Greetings! It is surreal to be writing this message for the first edition of the 2012-2013 KY HFMA's newsletter. As I assume the president’s role of one of the most fun and energetic chapters within HFMA; our chapter representing the State of Kentucky unbridled spirit finished one of its best years under the award winning leadership of Chris Woosley.

What do I mean by award winning? Well, from May 1st through April 30th each HFMA Chapter’s performance is measured by the Chapter Balance Score Card (CBSC). The metrics are approved by the Regional Executive Council on an annual basis with Chapter reporting requirements, education hours, number of certification exams passed, membership growth and retention. The data collection structure provides a foundation for effectively managing chapters by recording chapter activities and its design provides incentive and recognition to chapters for meeting their goals. At the Annual National Institute (ANI), awards are presented to Chapter’s in the areas of education, membership, and certification. In the spirit of the Summer Olympics it is with great admiration to report our Past President Chris Woosley brought home the following awards:

- Award of Excellence for Education: John M. Stagl Silver Award
- C. Henry Hottum Award for Education Performance greater than 6.0% increase over prior year
- Award of Excellence for Membership Growth and Retention: Gold
- Award of Excellence for Certification: Bronze

Another way excellent chapters are recognized is for their effort in process improvement and sharing ideas with other chapters is The Helen M. Yerger Special Recognition Award. “Yerger” awards traveled home to the KY Chapter:

- Education: "Showing Providers the Love" - 27% increase in provider attendance
- Innovation: “Bringing Education to You” - education offered via a live webcast
- Member Service: “KY HFMA ‘First Responders’” - MCO Medicaid panel
- Multi-Chapter: 2011 HFMA Tri-State event Fall Institute and Vendor Show

THANK YOU Chris for your leadership through the years, guidance and friendship. Congratulations on an outstanding year 2011-2012!

Now on to the current HFMA year 2012 - 2013. The theme established this year by the HFMA National Chair, Ralph E. Lawson, is “Leadership Matters.” He states, “Leadership Matters conveys the idea that we are all accountable for the fulfillment of our organizations’ missions. In today’s challenging healthcare environment, all stakeholders should take the initiative to help lead our industry toward a better future.” KY HFMA has created a new Volunteer Committee this year which provides anyone the opportunity to participate, learn, and share ideas. The current Leadership team installed at the Spring Institute will uphold our promise to guide the chapter into the future in one of the most exciting and challenging times in our industry’s history. I’m very excited about the entire leadership team and hope you will consider joining us and input your ideas so we can provide the best education that our members deserve.

I think back as to why I joined HFMA and interestingly enough it remains the same reason I renew my HFMA membership each year. HFMA offers education on current healthcare trends, is a connection to key industry decision makers, and additionally for me, invaluable friendships across the state and other chapters that I will forever treasure. It is a great privilege and honor to serve as the President of the HFMA KY Chapter for 2012-2013.

Thank you for allowing me to serve,
Theresa Scholl
The Clock is Ticking on Readmission Penalties
Author: Mark Aspenson, CEO, Avery Telehealth and Sunil Hazaray, COO, Avery Telehealth, Scottsdale AZ

Hospitals should focus on three areas where poor performance is contributing to high numbers of Medicare readmissions: execution of the discharge plans, patient education, and coordination of post-discharge care.

At a Glance
Hospital leaders who are considering initiatives to reduce readmissions by improving discharge processes and post-discharge care should begin with five action steps:

- Ascertain the hospital’s Medicare 30-day readmission rates from July 1, 2011, to June 30, 2012.
- Based on these numbers, estimate the potential readmission penalties the organization may face.
- Identify a clear strategy or program for the organization to reduce 30-day readmissions and avoid Medicare penalties.
- Determine the overall direct and indirect costs of this strategy or program.
- Calculate the potential ROI of the initiative.

Beginning Oct. 1, the Centers for Medicare & Medicaid Services (CMS) will penalize hospitals whose readmission rates for congestive heart failure (CHF), acute myocardial infarction (AMI, or heart attack), and pneumonia exceed the national average by withholding a percentage of these hospitals’ total Medicare payments. Major insurers are following suit, announcing penalties for preventable readmissions.

Medicare spends $17.4 billion a year on readmissions, according to a study published in the New England Journal of Medicine (Jencks, S., et al., “Rehospitalizations Among Patients in the Medicare Fee-for-Service Program,” April 2009). Research by Thomson Reuters indicates that a hospital with Medicare inpatient operating payments of $250 million per year will face penalties amounting to $2.5 million if its readmission rates for CHF, AMI, and pneumonia exceed the national average by 1.4 percent (Healthcare Reform: Pending Changes to Reimbursement for 30-Day Readmissions, Aug. 31, 2010). The effect on hospitals will be more severe if its private insurers impose penalties of their own.

An example of readmission rates for an actual 300-bed hospital compared with the national average can be seen in the exhibit below. Hospitals can view similar data on their readmission rates on the Hospital Compare website.
Why Readmissions Occur

Activities related to patient discharge—including the level of patient education provided regarding the discharge plan, execution of the discharge plan, and coordination of care after discharge—can be strong predictors of whether a patient will be readmitted to the hospital. When an avoidable readmission occurs, it can often be pinpointed to one of three failures in the patient discharge and post-care process. By taking a close look at these three primary reasons for avoidable readmissions—and developing preventive action around these categories—hospitals can begin to prevent such readmissions and protect patient safety as well as revenue.

Poor execution of the discharge plan. All patients who are discharged from hospitals are given discharge instructions—but whether these instructions make it out of the plastic “personal belongings” bag provided by the hospital is another story. According to the Agency for Healthcare Research and Quality (AHRQ), a lack of communication and care coordination after discharge increases the potential for medical errors and adverse events that may result in rehospitalization (Kripilani, S., “Care Transitions: Perspective,” December 2007).

For example, the patient’s primary care physician may not be aware that the patient was hospitalized. The patient may lack the transportation necessary to keep a postdischarge appointment with his or her physician—or the patient may not even have a primary care physician. According to a study published in the *New England Journal of Medicine*, fewer than 50 percent of the patients studied had visited with their primary care physician prior to readmission (Jencks, S., et al., “Rehospitalizations Among Patients in the Medicare Fee-for-Service Program,” April 2009). This is a significant—and modifiable—risk factor for readmission.

In the case of AMI patients, cardiologists may rely on primary care physicians to provide timely follow-up care, so that opportunities to alter patient’s care management plans based on their health status after discharge may be missed (National Healthcare Quality Report, 2010). Patients with pneumonia, for example, who do not meet Medicare homebound requirements for home health care may feel as if they have to “fend for themselves” upon discharge. When these patients experience side effects to their medications, they are more likely to stop taking the medications altogether, increasing the risks of reoccurrence and readmission.

Lack of patient education. Patients all too frequently mismanage their own postdischarge care for three reasons:

- They face challenges with their medications.
- They do not understand the nature of chronic conditions.
- They do not know who to call with questions regarding their health.

Studies show that 19 percent of Medicare discharges are followed by an adverse event within 21 days. Two-thirds of these adverse events are preventable drug events (Report to the Congress: Promoting Greater Efficiency in Medical Care, MedPac, 2007). When a patient is knowledgeable about the drug therapy that has been prescribed and has access to adequate outpatient medication reconciliation, the risk of drug duplication or adverse drug interactions is decreased (National Healthcare Quality Report, 2010). Adequate post-discharge management of high-risk medications, in particular, is an effective approach to reducing the risk of readmission (Allaudeen, N., et al., “Redefining Readmission Risk Factors for General Admission Patients,” *The Journal of Hospital Medicine*, February 2011).

Due to staffing challenges and discharge timing in the hospital setting, attempts to educate patients regarding medications during the discharge process may not be sufficient, particularly because patients are often overwhelmed with information on the day of discharge. Once patients have been released, our current healthcare delivery system does not foster further patient education. Primary care offices have limited time or resources to educate patients about their medications and chronic conditions, while changes in payment have led home health agencies to focus on a “teach and street” approach. Consequently, patients who have been discharged often do not understand the early warning signs that warrant a call to a physician or home health nurse—knowledge that could help prevent readmission or a trip to the emergency department.

Poor coordination of postdischarge care. There is a strong correlation between 30-day readmission rates and nursing home stays. When the quality of nursing home care or care from home health agencies does not meet a patient’s needs, or when a patient does not have appropriate access to primary care, these factors drive rates of both admission and readmission. Inadequate care after discharge is often a result of a lack of care coordination (e.g., the hospital may fail to share a list of the medications prescribed to a patient upon discharge with the patient’s primary care provider).
**Action Steps for Hospitals**

Hospitals can pursue several strategies to reduce hospital readmissions related to these three areas. For example, strategies related to improvements in care coordination, patient coaching before and during an inpatient stay, and telehealth have been identified by the Healthcare Intelligence Network as three ways to reduce readmissions and improve the patient experience (see the exhibit below).

![13 Strategies to Help Prevent Hospital Readmissions](image)

**Revamping discharge processes.** Programs that have proven to be effective in tightening the execution of the discharge plan in hospitals are not always effective in ensuring the plan is followed when the patient returns home or is admitted to another healthcare facility. Improving the quality of patient education and postdischarge care through initiatives such as Project BOOST (Better Outcomes for Older Adults through Safe Transitions) and Project RED (Re-Engineered Hospital Discharge) originated in the hospital setting. Project BOOST is a national initiative developed by the Society of Hospital Medicine to improve the quality of postdischarge care. Under Project RED, a nurse discharge advocate follows 11 specific steps that have been proven to improve the discharge process and reduce preventable readmissions.

**Using coordinated care models.** Coordinated care models are designed to provide interdisciplinary care coordination to high-risk chronically ill patients. Some models target time-limited postdischarge care for patients transitioning to different care settings, while others offer longitudinal care that can extend for months or years, or until a patient is deceased or can no longer live at home or in the community. These models are designed to monitor and assess a patient’s health status, educate the patient about managing his or her condition, and manage services.

For example, the Transitional Care Model, in which the patient’s home is the primary setting for care and advanced practice nurses coordinate care, and the Care Transitions Program, administered by the CMS Innovation Center, generally aim to provide the following:

- Improved care coordination between the hospital and posthospital settings and providers
- Enhanced education of patient and family caregivers
- Follow-up monitoring of a patient’s health status after discharge
- Care from a transitional coach or team to manage clinical, psychosocial, rehabilitative, nutritional, and pharmacy needs after discharge

These programs address the three causes of readmissions discussed previously.

Continues on page 5
Adopting home-based primary care. This model provides longitudinal primary care and care coordination in the home for patients with complex, chronic, and often progressive diseases who have problems with daily living activities. Home-Based Primary Care (HBPC), operated throughout the state of Virginia, offers physician-led, interdisciplinary care (including care provided by physicians, nurses, pharmacists, rehabilitation therapists, psychologists, dietitians, and social workers) to frail, older veterans. Many of these veterans have multiple chronic illnesses, such as heart disease, diabetes, heart failure, cancer, chronic lung disease, and dementia. On average, care is delivered in the home three times per month to HBPC-enrolled veterans, with veterans remaining in the program for roughly one year. Veterans are not required to be strictly homebound or to require skilled nursing care to receive HBPC services. This type of program addresses the lack of coordination of post-discharge care.

Implementing medical homes. A medical home model of care provides patients with access to a personal primary care physician or specialist and an administrative team that coordinates and facilitates care and provides guidance. Integrated health care is expected to enhance patient adherence to recommended treatments and help avoid hospitalizations and unnecessary office visits, tests, and procedures. Medical home care models address the lack of coordination of postdischarge care that can lead to preventable readmissions.

Using home telehealth to coordinate care. Another option is home telehealth, which makes use of technology to enable continuous, remote care delivery or monitoring between a healthcare provider and a patient from the patient’s home. Home telehealth generally involves the collection and transmission of clinical and vital sign data through electronic information processing technologies, such as messaging devices. Home telehealth brings patients and providers in different—and sometimes remote—settings together for the collection of patient data to monitor patients’ health status and provide patient education. Home telehealth can be used as a component of care coordination to increase its effectiveness in certain circumstances.

The goal of telehealth is to reduce unnecessary hospital stays and avoid costly and debilitating complications from patient illness by facilitating continual interactions between physicians and patients. Telehealth monitoring of people with chronic conditions allows providers to identify acute episodes early and then target more affordable interventions in an outpatient setting. In one study, hospitalizations among patients with congestive heart failure who were monitored by home-based telemonitoring were reduced by 43 percent (Cordisco, M., et al., “Use of Telemonitoring to Decrease the Rate of Hospitalization in Patients with Severe Congestive Heart Failure,” The American Journal of Cardiology, Oct. 1, 1999).

When coupled with care coordination provided via programs such as the Readmissions Avoidance Program, telehealth has the potential to address all three of the causes of readmissions discussed in this article. This approach provides the flexibility to determine whether patients who have a history of readmissions would benefit from telehealth.

The cost of telehealth programs should be an important consideration. In a study published July 25, 2011, by the Archives of Internal Medicine, the cost of an advance practice nurse to lead one hospital’s telehealth program was $1,126 per patient, but the approach reduced hospital costs by just $524 per patient (Voss, R., et al., “The Care Transitions Intervention: Translating from Efficacy to Effectiveness”).

The Value of Improved Discharge Care

HFMA defines value as quality divided by cost. In the readmissions scenario, value can be defined as the number of hospital readmissions reduced by a hospital within a given period multiplied by the DRG or payment rate of these readmissions. This is, in fact, the savings that Medicare or private payers will realize and is directly linked to efforts to improve the quality of care.
of discharge processes and post-discharge care by the hospital. The value increases in direct proportion to the number of readmissions saved by the hospital.

There are some factors that contribute to improvements in quality of care but that are not necessarily reflected in the above equation. We call these factors intangible values.

For example, a reduction in readmissions will provide greater access to care for other patients by freeing up beds. Reduced readmissions might also prompt a hospital to consider opening other service lines. And research has shown that readmissions that occur after patients have received intensive, postdischarge care and care coordination typically involve shorter lengths of stay than if such efforts had not taken place. This finding reflects an improvement in quality that will lead to reductions in hospital costs. Each of these benefits also has the potential to improve patient and employee satisfaction.

**Suggested Hospital Strategy**

Hospital leaders who are considering initiatives to reduce readmissions by improving discharge processes and postdischarge care should begin with five action steps:

- Ascertain the hospital’s Medicare 30-day readmission rates.
- Based on these numbers, estimate the potential readmission penalties the organization may face, understanding that penalties will increase to 3 percent of all Medicare payment by 2014.
- Identify a clear strategy or program to reduce the organization’s 30-day readmissions to avoid Medicare penalties.
- Determine the overall direct and indirect costs of this strategy or program.
- Calculate the initiative’s potential ROI.

Reducing preventable readmissions will significantly affect the bottom line and quality scores of hospitals as Medicare and other payers apply readmission penalties and publish data related to hospital readmissions—and will improve value for payers, purchasers, and the communities an organization serves.

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**The Budget Control Act: Implications for Medicare**

Author: Ken Perez, Senior VP and Director of Healthcare Policy, MedeAnalytics, Inc., Emeryville, CA

**At a Glance**

- The Budget Control Act of 2011 created a 12-member bipartisan congressional committee to develop proposed legislation aimed at reducing the federal deficit.
- When the committee failed to produce a bill, automatic across-the-board cuts were triggered that include cuts to Medicare.
- The Medicare cuts would be covered by reduced reimbursements to hospitals.
- If Congress does not vote to override the automatic cuts, they will take effect on Jan. 2, 2013.

History is littered with peace treaties that were not implemented. Add to that situation unhealthy doses of incompetence, inconsistency, and bickering between the would-be peacemakers and one can see why civil wars often resume soon after peace has been announced. As James Schear, former deputy assistant secretary of defense for peacekeeping and humanitarian affairs for the United States, told a Stanford University audience 15 years ago, “Peace . . . is a leap into the unknown. It involves bargaining concessions, contingent exchanges of promises than can come undone.”

Passed by Congress at the last minute to avert a federal default, the Budget Control Act of 2011, generally referred to as the “debt deal,” was a hard-fought fiscal peace treaty between Democrats and Republicans.

**The Budget Control Act**

Passed by the House of Representatives on Aug. 1, 2011, by a vote of 269 to 161 and by the Senate the following day by a vote of 74 to 26, the Budget Control Act of 2011, a 74-page bill, was signed into law by President Barack Obama on Aug. 2, 2011, as Public Law 112-25. The debt deal created and tasked a 12-member Joint Committee of Congress (the so-called “Super Committee”) to produce proposed legislation by Nov. 23, 2011, that would reduce the deficit by at least $1.5 trillion over 10 years.
The Super Committee failed to produce a proposal, which triggered a sequestration process to cut spending by $1.2 trillion across the board and ensure that any debt limit increase is met with greater spending cuts. The trigger plan’s across-the-board spending cuts apply to FY13 through FY21 and to both mandatory and discretionary programs. The debt deal specified that total reductions would be split equally between two categories of expense: defense discretionary and nondefense discretionary plus covered entitlements. The across-the-board cuts would apply to Medicare, although the cut to Medicare would be capped at 2 percent.

According to the March 2011 Congressional Budget Office (CBO) baseline, Medicare spending for FY13-21 is projected to total $7.1 trillion, so a 2 percent cut would equal $142 billion. (It should be noted that subsequent CBO baselines in August 2011 and January 2012 projected lower Medicare spending for FY13-21 - minus 4 percent and minus 5 percent, respectively - compared with the March 2011 baseline, but the cut to Medicare still looms.) Social Security, veterans’ benefits, civilian and military retirement, and all low-income subsidies, including Medicaid and “welfare” programs (e.g., food stamps), would be exempt, as would net interest payments.

**Potential Cuts to Medicare Payment for Hospitals**

Per the debt deal, 100 percent of the cuts to Medicare will be covered by reduced reimbursements to providers. So what proportion of these will be borne by hospitals? Consistent with the macro-level, across-the-board approach, one could reasonably assume that the hospital inpatient prospective payment system (IPPS) and hospital outpatient prospective payment system (OPPS) would each bear its proportional share of the cuts. Such an approach would trim $38 billion from the IPPS and $9 billion from the OPPS for FY13-21, for a total of $47 billion. In other words, as a result of these cuts, the average hospital would expect to see a $1.5 million decline in Medicare reimbursements each year from FY13 through FY21.

Of course, all this being said, hospitals could bear a disproportionate share of the cuts. In an absolute worst-case and extremely unlikely scenario, the full $142 billion in cuts would be made to the IPPS and OPPS, translating into a $4.6 million annual reduction in Medicare reimbursements, on average, for U.S. hospitals during the nine-year period.

**The Undoing of the Debt Deal**

Although the Budget Control Act is firmly established as part of current law, 10 months after its ratification, control over the budget deficit is nowhere to be seen. With the national debt approaching $16 trillion, former President Bill Clinton has contended that “this budget issue should become front and center in this election.” Meanwhile, each political party is accusing the other of voting to alter the numbers in the agreement: In the Democratic-controlled Senate, the vote was to accumulate more debt, while in the Republican-controlled House, the vote was to spend less on the annual appropriations bills than on the caps called for under the deal.

As a result, thus far, the promises of the debt deal have not been fulfilled.

Congress and the president face a slew of fiscal policy challenges, including:

- The debt deal’s automatic defense and nondefense cuts
- The expiring 2001 and 2003 Bush-era tax cuts
- The expiration of the Medicare “doc fix,” which has postponed reductions to physician reimbursements
- The expiration of the temporary payroll tax deduction
- The reconciliation of at least a dozen FY13 spending bills to arrive at a budget for the coming year

All of these challenges could come to a head at the end of this year and may need to be handled after the election by a lame-duck Congress and president. The confluence of all these challenges has been called “taxmageddon,” a “massive fiscal cliff,” and the “quintuple witching hour.”

Regarding the debt deal, if Congress does not vote to override the automatic cuts, they will take effect starting on Jan. 2, 2013, and presumably HHS will be responsible for apportioning the cuts to Medicare.

Notwithstanding last summer’s failed attempt to reach a “grand bargain” on the debt, Congress and the president could conceivably agree upon some sort of massive fiscal policy package that, among other things, repeals or reinforces the debt deal. Getting that done by election day seems implausible, and whether a lame-duck government can muster the will to meet these challenges and agree upon compromise legislation seems doubtful. We are clearly in the realm of the unknown, and time will tell whether the Budget Control Act’s promise will be undone like an ineffective peace treaty.

Supreme Court Upholds Healthcare Reform Law
By Daniel Schoenbaechler, CPA, CHFP

On June 28, the U.S. Supreme Court upheld the Patient Protection and Affordable Care Act (ACA) of 2010 by a 5 to 4 vote, ruling that the massive healthcare reform legislation does not violate the Constitution.

The majority opinion, written by Chief Justice John G. Roberts Jr., found the provision that became known as the individual mandate was a tax and therefore constitutional. He ruled the Commerce and Necessary and Proper clauses of the Constitution cannot be bent to compel Americans to buy insurance, but also said it is allowed under Congress’s tax and spending powers, which are broader, but are subject to the checks of the political system. The court’s four Democratic-appointed justices all joined the ruling by Roberts but wrote separately to say they would have allowed the individual mandate under the Commerce Clause too. Four other justices disagreed by saying in an opinion written by Justice Antonin Scalia that the court has granted nearly unlimited authority to congress to control Americans’ lives. While opponents to the individual mandate said it violated individual freedom, the administration said since everyone consumes health care at some point, government can control when they begin to pay for it.

On the issue of Medicaid expansion, the Court clarified that the federal government can make additional funds available to expand coverage. However, it cannot withhold existing Medicaid funding if states choose not to participate in the new program (coverage up to 133% of the federal poverty level) created by ACA. As there are 26 states challenging the ACA, the Medicaid expansion to 6.3 million Americans is at risk.

The ruling ends a legal battle that started soon after the reform legislation was enacted. Numerous lawsuits challenging various provisions of the ACA have been filed in federal courts.

At the heart of the debate was the argument that the individual mandate imposes a tax penalty on those who choose not to buy insurance, starting in 2014. ACA opponents had argued that such a mandate exceeds Congress’ power to regulate interstate commerce. The U.S. Supreme Court agreed to consider issues related to the constitutionality of the law and heard six hours of oral arguments in March. Senate Minority Leader Mitch McConnell states that “the court’s ruling doesn’t mark the end of the debate. It marks a fresh start on the road to repeal.” Majority leader Eric Cantor said the House will vote to repeal the health care law next month and added that “the Court’s decision brings into focus the choice the American people have about the direction of our country” and “the president and his party believe in massive government intrusions that increase costs and take decisions away from patients.”

“Today’s Supreme Court decision makes it clear that healthcare finance leaders must continue preparing for implementation of the ACA, as most have done since the law was passed in 2010,” said HFMA President and CEO Joseph Fifer, FHFMA, CPA. “Providers should be preparing for the changes necessitated by the insurance coverage expansion, insurance exchanges, and value-based reimbursement mechanisms in the healthcare reform law as well as changes occurring in the healthcare marketplace today. HFMA remains committed to helping the healthcare industry prepare for a value-based future. HFMA will continue to examine the effect of this ruling, particularly the Medicaid provisions, on the actual number of uninsured.”

HFMA’s guidance suggests that providers should take the following steps to prepare for the implementation of the ACA: (1) Build four key capabilities of people and culture, business intelligence, performance improvement and contract and risk management, (2) Develop strategic agility by simplifying organizational structures, empowering front-line staff, aligning with physicians and experimenting with payment methodologies, (3) Align value metrics that concentrate on outcome measures, (4) Differentiate on value as consumers are likely to base their choice of plan within an exchange on a variety of factors including price, quality and network provider choice, and (5) Explore strategic partnerships.

More information is available by accessing HFMA’s webinar “Assessing the Impact of the ACA Supreme Court Decision,” featuring HFMA President and CEO Joe Fifer and HFMA healthcare financial practices experts sponsored by McKesson.
The Region IV Mid-Atlantic conference was held in Louisville, KY at the Hyatt Regency on August 1 – 3, 2012. The last time this conference was held in Louisville was in 1998. It was very successful this year with 301 attendees from many states.

The opening speaker was Dr. Christopher Bauer with a discussion on professional ethics. His “Weekly Ethics Thought” is available at no charge through his website [www.bauerethicsseminars.com](http://www.bauerethicsseminars.com). Dr. Bauer’s discussion on Wednesday was followed by a reception and cornhole tournament.

The opening discussion on Thursday was provided by business humorist Todd Hunt from The Hunt Company. Todd discussed the challenge of communication in healthcare financial management. Larry Goldberg followed with an update on the Medicare reimbursement rules effective 10/1/2012. The morning breakout session was provided by Joette Derricks of Derricks Consulting and Cathy Zito of Lifebridge Health, Blue & Co., LLC personnel Mike Alessandini, Bill Rees and Dan Clark and Jamie Free of Diamond Healthcare Corporation. Joette Derricks and Cathy Zito discussed lessons learned from leading a hospital-owned physician CBO. Blue & Co provided the first of a 3 part series of Medicare cost reporting. Jamie Free discussed the requirements needed to improve Emergency Department throughput or the behavioral health patients.

Thursday afternoon breakout sessions were provided by Joette Derricks of Derricks Consulting, Blue & Co., Joe Koons of Centra Health and Jeff Moser of Sg2. Joette Derricks discussed her seven day educational trip to Cuba to study Cuban healthcare. Joe Koons discussed Centra Health’s achievement as the HFMA MAP award winner. Jeff Moser discussed requirements necessary to succeed in the Reform era as new payment models aim to incentivize value across the care continuum. The breakout sessions were followed by Jim Grigsby Consulting with a discussion of the 12 Labors of Hercules.

The final Thursday session included a CFO panel. Joe Becht of Deloitte & Touche, LLP moderated while the panelists included Melinda Hancock of Bon Secours Health System, Carl Herde of Baptist Healthcare System, Dan Honerbrink of Fairmont General Hospital and George Bayless of GBMC Healthcare, Inc.

After Thursday evening’s events including a cruise on the Belle of Louisville with music provided by Fat Billy’s Boombox in the Regency Ballroom, Friday opened with the keynote session provided by HFMA’s National Chair Ralph Lawson.

The first of 2 morning breakout sessions were provided by John Beakes, Jr. of Operational Performance Soutlions, Inc. and a 2 part session for preparing for the Certified Healthcare Financial Professional (CHFP) examination provided by Kent Thompson of Dixon Hughes Goodman, LLP and Cindy Sharp of Floyd Memorial Hospital. John Beakes discussed the right way to establish a culture of continuous improvement.

The second Friday breakout session was provided by Wayne Little of KPMG LLP and the second part of the preparation for the CHFP exam. Wayne Little provided an update on the ICD-10.
Below are pictures from the 2012 Region IV Mid-Atlantic Conference.

Left to right:
Ralph Lawson, 2012-2013 HFMA National Chair
Theresa Scholl, KY Chapter President
Scott Reed, KY Chapter President - elect

Corhhole Winners
Sponsored by UCB, Inc. ($100 each winning prize)

Left to right:
Jonah Michale, First American Healthcare Finance
Ken Stoll, Central Ohio Chapter, Region VI Regional Executive, 2012-2013
Joe Wood, RSource

Left to right:
Bob Barbier, CPA, Kentucky Chapter, Past Region IV Regional Executive, 2008-2009
Ken Stoll, Central Ohio Chapter, Region VI Regional Executive, 2012-2013
Jan Strope, CPA, CEBS, West Virginia Chapter, Past Region IV Regional Executive, 2011-2012
Ralph Lawson, FHFMA, CPA, Florida Chapter, National Chair, 2012-2013
Melinda Hancock, FHFMA, Virginia, Washington DC Chapter, National Director 2012-2013
Cathy Zito, CPA, FHFMA, CPC-A, Maryland Chapter, Past Region IV Regional Executive, 2009-2010
Andy Strausbaugh, FHFMA, KY Chapter, Region IV Regional Executive, 2012-2013
Kent Thompson, FHFMA, North Carolina Chapter, Past Region IV Regional Executive, 2010-2011
Katie Black, CHFP, Kentucky Chapter, Past Region IV Regional Executive, 2004-2005

HFMA Leaders
Left to right:
Theresa Scholl, KY Chapter President
Chris Woosley, KY Chapter Past President

Scott Reed and Chris Woosley

Chris Woosley with his wheelbarrow of awards

CFO Panelists answering questions at the conference.

Panelists (left to right):
Carl Herde, Baptist Healthcare System
Melinda Hancock, Bon Secours Richmond Health System
Dan Honerbrink, Fairmont General Hospital
George Bayless, GBMC Healthcare, Inc.

Bill Brown, active HFMA member and the band Fat Billy’s Boombox
2012 ANI Awards

The Kentucky HFMA chapter recently attended the 2012 ANI: The HFMA National Institute and received several outstanding awards!

- C. Henry Hottom Award for Educational Performance Improvement,
- Silver Award of Excellence for Education,
- Silver Award of Excellence for Membership Growth and Retention,
- Bronze Award of Excellence for Certification, and

4 Helen M. Yerger awards for:
- Outstanding performance in Innovation,
- Outstanding performance in Education,
- Outstanding performance in Membership Services, and
- Outstanding performance in Improvement

Left to right:
Ralph Lawson, 2012-2013 HFMA National Chair
Chris Woosley, 2011-2012 Chapter President, Kentucky Chapter
Greg Adams, 2011-2012 HFMA National Chair

From left to right:
Keith Morgan, 2011-2012 Chapter President, West Virginia Chapter
Keith Boyd, 2011-2012 Chapter President, North Carolina Chapter
Jan Strope, 2011-2012 HFMA Region IV Regional Executive
Jen Maher, 2011-2012 Chapter President, Maryland Chapter
Chris Woosley, 2011-2012 Chapter President, Kentucky Chapter
Bottom: Carl Johnson, 2011-2012 Chapter President, Virginia/D.C.

Left to right:
Top Row:
Jeanene Whittaker, 2011-2012 Chapter Secretary
Andy Strausbaugh, 2011-2012 HFMA Region IV Regional Executive Elect
Chris Woosley, 2011-2012 Chapter President

Bottom Row:
Ken Bramer
Theresa Scholl, 2011-2012 President-Elect
Scott Reed, 2011-2012 Vice President of Education
Tony Sudduth, 2011-2012 Vice President of Communications
NEW MEMBERS

Valerie Kaiser
Staff Accountant
Blue & Co., LLC

Melinda Hamilton
Assistant Corporate Controller
TJ Samson Community Hospital

Scott Rinehart
Director of Materials Management
Pattie A. Clay Regional Medical Center

Michelle Kannapel
Manager, Decision Support
Norton Healthcare

Dana Moran
Accretive Health

Steven Ratliff
Manager
Blue & Co., LLC

Michelle Kremer
Senior Associate
Grant Thornton, LLP

Jillian Hibbard
Associate
Grant Thornton, LLP

Simon Hughes
Division President Client Development
Firstsource Solutions USA, LLC

Bo Shi
Morehead State University

Joel Connor
Senior Provider Network Manager
Anthem

Gine Thompson
Operational Audit Analyst
Norton Healthcare

Jason Mouser
Director of Patient Access
Pattie A. Clay Regional Medical Center

Experience ideas

Work face-to-face with one of the three past presidents of the Kentucky HFMA or one of our more than 200 professionals focused on the health care industry. You’ll experience round-the-clock commitment to ideas that help you improve performance, reduce risk, lower costs and stay in compliance. Learn more at bkd.com.

Call us in Louisville at 502.581.0435
David Kottak
Mary McKinley
David Tate
KY HFMA Chapter Leadership
2012 - 2013
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Tony Sudduth
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VP Communications
Shelley Gast
Norton Healthcare

VP Member Services
Don Frank
Bottom Line Systems, Inc.

Secretary
Jeanene Whittaker
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PUBLICATION OBJECTIVE
The Financial Diagnosis is the official publication of the Kentucky Chapter HFMA and is written and edited principally to provide members with information regarding Chapter and national activities, current and useful news of both national and local significance, information about seminars and conferences and networking with colleagues, and to serve as a forum for the exchange of ideas and information.

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