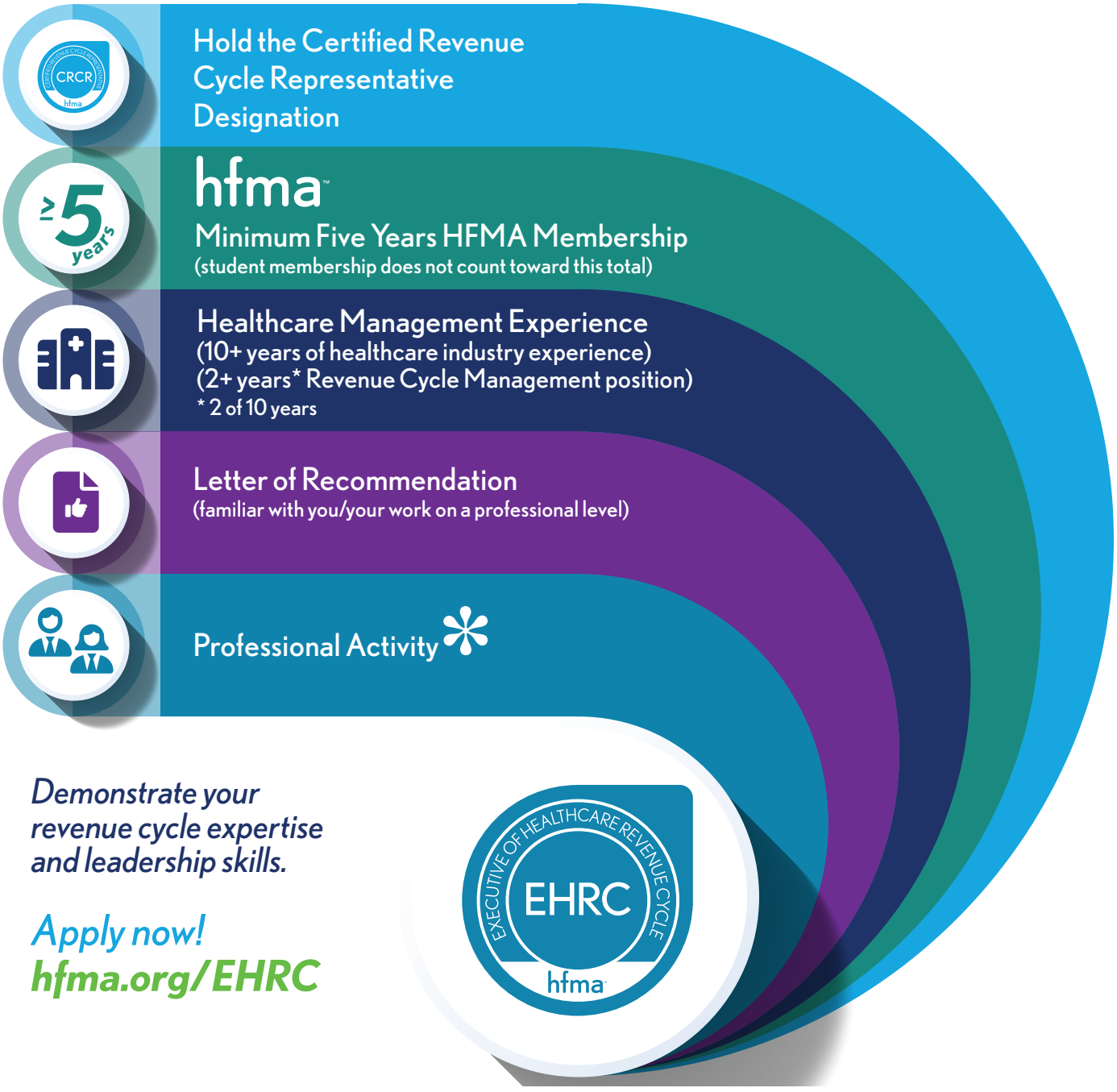
COMMITTEE	PHONE	DATES/TIME/ ACCESS CODE	MEETING LOCATION
CARE (Compliance, Audit, Risk, & Ethics)			
Chair: Fatimah Muhammad – fmuhammad@saintpetersuh.com	(732) 745-8600 Ext. 8280	First Thursday of the month	Conference Call
Co-Chair: Ryan Peoples – RPeoples2@virtua.org	(609) 560-9619	9:00 AM	(667) 770-1469
Board Liaison: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Access Code 473803	
Communications / FOCUS			
Chair: James Robertson – jrobertson@greenbaumlaw.com	(973) 577-1784	First Thursday of each month	Conference Call (667) 770-1479
Board Liaison: Brian Herdman – bherdman@cbiz.com	(609) 918-0990 x131	8:00 AM Access Code: 868310	In-person Meetings by Notification
Education			
Chair: Lisa Weinstein – lisa.weinstein@bancroft.org	(856) 348-1190	Second Friday of the Month	via Teams
Co-Chair: Tara Bogart – tara.bgart@pmmconlne.com	(704) 618-1531	9:00 AM	
Board Liaison: Kim Keenoy – kim.keenoy@bofa.com	(732) 321-5935	Access Code: 89425417190	
Certification (Sub-committee of Education)		See Schedule for	
Chair / Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Education Committee	
FACT (Finance, Accounting, Capital & Taxes)			
Chair: Alicia Caldwell – alicia.Caldell@bakertilly.com	(732) 687-3535	Third Wednesday of each month	Conference Call
Co-Chair: Mia Morse – mmorse@matheny.org	(908) 234-0011 x1380	8:00 AM	(872) 240-3212
Board Liaison: Alex Filipiak – Alexander.Filipiak@rwjbh.org	(732) 789-0072	Access Code: 720-430-141	via GoToMeeting
Institute 2024			
Chair: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	Last Monday of each month	Meetings to resume soon
Co-Chair: Christine Gordon – cgordon@virtua.org	(856) 355-0655	1:30 PM	
Board Liaison: Maria Facciponti – Facciponti.Maria@gmail.com	(973) 583-5881		
Membership Services/Networking			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Third Friday of each month	MS Teams meeting
Co-Chair: Ari Van Dine – Ari.VanDine@rsmus.com	(212) 372-1278	9:00 AM Access Code: 267693	In person Meetings
Board Liaison: Heather Stanisci – Hstanisci@annuityhealth.com	(862) 812-7923	Call Line (667) 770-1400	by notification
Patient Financial Services and Patient Access Services			
Chair: Daniel Demetrops – ddemetrops@medixteam.com	(845) 608-4866	Second Friday of each month	Conference Call
Co-Chair: Marco Coello – mcoello@affiliatedhmg.com	(973) 390-0445	at 10:00AM	Call Line (667) 770-1453
Board Liaison: Amina Razanica – arazanica@njha.com	(609) 275-4029	Access Code 120676	
Payer/Provider Collaboration			
Chair: Tracy Davison-DiCanto – tracy.Davison-DiCanto@scasurgery.com	(609) 851-9371	Contact Committee	
Board Liaison: Lisa Maltese-Schaaf – LMaltese-Schaaf@childrens-specialized.org	(732) 507-6533	for Schedule	
Physician Practice Issues Forum			
Chair: Michael McLafferty – michael@mjmaes.com	(732) 598-8858	Third Wednesday of the Month 8:00 AM	Wilentz, Spitzer &
Board Liaison: Maria Facciponti – maria.facciponti@elitereceivables.com	(973) 583-5881	In person with call in available	Goldman offices
		via WebEx (Contact Committee)	90 Woodbridge Center Dr.. Woodbridge, NJ
Regulatory & Reimbursement			
Chair: James O'Connell – OConnellJ@ihn.org		Third Tuesday of each month	MS Teams Call
Co-Chair: Paul Croce – pcroce@greenbaumlaw.com	(973) 577-1806	9:00 AM Call Line: (732) 515-4266	
Board Liaison: Chris Czvornyek – chris@hospitalalliance.org	(609) 989-8200	Phone Conference ID: 670 733 396	
Revenue Integrity			
Chair: Tiffani Bouchard – tiffani2014@gmail.com	(561) 350-0623	Second Wednesday of each month	Conference Call
Co-Chair: Jonathan Besler – jbesler@besler.com	(732) 392-8238	9:00 AM Access Code: 419677	
Board Liaison: Jonathan Besler – jbesler@besler.com	(732) 392-8238	Call Line (667) 770-1275	
CPE Designation			
Chair: Lew Bivona – lewcpa@gmail.com	(609) 254-8141		

Executive of Healthcare Revenue Cycle

ADVANTAGES OF BECOMING AN EHRC

The EHRC certification designation demonstrates revenue cycle excellence. Earning this represents a high level of achievement and distinguishes you as a leader and role model in the revenue cycle industry. This designation demonstrates your commitment to leadership within the revenue cycle area of healthcare as well as continued involvement and education in healthcare revenue cycle.

Note: EHRC candidates must meet all the requirements prior to applying. Maintenance requires HFMA membership.



Candidates must complete one of the following 3 options; Provider, Business Partner or Volunteer:

OPTION 1: PROVIDER

hfma Patient Financial Communications Adopter Recognition Program

or

mapaward®
Applicant w/in the last two years.

or

mapapp℠
Subscriber

OPTION 2: BUSINESS PARTNER

hfma | Annual Conference
Speaker/Sponsor

or

hfma | Revenue Cycle Conference
Speaker/Sponsor

or

PEER REVIEWED by HFMA®

OPTION 3: VOLUNTEER

1. Service as an adjunct instructor at an accredited (post-secondary school) educational institution.
2. Service in an education, certification, or leadership committee role within the local HFMA chapter or service on one of the HFMA association boards or committees.
3. Demonstrating a minimum of 10 Hours in the service or preparation of one of the following:
   a. Preparation and publication of professional articles in a publication accepted as authoritative in the healthcare industry.
   b. Speaking to community groups on health care issues
   c. Providing internal staff education on healthcare finance topics
   d. Presenting at an HFMA educational program
   e. Presenting at a related healthcare industry educational program
   f. Assistance to those desiring HFMA certification
   g. Mentorship of healthcare finance professionals

How to Deal with Burnout Before it Happens

Lisa Hammett

by Lisa Hammett

Envision, having the tools to manage stress and other negative emotions in the moment, preventing burnout. Feelings of overwhelm, anger, frustration, shame, and blame would no longer sabotage productivity, communication, relationships, and health and wellbeing. Peak performance and peace of mind would be maintained, even in the most challenging situations. Conversations would be open, honest, authentic, and not controlled by feelings of judgement, impatience, and disappointment. When we're mentally fit, this is possible.

Mental fitness is the capacity to respond to life's challenges with a positive rather than a negative mindset. The direct impact is peak performance, peace of mind/wellness, and healthy relationships.

Positive Intelligence mental fitness was founded by Stanford educator, best-selling author, and executive coach, Shirzad Chamine, after extensive research in neuroscience, positive psychology,cognitive behavioral psychology, and performance science. Shirzad's research identified 10 Saboteur traits that impact our productivity, relationships, and health and wellbeing. These traits are not exclusive to certain individuals. We all have them. However, our top Saboteur traits differ from person to person.

To learn about your Saboteur traits, take this free assessment: www.positiveintelligence.com/assessments

Understanding Saboteur traits makes it easier to identify Saboteur hi-jackings, those occurrences when negative thought patterns impact our belief system and behavior. For example, feeling stressed and overwhelmed at work, can lead to impaired cognitive ability, poor productivity, and communication challenges.

Once a Saboteur hi-jacking is identified, a simple technique, called a PQ rep, is used to activate the positive, right side of the brain, transferring focus from the negative, left side of the brain.

PQ (Positive Intelligence Quotient or Positivity Quotient) measures the relative strength of your positive versus negative mental muscles, and is the measure of your mental fitness.

The objective of PQ reps is to become fully present by focusing intently on one or more of the senses. The duration of a PQ rep is between 10-15 seconds. When PQ reps are completed in succession, the right brain is fully activated, making it easier to respond to challenging situations with a positive mindset.

Here are several examples of PQ reps using different senses:

Sight

- Look at something so intently, noticing tiny details, such as shapes, colors, textures, or a reflection in the surface.

Touch

- Slowly rub two fingertips together, noticing the ridges of the fingers. Are the fingertips dry or smooth? What is the temperature of the fingertips?

Hear

- Focus on the farthest away sound you can hear, such as a passing car, or a voice in another room. Concentrate on this sound for five seconds. Then, shift the focus to the closest sound you can hear. It might be the breath. Do this for five seconds.

It's okay if you find your mind wandering while completing PQ reps. Mind chatter is very common. When this occurs, gently redirect your attention to what you were focusing on.

Developing mental fitness is a process. Just like any muscle, it takes work to build. With practice, it becomes easier. Because PQ reps can be done at any time and in any situation, they are very effective for managing stress and anxiety in the moment.

Imagine that you're having a conversation with a supervisor or colleague. As you listen to the other person, you feel negative emotions building. You find their tone of voice offensive. You start to feel defensive and resentful. You stop listening to what they are saying, and begin thinking of all the ways in which to interject, most of which, are unfavorable. You know that interrupting, by giving the other person a piece of your mind, is not the best solution. To diffuse your negative emotions, you decide to focus on the shape and color of your colleague's eyes. You stare at them intently. Slowly, your strong

desire to interrupt with a negative retort, is replaced with calm focus. When your colleague stops talking, you are able to respond calmly, preventing an outburst.

It's important to note that PQ reps do not eliminate the negative emotion forever. Saboteurs are sneaky and can catch you off guard at any moment. However, the more mentally fit you become, the more quickly you can stop a Saboteur hijacking and shift to a positive mindset.

In the Positive Intelligence program, a positive mindset is referred to as the Sage perspective.

Emotions associated with the Sage, right brain, include:

- Positive emotions
- Peace and calm
- Clear-headed focus
- Creativity
- Big picture

When we experience life from the Sage perspective, we are able to handle challenges objectively, with curiosity and clear-headed focus. We focus on the possibilities and not the problems. Every outcome or circumstance can be turned into a gift and opportunity.

The next time challenges arise, and a Saboteur hi-jacking occurs, threatening to impact your productivity, peace of mind, mental clarity, communication, and wellbeing, consider engaging your senses in a series of PQ reps.

About the Author

Lisa Hammett is an accomplished transformational and TEDx speaker, an international best-selling author, a Certified Positive Intelligence PQ Coach, and a wellness expert, helping stressed and burned out Leaders and Organizations in Healthcare and HR create work/life balance to increase productivity, profitability, and wellbeing. She reached burnout, after 26 years in the corporate retail sector. After a transformative health and wellness journey, where she lost 65 pounds, Lisa decided to dedicate her life to helping others achieve their health and wellness objectives. She has empowered thousands of individuals to make sustainable, healthy lifestyle changes. Lisa can be reached at info@lisahammett.com.

•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

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

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

Job Position and Organization

MANAGER OF PURCHASING
Englewood Health

MANAGED CARE ANALYST
The Valley Health System

DIRECTOR, BUDGET & REVENUE ANALYTICS
Hackensack Meridian Health - HMH HOSPITALS CORP

MANAGER, REVENUE INTEGRITY
AtlantiCare

DIRECTOR, UTILIZATION MANAGEMENT & REVENUE INTEGRITY
AtlantiCare

HIPAA Hot Topics and Headaches

Elizabeth G. Litten

by Elizabeth G. Litten, Esq.

For most people, the Health Insurance Portability and Accountability Act (as amended and its implementing regulations, or HIPAA) is associated more with headaches than hot topics. Yet staying on top of recent regulatory adoptions, guidance publications and enforcement actions by the U.S. Department of Health & Human Services (HHS) will avoid compliance headaches. This article summarizes a recent "Wednesday Webinar" co-hosted by HFMA NJ and my firm, Fox Rothschild, with an update for the regulation adopted shortly afterward.

HIPAA 101: Who (and What) is Subject to HIPAA?

HIPAA does not apply to all health information or to all those who handle health information, so it is important to consider HIPAA applicability before diving into HIPAA compliance matters. The first step in determining HIPAA applicability is identifying a covered entity. HIPAA defines a covered entity as including a health plan, a health care clearinghouse, and a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA.[1] The next step is identifying whether the health information is both individually identifiable health information (IIHI), a subset of health information, and also protected health information (PHI), a subset of IIHI. HIPAA defines PHI as including most categories of health information, with limited exceptions.[2]

HIPAA applies to the covered entity's business associates (in general, persons or entities providing services on behalf of the covered entity that involve the creation, receipt, maintenance, or transmission of PHI) and the business associates' subcontractors.[3]

In practical terms, this means that not all health information is subject to HIPAA. There must be a covered entity involved in its creation, receipt, maintenance and/or transmission, and it must also be PHI. If there's no covered entity involved (such as where, for example, an individual shares her own health information with a friend or the human resources department of her employer), HIPAA does not apply. HIPAA also does not apply if the health information is not IIHI, but here attention must be paid to the breadth of this definition: it includes both demographic information and information for which there is a reasonable basis to believe the information can be used to identify the individual. Furthermore, once the IIHI is PHI, it is subject to HIPAA protection (by covered entities, business associates, and subcontractors) until it is fully de-identified in accordance with HIPAA.[4]

Finally, once PHI is disclosed to persons who are not covered entities, business associates or subcontractors in accordance with HIPAA, it is no longer subject to HIPAA. For example, PHI may be disclosed pursuant to the individual's signed HIPAA authorization,[5] and without the individual's signed HIPAA authorization under certain circumstances when the individual has the opportunity to agree or object[6] or under certain circumstances expressly permitted by HIPAA, such as when the disclosure is required by law;[7] to a public health authority[8] for public health activities; in connection with judicial or administrative proceeding; regarding victims of abuse, neglect and domestic violence; to a health oversight agency[9] for oversight activities authorized by law; and for a number of other specified purposes.[10] Special limitations and requirements apply to each of these categories, though, and covered entities and business associates face enforcement actions[11] and the potential for private lawsuits when PHI is disclosed without understanding or heeding these limitations and requirements.[12]

HIPAA Hot Topics

Recent HIPAA enforcement actions,[13] regulatory proposals,[14] and adoptions[15] provide an excellent overview of current HIPAA hot topics. New and relatively new hot topics of interest discussed during the webinar included:

- HHS publication of a bulletin regarding the use of online tracking technologies by covered entities and business associates[16]

- HHS publication of guidance regarding remote communications technologies and HIPAA[17]
- HHS regulatory proposals (including those to better align the privacy protections that apply to substance use disorder patient records under 45 C.F.R. part 2 with the HIPAA privacy protections, the adoption of which was published following the webinar)

Other recent hot topics discussed are more familiar, and serve as reminders that we often fail to learn from past HIPAA mistakes:

- HHS settlement for disclosure of patient photographs and information to the media[18]
- HHS settlement for medical records snooping[19]
- Multiple HHS settlements[20] for failure to respond to individuals' requests for access to PHI contained in designated record sets[21] on a timely basis, in violation of HIPAA[22]
- HHS settlement related to health care provider's online response to a negative patient review[23]

Whether new and surprising or familiar and frustrating, these HIPAA topics are worth reviewing to avoid...

HIPAA Headaches

HIPAA compliance requires knowing who and what is covered by HIPAA, ongoing monitoring of changing regulations, bulletins and guidance documents, and an awareness of recurring problems. It requires implementing and updating policies and procedures, providing training that reflects the policies and procedures, and regularly asking questions of your employees and vendors, such as "What data is needed to do your job?," "What devices and software/applications do you use?," "What data is exposed during troubleshooting?," "Do we maintain a designated record set?," and "Is the data PHI?" For covered entities, HIPAA compliance requires understanding who your business associates are, making sure you have signed business associate agreements with them, and limiting the amount of PHI they receive and maintain to the minimum necessary. For business associates and subcontractors, it requires making sure your upstream and downstream business associate agreements are compliant yet compatible.

Finally, HIPAA is not the only law in town when it comes to health care information. Many states (including New Jersey) have enacted laws that pertain to individually identifiable information, including health information. While some contain exclusions for PHI, covered entities, and/or business associates, the definitions and exclusions vary and require analysis to determine applicability to the entity and the data. The Federal Trade Commission regulates vendors of personal health records under the health breach notification rule and has taken actions related to the privacy of health information under Section 5 of the Federal Trade Commission Act. Even the Office of the National Coordinator within HHS has published rules that pertain to PHI and provide new patient access rights.

The bottom line is that awareness of developments related to data privacy laws, regulations and enforcement will support HIPAA compliance efforts and minimize headaches.

About the author

Elizabeth Litten is a Partner and the Chief Privacy and HIPAA Compliance Officer of Fox Rothschild LLP. Elizabeth Co-Chairs the Firm's Privacy and Data Security practice group and has been a Chambers-ranked attorney for Health Care in New Jersey since 2011. She can be reached at ELitten@foxrothschild.com.

Footnotes

[1] *See* 45 C.F.R. 160.103 for the definitions of the terms covered entity, health care clearinghouse, health information, health care provider, health plan, and transaction.

[2] *See* 45 C.F.R. 160.103 for the definitions of the terms individually identifiable health information and protected health information. Note that the definition of protected health information excludes individually identifiable health information included in specific types of education-related records, employment records held by a covered entity in its role as an employer, and regarding a person who has been deceased for more than 50 years.

[3] *See* 45 C.F.R. 160.103 for the definitions of the terms business associate and subcontractor.

[4] 45 C.F.R. 164.514

[5] 45 C.F.R. 164.508

[6] 45 C.F.R. 164.510

[7] *See* 45 C.F.R. 164.103 for the definition of the term required by law.

[8] *See* 45 C.F.R. 164.501 for the definition of the term public health authority.

[9] *See* 45 C.F.R. 164.501 for the definition of the term health oversight agency.

[10] 45 C.F.R. 164.512

[11] *See* 45 C.F.R. 160.400 *et seq.* regarding the imposition of civil monetary penalties by the Secretary of the U.S. Department of Health & Human Services (HHS) and https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html regarding HHS investigation and enforcement (accessed February 13, 2024).

[12] While there is no private right of action under HIPAA, plaintiffs have successfully brought claims alleging HIPAA does not preempt state law common law claims for privacy violations. *Byrne v. Avery Center for Obstetrics and Gynecology, P.C.*, 212 Conn. App. 339 (Conn. App. Ct. 2022); *Walgreen Co. v. Hinchy*, 21 NE 3d 99 (Ind. Ct. App. 2014)

[13] https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/index.html (accessed February 13, 2024)

[14]https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/index.html (accessed February 13, 2024)

[15]https://www.hhs.gov/hipaa/for-professionals/regulatory-initiatives/fact-sheet-42-cfr-part-2-final-rule/index.html#:~:text=On%20February%208%2C%202024%2C%20the,at%2042%20CFR%20part%202%20(%E2%80%9C (accessed February 13, 2024)

[16] https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-online-tracking/index.html (accessed February 13, 2024)

[17]https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html (accessed February 13, 2024)

[18] https://www.hhs.gov/about/news/2023/11/20/hhs-office-civil-rights-settles-hipaa-investigation-st-josephs-medical-center-disclosure-patients-protected-health-information-news-reporter.html (accessed February 13, 2024)

[19]https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/yakima/index.html (accessed February 13, 2024)

[20]https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/mente/index.html, noting settlement marks 44th case to be resolved under the "HIPAA Right of Access Initiative" (accessed February 13, 2024)

[21] *See* 45 C.F.R. 164.501 for the definition of the term designated record set.

[22]45 C.F.R. 164.524; see also Notice of Proposed Rulemaking at 86 Fed. Reg. 6446 (January 21, 2021)

[23]https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/manasa/index.html (accessed February 13, 2024)

[24]https://www.njleg.state.nj.us/bill-search/2022/S332 (accessed February 13, 2024)

[25]16 C.F.R. 318.2(h)

[26]16 C.F.R. part 318

[27]https://www.ftc.gov/business-guidance/blog/2023/07/protecting-privacy-health-information-bakers-dozen-takeaways-ftc-cases (accessed February 13, 2024)

[28]89 Fed. Reg. 1025 (January 9, 2024)

New Year's Resolutions. How Are Yours Going?

A few members share their progress with us!

Every year I tend to make the same resolutions. My two favorites are :

1. Send greeting cards via snail mail for birthdays. I can tell you that those people in the first few months of the year are those who get cards. Those with birthdays later in the year, not so much. We shall see how this year goes.

2. Stop cursing. Already surrendered this year. I keep on trying, if that counts for anything.

The best news about resolutions is that I quit smoking about 10 years ago - the result of a NY resolution.

~Pat Simmons, MPA, FHFMA, FACHE

****

Hoping to read more. The book Legacy is already selected as well as a few other books.

~Fatimah Muhammad, MPH

****

Wear sunblock, drink more water… and try to do a 2-minute plank every day. Still working on doing the 2-minute plank daily. Elbow injury!

~Heather Stanisci

Natasha Schlinkert: Shaping the Future of Healthcare Revenue Cycle Management by Incorporating Artificial Intelligence

Fatimah Muhammad

by Fatimah Muhammad

Natasha Schlinkert

As revenue cycle leaders continue to drive innovation and efficiency in addressing the challenges faced by healthcare entities, Natasha Schlinkert stands out as a visionary in this field. With over 25 years of experience as a revenue cycle leader, she now serves as the CEO of Innobot, a company that specializes in healthcare automation solutions and robotic process automation (RPA). In our exclusive interview, Natasha shares her journey and insights into incorporating artificial intelligence into the revenue cycle arena.

Fatimah Muhammad: Natasha, thank you for taking the time to sit with me and talk about your journey in the healthcare revenue cycle and your amazing new company. Please tell us about yourself.

Natasha Schlinkert: I'm Natasha Schlinkert. I've been in healthcare administration and revenue cycle management for almost three decades. I started in insurance verification and authorization, scheduling appointments at the front desk of a doctor's office, and eventually moved my way up through supervisor, manager, director, VP over departments for hospitals and healthcare systems to Associate Chief Internal Auditor for five hospital healthcare systems. I held all kinds of roles from Director of Health Informatics, to COO for a few different RCM companies, and performed a lot of process improvement consulting, traveling all over the U.S. I looked at denial data and then watched the processes from beginning to end which allowed me to put together process improvement plans to better streamline and improve the entire process flow. I've always done that from a people standpoint.

About seven to eight years ago, I needed to build some kind of automation because we were experiencing such high volumes of low value tasks and the attrition was through the roof – we couldn't keep the staff! It was getting challenging for us to be able to get through all the volume. This led to me hiring a company out of India to help us build out the automation. The first time it was a mess because they didn't understand all the nuances of our healthcare system. Understanding automation was foreign to us so we ended up just tearing it down and starting over from scratch and learned a lot along the way. We became super involved in every aspect of creating the "if, then" logic, what workflows we want it to look at, what we want our business exceptions to be, and having a person handling it, et cetera.

So after doing that and having a great deal of success with millions of dollars in increased revenue and reduced overhead, we would move to the next company and do the same thing. This would continue with another company, and the more we implemented RPA, the larger the positive trend line became. So about three years ago I decided to start Innobot to bring automation to healthcare in a really meaningful and purposeful way.

Fatimah Muhammad: Wow! That is truly excellent, and I feel like it's just so right on time. It's very exciting to see that, especially as you are a woman in this healthcare artificial intelligence space, implementing something so significant in the industry and making it congruent with how we vocalize enhancing the revenue cycle. So, with that being said, being open to robotic processing can be a bit scary. Especially considering the times that we live in, regarding cybersecurity and protecting patient health information. How would you explain RPA to someone unfamiliar with the concept or a team that is experiencing challenges with staffing shortages and so forth? How would you explain to them the huge benefit factor of incorporating that into their organization?

Natasha Schlinkert: It's interesting because I get this question often since it hasn't been around forever, it is still new within the healthcare industry. The way that I describe it is that RPA is a series of mouse clicks and keystrokes placed in order, with "if, then" logic. So, imagine that you're training an employee to do a function. You're going to instruct them to double-click on this icon, and then you're going to get the username and password from this encrypted location and then navigate to a payor portal and enter the patient demographic and date of service information and these are the pieces of information we want from the portal and here are the fields we update in the practice management software.

We're just scheduling sets of mouse clicks and keystrokes and training the bot the exact same way that you would train a person to go through and perform these steps. It's so fast when it's running in the back end, it looks like a strobe light. Where a person would be able to perform 60 tasks in a day, the bot can do 60,000 in one day and so much more. We can clone a copy of a bot when volumes have surpassed what a single bot can complete and split the work between bots. It's imperative to know they are completely scalable.

When people say, it's going to take forever to try to write out the logic and think of all of the nuances, we should think of how many times we train staff and then they leave. Even though they do that "knowledge transfer" and we try to cross-train so that there are always other people there, a little bit of that knowledge kind of goes away. The sticky notes get thrown in the trash, et cetera. We've seen it over and over again in every organization.

Fatimah Muhammad: Nice, when I think of the bot being incorporated, I think of efficient processes. We are living in a timeframe where we're seeing more patients, providing more procedures, submitting more invoices or patient claims and having employees maintain the load is challenging. I feel like that is a significant need because how is an organization able to incorporate a significant number of FTEs to ensure that all these deliverables are carried out and you're maintaining the cash flow in an entity? That leads to my next question. How does the implementation phase of RPA or intelligent process automation help hospitals maintain a steady cash flow and adjust seamlessly? And also with this question, I want to put into perspective, that when a lot of people think of having a bot being incorporated into their organization, many may feel that they're not going to need people to be in these positions to work. So, if you could touch a little bit on that as well, regarding dealing with maintaining that steady cash flow and adjusting seamlessly, you can't do one without it impacting the other. How do you foresee the challenges of incorporating bots, which is phenomenal work that you are doing, but people are worried about their jobs and the integrity of the work? Yes, robots are more than capable, but there's also error that follows and they do have their own set of challenges, as with any potential human error.

Natasha Schlinkert: Yes. So, I will say to the end of time, healthcare is way too nuanced to eliminate humans forever.

If you didn't tell the system what to do when that pop-up comes, it's not going to do anything. The bots say, I don't have instructions on this, so it's going to throw a business exception or a failure. So, as we're going through, there's no way to think about every single scenario, but as we go through, we do a test. We say, okay, we've built this process, now let's take a fresh copy of the production database and put it into the test environment. The bot will run through every single one of these accounts, and then we're going to look at all of the exceptions and failures, and then we're going to write that processing in.

What would you tell a person to do? You're getting a fresh person who didn't learn a bad way of doing things from a different or previous employer and you're having to break those habits. They're not going to have a bad day because they had a breakup. They're not going to post about their peers on Facebook. They're not going to call in sick. So, these are where we have the opportunities to put those bot trainings in place, and they're not going to get a better offer somewhere else and leave you. Once it's built, it's built.

Fatimah Muhammad: I love that perspective. And that is a very pragmatic way of thinking when we think about why bots were created in the first place.

Let's take out the emotion and have something that's just going to be able to come in, do the job, process it, and not have to deal with all the other challenges or unnecessary bottleneck issues that can slow down processes, and work output. It does have its challenges, but they're far less than dealing with the human challenge. I love the way you put that, very well said.

So, let's shift to dealing with monitoring how that cash flow is brought back into an organization, the role that the bots play and what that percentage looks like. Since the healthcare industry is being subjected to the challenges of trying to increase their bottom line, whether that's with revenue, savings, or across all areas. So, when we are talking about the main chal-

lenges of the bot that healthcare providers face when it comes to insurance verifications, deductible monitoring, authorization, and Medicaid application, how does Innobot automation solutions address these challenges?

Now, with that question, I also would like for you to say what kind of percentage of return it looks like in regards to when you incorporate Innobot versus not. From what you've seen with your clients, what does that increase in revenue look like? What does that savings look like? How is it becoming an asset to that organization and why do you think every organization should incorporate it to increase that bottom line?

Natasha Schlinkert: Let's just talk about a couple of these processes that we put in place where we're talking about a reduction in overhead because as you have attrition, your employees leave, you won't need to replace them necessarily because you have some of these things automated. As you continue to grow, then, you're not going to have to continue to hire more employees. So, there's that cost reduction, in that if you're paying for automation, let's say that you're paying six cents per touch, that's the average.

Let's think about eligibility denial rates. The average denial rate is typically around 32% identifying that we're not getting the correct information upfront or we're not checking the eligibility or we're not checking it often enough. If we're not checking eligibility, what does that mean for the No Surprises Act? How can you possibly give a patient their calculated liability if you don't even know that their insurance is right? That's going to set up huge flags that you're going to get audited for not meeting the No Surprises Act legislation. And the easiest way to see that is, what is your eligibility denial rate? The insurance companies have all that information.

When you automate the RCM workflow and repurpose your staff to handling the exceptions, you're not going to miss the timely filing or appeal deadlines. That alone would certainly pay for your automation journey.

Fatimah Muhammad: Wonderful. I'm interested to see what this looks like incorporated into the pharmacy perspective or even a 340B space, but that's another conversation. I think it would be very impactful. So, you spoke a little bit about the compliance side of it, which is something that is needed. So how does RPA enhance accuracy, efficiency, scalability, and compliance in healthcare operations?

Natasha Schlinkert: Yes, when we are dependent on humans to look at all of these different aspects and believe me, I know we just went through SOC 2 (System and Organization Control 2 review). That was NO cake walk! It shows how many different things need to be monitored. So, having a person go and check, does the team have anything saved on their desktop versus in SharePoint or in an encrypted space on their laptops. So, you'd have to go and look, but you can train bots to go and log onto each computer and search for any PHI and can alert that. You can train bots to go and make sure that if a report falls below a certain percentage, it will send an alert to somebody. Previously I worked for a hospital that was under a corporate integrity agreement imposed by the OIG. One of the findings that resulted in a Corporate Integrity Agreement was that they had a lot of credit balances that were not being returned timely.

You have a certain amount of time to identify whether that credit belongs to the insurance or the patient and return those credits. You can't just hold onto them forever. The bot could say, hey, you have these credits that are getting ready to be outside of compliance. You might want to have somebody look at this stuff. Either a bot that can go through and identify who it belongs to and initiate the refund request process and have somebody approve them or a person to review them, but those are some of the scenarios where you can train a bot to do a lot of those quality audits where it would take an army of people to be able to look at every single component that needs to be looked at to make sure that we are staying compliant. They are all extremely important, so how do you choose which ones you're going to have people focus on and which ones you're going to let slide?

Fatimah Muhammad: I completely agree. And it is a lot.

So now we're going to segue into one of the areas that's very dear to my heart, which is dealing with population health management, because that covers an array of areas, whether it's social determinants of health, whether it's charity care patients, whether it's disease management for vulnerable populations. How does Innobot help healthcare providers with value-based care and population health management?

Natasha Schlinkert: Absolutely! I think that's a great question.

We have all of these different Healthcare Effectiveness Data and Information Sets (HEDIS) measures and Pay for Performance (P4P) measures, value-based care, and so when we look at, even from a human standpoint, the payers, even though they give you a gap report and a roster and all of those things, it's so crazy to me, most providers don't even pull their roster or their gap reports. They're just seeing patients. Those who are looking at them, you'll notice that they stay usually about 120 days behind.

If I treated the patient, Sally Smith yesterday, it's going to be 120 days before it shows on that gap report that I completed all her preventative care. So, when I'm getting paid $12 per member per month (PMPM), whether I see the patient or not, but if I meet tier four, which means that I'm seeing 75% of the patients for preventative care, then I want to pull that roster and look and see who have I not yet seen, who needs to have these services provided. So, what we did was create this automation that reads through the gap report, it pulls the roster, it pulls the charges, so I know who I've seen in the last 120 days that's not showing on that gap report yet, and then it creates a call list.

There are so many measures: for pediatrics you have nutrition and BMI, both of which can be done over telemedicine. So, you have a nurse practitioner or physician's assistant on Friday afternoons calling little Johnny's mom to ask if he has checked his weight. How are his eating habits, et cetera. So, you can meet some of those criteria. When you get to tier four instead of $12 PMPM, you're getting $38 PMPM because you're keeping your population of patients healthier. You are avoiding hospital stays. One, you're doing well in population health management and two, you're getting an increase per member per month of PMPM and three, you are proactively reaching out and saving money because it will tell you, here, patient Bob meets six of these measures. So, if you get Bob in, you're closer to being at a higher tier for every one of these six measures. Versus patient Joe that only meets one or two measures. So, Joe may not be as high of a priority on your call list. You want to get those call lists prioritized, get those patients in, and increase your PMPM.

Fatimah Muhammad: I couldn't agree more. How does Innobot leverage automation for data-driven decision-making in healthcare organizations?

Natasha Schlinkert: I think that's a really good question. There are many instances where we think bots cannot make decisions, we must have a person look at this. But it's not always necessarily true. When we look at KPI dashboards, that's how we make decisions a lot of times as VPs, COOs, CEOs, and CFOs, certainly like to see those KPI dashboards, those monthly and annual revenue reports. That's how we know what we're going to do or how we're going to do it. So, we use automation in decision-making and use bots in revenue decision-making by, for instance, checking claim status.

Do we want the bot to post the payment? Well, it depends on whether the finalized date on that claim status was yesterday, then probably not, because if there's a payment or denial that's going to be on an electronic remittance advice that comes in tomorrow, then it's going to be double posted if we have the bot post it today. Whereas if it was finalized three months ago, then we want to make sure the funds were received and post it.

Fatimah Muhammad: That's pretty awesome. Can you explain the benefits of implementing automated analytics in healthcare organizations? Because, if they're doing everything else, they might as well be doing healthcare analytics. So can you explain what those benefits are?

Natasha Schlinkert: We all know you can't manage what you can't see. If I could get all the hours back that I have spent pulling reports, doing the VLOOKUPS and match indexes, and creating charts, reports, and PowerPoints to present on these calls by department to the CFO, to the board of directors... If I could get all those hours back to spend with my daughter, I would do anything.

Fatimah Muhammad: I second that. I hated the days early in my career when I was doing a million VLOOKUPS in a day. Because these systems are not one-size-fits-all.

Natasha Schlinkert: I think everyone knows the pain because these systems are not one-size-fits-all. These EHR and practice management systems have reports, but some data fields are not in the available data tables. Each report only has two to three different data tables. So, if you want to get patient demographics and payment information, it's not possible without customized programming. Now imagine revenue cycle management companies. They have month-end reports for all their clients. Let's say you have clients and there are twenty different systems.

What we've done is create the bots to go and pull the charges, payments, adjustments, denials, AR, fee schedules, bad debt, appointment scheduling, literally everything, and then pull it all together. We know that one system calls it an encounter number, another system a billing number, and another system is a visit number or a hospital account record. So, as we have the bots pulling that information, then we create a mapping so that it can standardize the naming conventions, and you can have all of that pushed through a Power BI or Tableau, automate the data visualization, you've got all the data to back it up behind it, and you've now created a data source with all kinds of different reporting capabilities, and it's customizable. Now you get all those month-end reports, all those CFO reports, completed month after month without a person having to spend all those hours doing it.

Fatimah Muhammad: I love it. I pray for the day when we can just depend on that. The only thing a human being will be required to know is how to interpret it and present the data. Believe it or not, I think that's going to be much more of a challenge in the future than being able to create those processes. That is awesome. For our final question, what do you see as the future of RPA and automation in the healthcare industry, and how is Innobot contributing to that future? And if you, Natasha, are leaving that imprint on the forefront of this amazing organization that you've created to help the revenue cycle across this nation, what exactly would that final imprint be for you in this space?

Natasha Schlinkert: Oh, you know, I wrote my master's thesis paper on how robotic process automation can positively impact the percentage of the American GDP that is spent on just the administrative functions in delivering healthcare in America. So as for me, if I never get rich and I never get to buy that boat or whatever, you know, that big financial dream.

Fatimah Muhammad: You're buying the boat, Natasha.

Natasha Schlinkert: Hopefully one day… and you're invited! So, if maybe someday when I'm very old and all of my hair turns white, there is some paper article that is printed that says Natasha made an impact in the percentage of the American GDP spent in the administrative functions of delivering healthcare in the United States. I think that would be the imprint that I would want to leave. I think the future is here. Just like in the very beginning when we were offshoring to India, and there were so many who didn't want to adopt it. Now look, there's almost no way that you could keep your doors open if you had 100% onshore staff. I believe especially post-COVID, we're seeing the last few that clung to that onshore model have gone offshore. So, I think again, we're going to see the early adopters and we're going to see the few that are clinging to the way "we have always done it".

Unfortunately, I think they're going to be the few that are once bitten twice shy. So, they might go wrong with selecting the vendor and that vendor doesn't understand healthcare. Just like my first experience as a VP needing to find solutions and going to a company that just doesn't understand healthcare. I'm so glad that I didn't give up because I think my future would look very, very different from what it does now. I guess I would just want to encourage those who maybe didn't have a good first experience with automation. Don't throw the baby out with the bath water. Give it another shot. Understand that there are going to be challenges as with anything. We didn't decide we're not going to employ people because the first one didn't learn well, or showed up late every day or whatever it is. So, we continue to go down that path, and I think that we will see in the future that automation is as well accepted and widely adopted as back in the meaningful use days when we had paper charts and we had to go to a digital transformation. CMS provided all this money for meaningful use. They would pay you to go to an electronic medical record. Now it's unheard of that somebody is still documenting in a paper chart. We don't chisel in stone anymore. Automation will absolutely be there.

Fatimah Muhammad: Thank you so much, Natasha. I appreciate the fact that I even know someone as knowledgeable as yourself in this space, where many are so intimidated by it. Also, thank you for being able to incorporate something that is going to impact this nation's economy. This is what paves the way for enhancing the healthcare system in our country minimizing the debt that we have but ensuring that we create efficiencies and processes to have a positive revenue health cycle for every organization.

In a landscape where the intersection of healthcare and technology is increasingly vital, Natasha's forward-thinking approach exemplifies how embracing innovation can lead to tangible improvements in revenue cycle management. By championing the integration of artificial intelligence and robotic automation, Natasha is not only enhancing operational efficiencies but also paving the way for a more sustainable and resilient healthcare environment. Her work serves as a beacon of inspiration for industry professionals seeking to navigate the complex challenges of healthcare finance with confidence and ingenuity. Together, with leaders like Natasha at the forefront, the future of healthcare revenue cycle management looks brighter than ever before.

About the author:

Fatimah Muhammed has extensive experience in pharmacy, public health, and professional research while possessing an eclectic blend of interpersonal skills. She serves as the 340B Pharmaceutical Services Director at Saint Peter's University Hospital where she presides over all projects related to 340B. Her current endeavors focus on Health Disparities, Health Equity, Patient-Reported Outcomes, Community Health Promotion, and Disease Prevention and Health Services Research. She can be reached at fmuhammad@saintpetersuh.com.

SAVE the DATE

April, 17, 2024, 12pm-1:pm
NCI Edits: Highlights of 2024
Policy Manual Guidance & Modifiers
Free Lunch & Learn Webinar

April, 24, 2024, 11am-1:50pm
Emerging Topics in Healthcare Finance
Free Webinar courtesy of the FACT Committee

May 1, 2024
Annual Women's Leadership & Development Session
DoubleTree by Hilton Hotel Tinton Falls Eatontown

May 9, 2024 - All day
Annual Golf Outing
Mercer Oaks Golf Course
Princeton Junction, NJ

October 9-11, 2024
Annual Institute
Hard Rock Hotel & Casino, Atlantic City, NJ

Watch for updates on all of these events, or visit the Chapter website at hfmanj.org

HHS OIG Seeks To Re-Focus And Re-Educate The Healthcare Industry on The Importance of Effective Voluntary Compliance Programs

John W. Kaveney

by John W. Kaveney

On November 6, 2023 the United States Department of Health and Human Services Office of Inspector General (OIG) issued a new general compliance program guidance document.[1] It was published in accordance with the OIG's efforts "to produce useful, informative resources . . . to help advance the industry's voluntary compliance efforts in preventing fraud, waste, and abuse in the health care system."[2] This document is the first in an upcoming series of new compliance program documents the OIG will be issuing to the healthcare industry.[3] This general compliance program guidance document applies to all individuals and entities involved in the healthcare industry.[4] It will be followed up, beginning in 2024, with several industry segment-specific compliance program guidance documents that will be applicable to different types of providers, suppliers, and other participants in the healthcare industry and tailored to specific fraud and abuse risk areas for each industry subsector.

The OIG has always characterized its publications as "voluntary, nonbinding guidance." Moreover, its publications "do not constitute a model compliance program" nor are they "intended to be one-size-fits-all, completely comprehensive, or all-inclusive" of all considerations and risks for every organization. Nevertheless, providers, suppliers, and other participants in the healthcare industry would be wise to review and update their compliance programs consistent with this latest guidance document.

The OIG has always characterized its publications as "voluntary, nonbinding guidance." Moreover, its publications "do not constitute a model compliance program" nor are they "intended to be one-size-fits-all, completely comprehensive, or all-inclusive" of all considerations and risks for every organization.[5] Nevertheless, providers, suppliers, and other participants in the healthcare industry would be wise to review and update their compliance programs consistent with this latest guidance document.

The general compliance program guidance document consists of the following four sections, each of which contains valuable and helpful information and links to other important and informative materials. The following are some highlights of the information contained therein.

Healthcare Fraud Enforcement and Other Standards: Overview of Certain Federal Laws

This section of the document begins with an important disclaimer that "[t]his guidance does not create any new law or legal obligations, and the discussions in this guidance are not intended to present detailed or comprehensive summaries of lawful and unlawful activity."[6] Nonetheless, the discussion in this section provides a general working knowledge of applicable federal laws with which those in the healthcare industry should be familiar when developing a new, or re-examining an existing, compliance program.

In terms of substance, the OIG summarizes in this section

the federal anti-kickback statute and physician self-referral law along with identifying key questions to ask and elements to focus on when analyzing a particular arrangement under these laws.[7] It also highlights the False Claims Act along with the various civil monetary penalty (CMP) authorities, including the beneficiary inducements CMP, CMPs related to improper information blocking, and CMPs related to HHS grants, contracts, and other agreements.[8] This section also summarizes the mandatory and permissive authorities bestowed upon the OIG to exclude individuals and entities from participating in Federal healthcare programs.[9] Finally, the section notes the existence of the criminal health care statute and the HIPAA Privacy, Security, and Breach Notification Rules.[10]

Missing from this section of the document are any discussions of State fraud and abuse laws, which those in the healthcare industry must also be cognizant of as part of any compliance review. As noted above, while nothing contained in this section is new law, it serves as a helpful refresher of the various legal authorities upon which the federal government may utilize to pursue civil and criminal claims against providers, suppliers, and other participants in the healthcare industry.

Compliance Program Infrastructure: The Seven Elements

The next section of the OIG's general compliance program guidance document is a discussion of the "7 Elements of a Successful Compliance Program."[11] The OIG continues to believe that "an entity's leadership should commit to implementing all seven elements to achieve a successful compliance program."[12] The following are highlights from the OIG's discussion of each element:

- *Written Policies and Procedures:* Organizations should have a code of conduct along with compliance policies and procedures that are developed by the compliance officer in collaboration with the compliance committee. Both sets of documents should help foster the compliance culture. The OIG suggests that CEOs endorse in writing the compliance program and that applicable stakeholders review the materials at least annually to ensure that they are operationally effective.[13]
- *Compliance Leadership and Oversight:* Leadership must appoint a compliance officer and give the individual sufficient staff and resources to carry out all compliance responsibilities. Moreover, for organizations of sufficient size, there should be a compliance committee comprised of individuals that have received sufficient training along with a full understanding of the organization's expectations of them. Ultimately, the organization's board should provide oversight and ensure that both the compliance officer and compliance committee have both the power, independence, and resources to carry out their responsibilities and also that they are in fact carrying out their responsibilities using the tools and resources provided to them.[14]
- *Training and Education:* At least annually, training and education should be provided to members of the organization both on the general aspects of the compliance program and its efforts, along with more targeted training depending upon the individual's roles and responsibilities and any specific compliance risks related to them. Compliance training and education should be mandatory and a condition of continued employment.[15]
- *Effective Lines of Communication:* Open lines of communication between the compliance officer and entity personnel are critical to a successful compliance program. The specific means of communication to the compliance officer should be well known and posted in physical and virtual spaces. The OIG also emphasizes the importance of protecting whistleblowers against retaliation and ensuring that concerns brought to compliance be thoroughly vetted either by the compliance officer or other relevant individuals depending upon the circumstances of the communication.[16]
- *Enforcing Standards:* There must be well-established and consistently applied consequences for instances of noncompliance, and incentives for compliant conduct.[17]
- *Risk Assessments, Auditing, and Monitoring:* In recent years, the OIG, along with those in the healthcare industry, have placed increasing emphasis on the importance of conducting a formal compliance risk assessment on at least an annual basis. Risk assessments help focus compliance efforts in areas of greatest concern and there are a number of available tools, through the OIG and others in the industry, that can help with this task. Through the risk assessment, areas of concern can be identified to focus auditing and monitoring efforts as part of an annual compliance work plan. The scope of such efforts will depend upon the outcome of the risk assessment, along with staffing and resources available to the compliance department.[18]
- *Responding to Detected Offenses and Developing Corrective Action Initiatives:* Regardless of how comprehensive and diligent a compliance program, it is inevitable that potential concerns will be raised in connection with auditing, monitoring, or hotline calls. Effective compliance programs should have a well-defined investigation process, a set of guidelines for reporting specific types of misconduct to the government, and means to implement necessary corrective action initiatives to ensure such misconduct does not occur again in the future.[19]

Compliance Program Adaptations for Small and Large Entities

This next section of the guidance document discusses ways in which an organization can "right-size" their compliance program

to meet their entity's needs.[20] There is no one-size-fits-all compliance program and thus while the seven elements listed above are the cornerstone of an effective program, how they are implemented requires customization to a particular organization.

For small entities, the OIG recognizes they may face financial and staffing constraints. Small entities should still have either a compliance officer or compliance contact to ensure the entity's compliance activities are completed. Moreover, this individual should still have the ability to report to the board, or in the absence of a board, the owner or CEO. Small entities should still have written policies and procedures, though they may be able to avail themselves of more form template-based documents to minimize the time and expense of developing their own. Moreover, absent a formal disclosure program for compliance concerns, there should still be a user-friendly method to facilitate compliance communications. Finally, though they may not need to be as complicated or resource intensive, a compliance risk assessment should still be performed at least annually, and audits conducted at least annually in the areas identified of greatest concern during the risk assessment.[21]

The OIG also emphasizes the importance of large entities sufficiently scaling up their compliance programs to meet the greater needs of a larger organization. This means the need for entire compliance departments, staffed with individuals of varying skill sets, to meet the needs of the organization. Moreover, such programs require greater involvement from the compliance committee, which should consist of members from various operational components of the organization. Finally, the boards of such organizations should consist of appropriate subcommittees to ensure compliance matters are effectively addressed and resolved at the board level.[22]

Other Compliance Considerations

This final section of the guidance document highlights a few "important compliance considerations related to several generally applicable risk areas."[23] Health care providers, suppliers, and other participants should consider these categories as areas to focus upon when re-evaluating their compliance programs.

- *Quality and Patient Safety:* While most organizations treat quality and patient safety as separate and distinct from compliance, these areas have long been a focus of the OIG and Department of Justice. Many cases have been investigated and settled based upon the submission of false claims for care and thus the OIG notes that this will continue to be an area of focus. Consequently, it is important for quality and patient safety oversight to be incorporated into a compliance program. By doing so, compliance can assist in identifying potential areas of risk and alert the organization to such concerns.[24]
- *New Entrants in the Healthcare Industry:* There has been a significant increase in the number of new entrants into the healthcare industry, including technology companies, investors, and organizations that are providing "non-traditional services in health care settings (such as social services, food delivery, and care coordination services)." The OIG therefore cautions these new entrants to be mindful of the legal landscape surrounding the healthcare industry as business practices in other industries can create risk in health care of civil, criminal, and administrative liability. Moreover, the OIG notes that even existing healthcare entities are expanding into new areas of business and while they may generally be aware of the legal landscape, they should be cautious to pay particular attention to how the laws apply to their new ventures.[25]
- *Financial Incentives:* The OIG has made note of the "growing prominence of private equity and other forms of private investment in healthcare" and has raised concerns about "the impact of ownership incentives (i.e., return on investment) on the delivery of high quality, efficient healthcare." Thus, healthcare entities should carefully scrutinize such ownership arrangements. Similarly, close attention should also be paid to the payment methodologies being utilized to reimburse healthcare entities for items and services they provide. Understanding what payment incentives exist will help the organization identify areas of potential risk requiring greater scrutiny.[26]
- *Financial Arrangements Tracking:* The OIG notes that many healthcare entities, especially larger institutions, have significant volumes of financial arrangements and transactions. While it is important to ensure the terms of those agreements are in compliance with the Federal anti-kickback statute and physician self-referral law, it is just as important to ensure that there is "ongoing monitoring of compliance with the terms and conditions set forth in the agreements." In other words, compliance does not end when the deal is signed, but rather ongoing monitoring is also important to ensure the agreement is carried out consistent with those terms.[27]

The OIG concluded its new general compliance program guidance document by reaffirming the fact that "compliance is a dynamic process" and therefore it will be updating the document as new developments occur and new resources become available. In an effort to partner with industry stakeholders, the OIG welcomes submitted feedback to its email at Compliance@oig.hhs.gov.[28] It also appended a set of links to various OIG resources and processes to aid those in the healthcare industry with their compliance programs.[29] As we move further from the pandemic, and investigation efforts continue to ramp back up, health care entities should take this opportunity to reassess their compliance programs.

About the Author
John W. Kaveney is a partner in the Healthcare and Litigation Departments at Greenbaum, Rowe, Smith & Davis LLP, where he concentrates his practice on corporate compliance matters, information privacy and data security, and Medicare reimbursement matters, as well as general regulatory guidance and litigation. He can be reached at 973.577.1796 or by email at jkaveney@greenbaumlaw.com.

Footnotes

[1]https://oig.hhs.gov/compliance/compliance-guidance/
[2]Id.
[3]https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf
[4]Id. at p. 7.
[5]Id. at p. 8.
[6]Id. at p. 10.
[7]Id. at pp. 10-17.
[8]Id. at pp. 17-24.
[9]Id. at pp. 24-27.
[10]Id. at pp. 28-30.
[11]Id. at pp. 32-63.
[12]Id. at p. 32.
[13]Id. at pp. 33-37.
[14]Id. at pp. 37-46.
[15]Id. at pp. 46-49.
[16]Id. at pp. 50-52.
[17]Id. at pp. 53-55.
[18]Id. at pp. 55-59.
[19]Id. at pp. 59-63.
[20]Id. at pp. 65-74.
[21]Id. at pp. 65-70.
[22]Id. at pp. 71-74.
[23]Id. at pp. 76-80.
[24]Id. at pp. 76-78.
[25]Id. at pp. 78.
[26]Id. at pp. 79.
[27]Id. at pp. 80.
[28]Id. at pp. 90.
[29]Id. at pp. 81-88.

Photos from the Laundromat Joint Social with ACHE

Thanks to Our Event Sponsors

THE DUTCH MENTOR
PURE LEADERSHIP POWER™

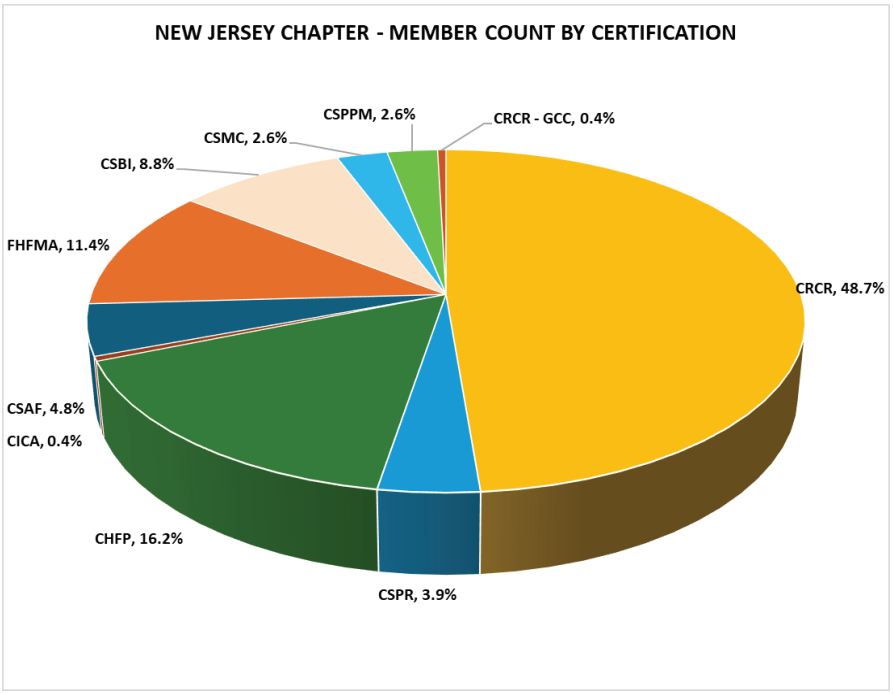
RSM

Medix HEALTHCARE

Optum

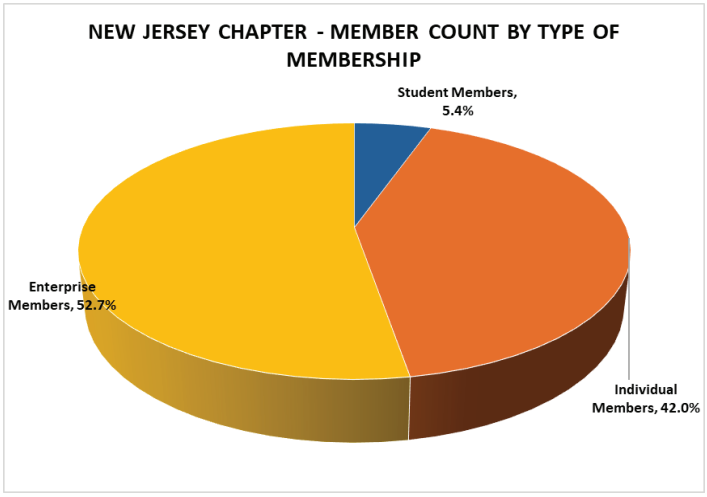

Medix
Optum

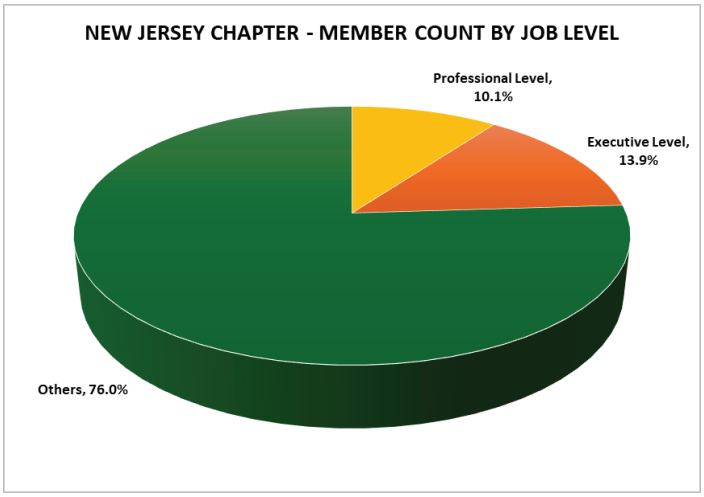
CERTIFICATION CORNER: WHO ARE OUR MEMBERS?



Legend:

CHFP	Certified Healthcare Financial Professional
CICA	Certified Inpatient Coding Auditor
CRCR	Certified Revenue Cycle Representative
CRCR - GCC	Certified Revenue Cycle Representative - GCC
CSAF	Certified Specialist Accounting & Finance
CSBI	Certified Specialist Business Intelligence
CSMC	Certified Specialist Managed Care
CSPPM	Certified Specialist Physician Practice Management
CSPR	Certified Specialist Payment & Reimbursement
FHFMA	Fellow of HFMA





•Focus on Finance•

Medical Practice Accounting 101: Understanding Your Financial Statements

Ana Costa

By Ana Costa

Q. What should I know to get familiar with my financial statements?

A. The two most basic financial statements are the balance sheet and income statement. In medical practice accounting, most practices use the cash-basis method of accounting. Under the cash-basis method of accounting, revenue is not recognized until it is received, and expenses are not recognized until they are paid.

The balance sheet will present the assets, liabilities and owners' equity for a specific date. Assets are the economic resources owned by the practice, including cash, equipment, furniture and fixtures, vehicles, leasehold improvements and security deposits. Liabilities are the debts or other obligations of the practice. Debts are usually classified as short-term or long-term. Short-term liabilities are those due and payable within one year. Owners' Equity represents the residual financial interest in a business, think of this as the net worth of the business. Owner's Equity will fluctuate based on three factors: performance of the practice (income or loss), contributions (monies or assets brought into the business) and draws (distribution of profits).

The income statement reports both revenues and expenditures for a specified reporting period, this could be monthly, quarterly or annually. Revenues can consist of patient services collected and sales of tangible goods. Expenses are the operating expenses related to running the practice and providing services. Other Income or Other Expenses are those items that do not stem from the ordinary course of business. An example would be an insurance payout from a business interruption policy. Another example would be interest income received from a business savings account.

Q. How should I review these numbers to make sure they are accurate to the activities of my practice?

A. You want to compare current periods to prior periods.

Most fixed expenses will be the same month over month. For example, rent, utilities, insurance and salaries. You want to look at any large or unusual fluctuations month over month.

Any unusual increase or decrease in expenses should be investigated. It could be duplicate payments to a vendor or missed payments to a vendor. There could be misuse of supplies. There might be a capital expenditure that may be coded to the income statement instead of the balance sheet.

Most businesses look at profitability as the revenues collected less the expenditures made during a period. Some of these expenditures could be operating expenses, which would go on the income statement, while others could be capital expenses that are reported on the balance sheet. So, while it may look like the practice generated some net income, that doesn't necessarily mean that you will see that profit in the bank account. Another item that most people forget to consider in healthcare accounting is the repayments of loans. This cash outflow is reflected on the balance sheet therefore it does not impact your income statement and bottom line, but it is money coming out of the business.

Q. What other reports should I be reviewing?

A. Other reports that must be reviewed on a periodic basis are the accounts receivable aging and accounts payable aging. Knowing that submitted claims are being paid and collected in a timely fashion is vital to your medical practice profitability. While reviewing your accounts payable, you should see if it's accurate and that the bills listed are still outstanding and not duplicates while ensuring that you are taking advantage of any net term discounts.

Understanding your medical practice's financial statements

is critical to evaluating the performance of your medical practice. Reading and analyzing financial statements may not have been something you anticipated to be in the job description, but obtaining these skills will lead to better decision-making for your practice. By building a team of trusted advisors that can help navigate you on the ins and outs of financial reporting, you are one step closer on your path to success.

About the author
Ana Costa is Lead Consultant at Withum and can be reached at acosta@withum.com.

Spotlight on the Compliance, Audit, Risk and Ethics Forum

By Ryan Peoples and Fatimah Muhammad

Ryan Peoples

Fatimah Muhammad

Another active committee that is an integral part of the New Jersey Chapter and is also unique is the CARE (Compliance, Audit, Risk & Ethics) Forum. Formerly known as the Compliance and Ethics Committee, and before that the Internal Audit Committee, the CARE Forum offers members the opportunity to learn from experts through the presentation of educational topics as well as provide a forum for interactive discussion of emerging topics they deal with on a daily basis. Information on recent regulatory updates along with federal and state audit activities are often part of these discussions, allowing the members to learn from each other's experiences. Special thanks go to Fatimah Muhammad and Ryan Peoples, the Chair and Co-Chair of the CARE Forum, for taking the time to provide their insights into the focus and workings of the group.

How did you first become involved with the Chapter's CARE Forum?

Ryan: A leader in my organization thought it would be a good idea for my professional development to jump onto the CARE forum calls. I would participate and ask questions during the monthly meetings. The Chair and Co-Chair at the time then reached out to me and asked if I was interested in becoming a Co-Chair.

Fatimah: I first became involved with the Chapter's CARE Forum due to my extensive background in pharmacy, pharmacy revenue cycle, and 340B program operations. I was working under the Chief Financial Officer at Saint Peter's University Hospital, who has been a long-time member of HFMA and past New Jersey chapter president, and he thought it would be a great idea for me to join the HFMA New Jersey chapter. I realized that by sharing my expertise I could benefit other HFMA members by educating them on pharmacy compliance and revenue cycle and programs that have the potential to enhance hospital revenue and savings while ensuring compliance, audits, risk management, and ethical practices. Notably, the New Jersey chapter lacked members who were hyper-focused on pharmacy and addressing social determinants of health, which are now crucial topics of discussion. Given the importance of these aspects in healthcare management today, it was a clear decision for me to get involved.

Tell us a little about yourselves, such as what you do in your daytime job, and how you like to spend your off hours. Is there anything you'd like to share with our readers?

Ryan: I am the Compliance Manager for a not-for-profit healthcare system in southern New Jersey. In my spare time I like to run, hike, fish, travel, watch sports and spend time with my wife and dog. Additionally, I am expecting to become a father in the spring.

Fatimah: Currently, I hold the position of Director for 340B Pharmaceutical Services and Drug Reimbursement at Saint Peter's University Hospital. I created and am responsible for leading the Intern program, an initiative aimed at nurturing the healthcare leaders of tomorrow. I am also a member of the OPIOD Task Force. Outside of work, my time is devoted to my family and various interests as well as volunteer initiatives that I am very passionate about. I enjoy playing tennis, running, working out, reading, and listening to our daughter play the piano. Additionally, ice skating and painting with our daughter, and exploring art exhibits in our vibrant city are activities that always bring me joy.

The NJ Chapter is unique in that it provides educational content through its various Forums. How would you explain the value to our members of active participation in one or more Forums to someone new to the Chapter?

Ryan: There is substantial value in attending and participating in the various forums. Best practices are shared and current topics are discussed. Every organization is different, but every organization has to abide by the same rules and regulations enforced by the government. Listening to what other organizations are concerned about and what practices they are doing to mitigate their risks brings a lot of value to your organization.

From a personal development perspective, the forums are

a great way to network, share experiences and to gain a better understanding of current practices and risks in healthcare finance and compliance.

Fatimah: Active participation in the various Forums offered by the HFMA New Jersey is extremely valuable for members. By engaging in these Forums members have the opportunity to access educational content, network with industry professionals, share best practices and stay updated on the latest trends and developments in healthcare finance. Participation allows members to broaden their knowledge, gain insights from peers, and enhance their professional growth. It's impossible to grow without continuously learning and being actively involved in the Forums can help members stay informed, connected, and successful in their careers within the healthcare finance industry.

How long have you been an active member of the CARE Forum?

Ryan: I have been co-chair for two years and have been active with the forum for 6 years.

Fatimah: I have actively participated in the CARE Forum for six years. I started as a member and eventually became the Chair.

Please describe the normal agenda used on your Forum calls. Are guest speakers invited to present?

Ryan: The usual agenda consists of an HFMA update and a roundtable discussion which encompasses general Compliance, Audit, Risk, and Ethics concerns within healthcare. Occasionally we do invite guest speakers to cover hot topics in the ever-changing world of healthcare compliance.

Fatimah: The normal agenda for the CARE Forum calls typically includes a mix of activities aimed at fostering learning, networking, and collaboration among members. Guest speakers are often invited to present on various topics of interest, bringing their expertise and insights to the Forum. These renowned speakers help in sharing valuable knowledge and perspectives with the members.

In addition to guest speakers, round table discussions are held on hot trending topics within the compliance, audits, risks, ethics, and the healthcare finance industry. This allows members to engage in open dialogue, share their experiences, insights, and challenges and learn from one another. The round table discussions provide a platform for brainstorming, problem-solving, and exchanging best practices.

Does the Forum leadership act as a clearing house providing updated information on relevant topics to the members?

Fatimah: Yes, we as CARE Forum leaders serve as a clearinghouse by providing updated information on relevant topics to its members. Through effective communication channels, the leadership ensures that members stay informed about the latest trends, developments, regulations and best practices in healthcare finance. By acting as a central hub for information dissemination, the leadership helps members stay current and well-informed in their professional practice.

Does the Forum provide an annual update either at an in-person meeting or virtually that's promoted to all Chapter members? How is that event planned?

Ryan: Historically, the CAREs forum has provided a virtual education opportunity, where participants will be able to listen to guest speakers and receive CPE credits.

Fatimah: During my tenure, we have conducted the education sessions as webinars with the anticipation of having an in-person education session in the future. Unfortunately, since the pandemic, getting a positive in-person turnout has been a challenge. We plan to get back to conducting the CARE education session in-person annually.

The annual update event is typically promoted to all Chapter members through multiple channels, such as forum announcements, emails, social media posts and word of mouth. The event planning process involves coordinating with guest speakers, securing a venue (for in-person events), setting the agenda, and managing registrations. The leadership team works together to ensure that the event provides valuable insights, fosters networking opportunities, and meets the educational needs of the members.

Is there anything additional you'd like to say related to your experiences with the CARE Forum and/or HFMA New Jersey in general?

Ryan: The forum is a great way to stay up to date with current topics. It is challenging for everyone to stay up to date with all the potential risks to our organizations. The roundtable discussions and guest speakers give you insight into potential risks that might not have been on your radar. Also, best practices are shared and it is a great way to network with individuals who have similar day-to-day tasks and challenges.

Fatimah: My journey within HFMA New Jersey has been quite remarkable. Dedication and active involvement in various capacities, such as moving up to a board position, mentoring new members, presenting for HFMA numerous times and being very involved with the CARE and FOCUS committees have truly exemplified my commitment to the organization and the healthcare finance profession. My leadership, expertise, and willingness to share knowledge have not only contributed to the growth of HFMA New Jersey but have also inspired and

continued on page 42

Spotlight on the Payer and Provider Collaboration Commitees

By Tracy Davison-DiCanto

Tracy Davison-DiCanto

The New Jersey Chapter has an active committee that allows for interaction between the provider and payer communities, which is one of the unique vehicles available to our members that you might want to consider based on your responsibilities and job function. Formerly known as the Managed Care Committee, the revitalized Payer and Provider Collaboration Committee (P2C2) provides an opportunity for participants from both sides of the aisle to openly discuss areas of common interest, leading to enhanced understanding of the constantly changing dynamics of the healthcare revenue cycle. A special thanks is due to Tracy Davison-DiCanto, Chair of P2C2, for taking time to answer these questions regarding the operations of P2C2.

How did you first become involved with the Chapter's Provider Payer Collaboration Committee (P2C2)?

I have been a part of the P2C2 committee since it began. I most recently have been chair of the committee for the 2022-23 and 2023-24 chapter years.

Tell us a little about yourselves, such as what you do in your daytime job, and how you like to spend your off hours. Is there anything you'd like to share with our readers?

I am currently the VP, Strategy & Payer Engagement for our Health Innovation Value Enterprise (HiVE) at SCA Health. In my role, I work with independent physician practices on the expansion into risk-based models of reimbursement in partnership with payers, Care Delivery Organizations (CDO's), Accountable Care Organizations (ACO's), Clinically Integrated Networks (CIN's), etc. I have also previously served as the NJ HFMA Chapter President and Regional Executive for Region 3. In my off hours I love spending time with my family, supporting my daughters with their softball teams and going to my husband's band gigs.

The NJ Chapter is unique in that it provides educational content through its various Forums. How would you explain the value to our members of active participation in one or more Forums to someone new to the Chapter?

There are a number of key value drivers for active participation in a forum in our Chapter. The forums provide an avenue for members to share insights and expertise with each other. By actively participating in discussions, members can gain knowledge from their peers which helps them stay updated in best practices, emerging ideas and industry trends. Another key opportunity that comes with participation is the opportunity to network. Our forums allow members to connect with fellow professionals in their field and these could lead to job opportunities, collaborations and partnerships. As we all know, building a strong professional network is essential for career development and growth. Immersing in one of our forums also provides a great opportunity for professional development. Members can share their success and challenges and gain insights to enhance their skills. It also provides an opportunity for progression in leadership roles within the Chapter and a potential track to increase involvement through the Board or National levels. One other key opportunity is to leverage the forums to solve problems. Advice and guidance from peers discussed in the forums could assist in overcoming challenges or obstacles in their work or personal lives.

How long have you been an active member of P2C2?

I've been a member of the forum since it was started.

Please describe the normal agenda used on your Forum calls. Are guest speakers invited to present?

For our forum, our agenda provides an update from key leaders at the NJHA (New Jersey Hospital Association) and NJAHP (New Jersey Association of Health Plans) and then has a number of speaker presentations as well as roundtable discussions.

Does the Forum leadership act as a clearing house providing updated information on relevant topics to the members?

The Forum provides current information on hot and relevant topics to its members including news and scholarly articles, white papers and industry insights.

Does the Forum provide an annual update either at an in-person meeting or virtually that's promoted to all Chapter members? How is that event planned?

continued on page 42

continued from page 40

guided future young healthcare leaders nationwide. As a result of my teamwork and efforts, I was honored by the chapter with the President's Award in 2023 for my contributions. I do not doubt that my continued engagement will have a lasting impact on shaping the healthcare finance landscape.

I look forward to sharing more about my experiences and contributions within HFMA New Jersey as I continue to play a pivotal role in educating and empowering future healthcare leaders of tomorrow.

For more information about the CARE Forum, as well as the other committees and forums provided by the New Jersey Chapter, be sure to visit our website at https://www.hfma.org/chapters/region-3/new-jersey/.

---

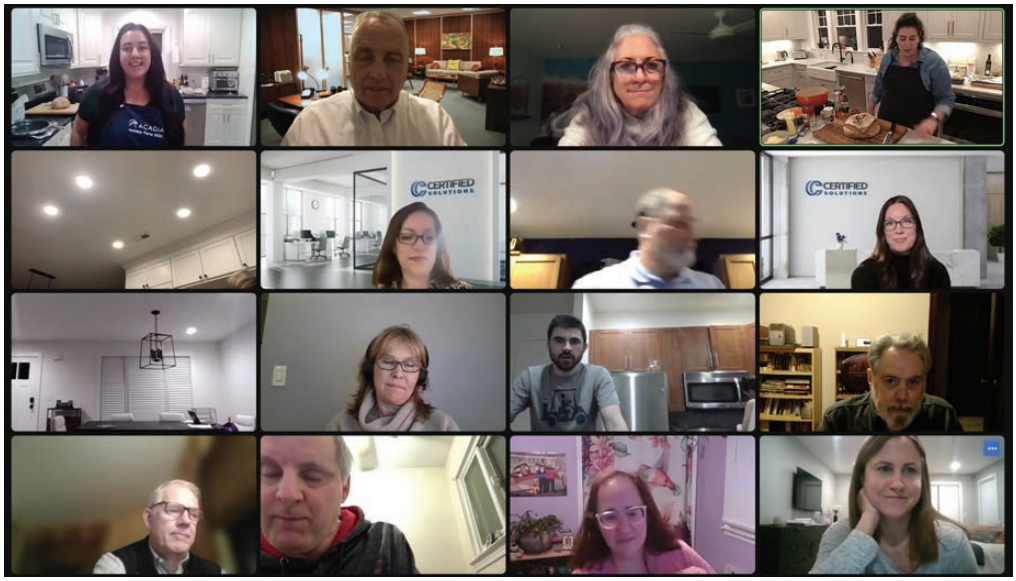
continued from page 41

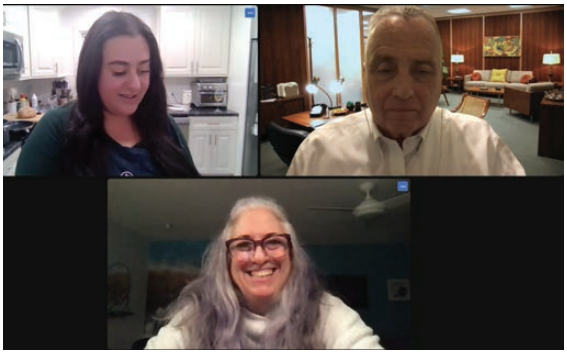
We currently do not host an annual update either in-person or virtually at this time but if there was interest the Forum would happily coordinate an event.

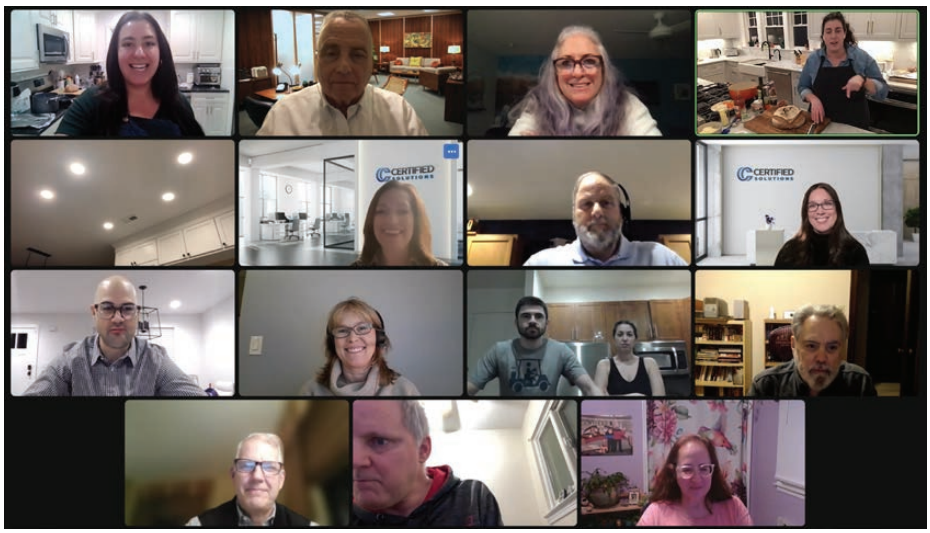
Is there anything additional you'd like to say related to your experiences with the P2C2 and/or NJ HFMA in general?
I'd encourage you to join a Forum to truly get the best experience and value from your local NJ HFMA membership. You never know where the relationships you establish both professionally and personally will take you! I personally have had career opportunities as well as 20+ year friendships from my involvement in the chapter and have a deep appreciation for the value that HFMA can drive if you take advantage of what is available.

For more information about P2C2, as well as the other committees and forums provided by the New Jersey Chapter, be sure to visit our website at https://www.hfma.org/chapters/region-3/new-jersey/.

NJ HFMA Superbowl Virtual Cooking Class with Jeanette Donnarumma from the Rachel Ray Show








Jacid Soto
Excellent thank you so much

HFMA NEW JERSEY PRESENTS

2024 Golf Classic

Thursday, May 9, 2024

11:30 AM - REGISTRATION, LUNCH BUFFET

1:00 PM - SHOTGUN START

3:30 PM - GOLF CLINIC

5:30 PM - COCKTAIL HOUR, HORS D'OEURVES, DINNER WITH OPEN BAR

Mercer Oaks Golf Course
West Windsor, NJ

Registration

- Please register online at www.hfmanj.org
- Payments, can be made with credit card on the website or with check by mail. Mail checks to: Laura Hess, HFMA-NJ Chapter, PO Box 6422, Bridgewater, NJ 08807
- Registrations or Cancellations must be received by May 2, 2024.

Registration Fees

- GOLF* $400
- COCKTAIL HOUR & DINNER ONLY $150
- FOURSOME* $1600
- FOURSOME & TEE* $1800
- GOLF CLINIC** $200

Includes Lunch Buffet, Refreshments & Snacks on the Course, Cocktail Hour & Open Bar, Dinner & Raffle Prizes.

***Includes Cocktail Hour & Open Bar, Dinner & Raffle Prizes.*

SPONSORSHIP OPPORTUNITIES

- GOLF CARTS $2000
- BAG TAGS $1750
- DINNER CO-SPONSOR $1500
- LUNCH CO-SPONSOR $1500
- COCKTAIL PARTY CO-SPONSOR $1500

  ONE COCKTAIL SPONSOR AND ONE SIGNATURE COCKTAIL SPONSOR
- BEVERAGE CART CO-SPONSOR $1000
- DRIVING RANGE CO-SPONSOR $500
- PUTTING GREEN CO-SPONSOR $500
- CONTESTS $500

  CONTESTS TO BE DETERMINED, CONTACT NJHFMA@AOL.COM FOR DETAILS
- GIVEAWAYS $500

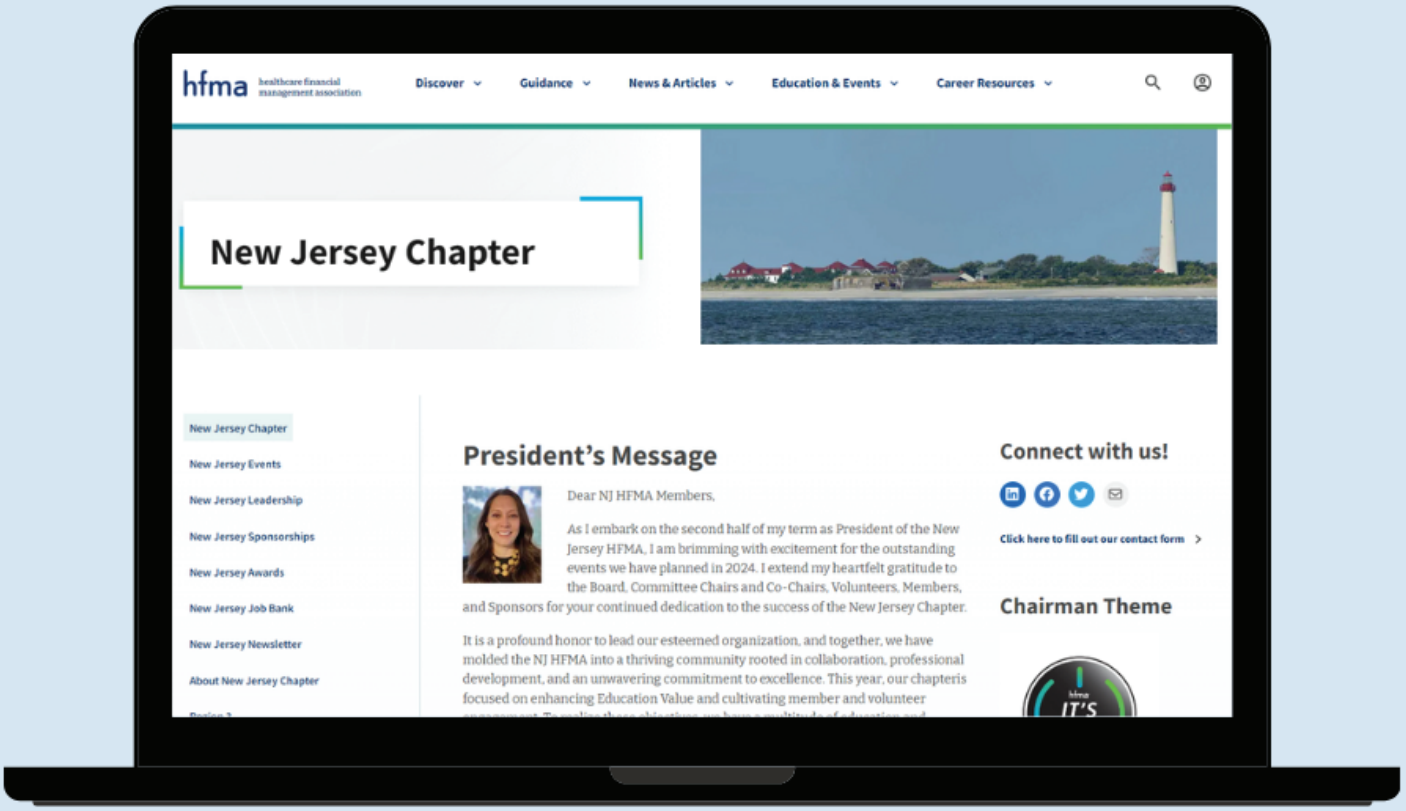
  SPONSORS TO PROVIDE, CONTACT NJHFMA@AOL.COM FOR DETAILS
- TEE SPONSORSHIP (EACH) $250

Check Out Our New Website!

HFMA New Jersey has transitioned to a new website to align with the Association, other chapters and regions.

HFMA New Jersey specific content can be accessed using the buttons on the left side of the home page.

Buttons across the top will provide access to the Association's website. A login may be required to access some features.



WWW.HFMA.ORG/CHAPTERS/REGION-3/NEW-JERSEY/

Need to Get Your Name Out There?

CONSIDER TAKING OUT AN AD IN THE GARDEN STATE FOCUS!

THE AWARD WINNING MAGAZINE IS PUBLISHED FOUR TIMES A YEAR AND REACHES MORE THAN 1,000 OF OUR MEMBERS IN THE HEALTHCARE COMMUNITY

CONTACT NJHFMA@AOL.COM FOR MORE INFORMATION

To view our most recent publications visit: www.hfma.org/chapters/region-3/new-jersey/newsletter/