



President's Message



Greetings and Happy New Year to all:

I hope everyone had a pleasant holiday season. I hope the Spokane area members are surviving; I cannot imagine dealing with the record snow fall that has slammed the Inland Empire. I know traveling was difficult this year, I hope everyone made it to your destinations safely!!!

We are all facing extraordinary challenges this New Year. Healthcare has never been more challenging, I almost hate to turn on the news or open my emails these days. The world of finance seems to be spinning out of control with no good news in sight. With all this in mind, I came across a simple New Year's reflection that seems to offer guidance for the challenges we face this coming year:

NEW YEAR'S RESOLUTION

People are unreasonable, illogical, and self-centered.

Love them anyway.

If you do good, people may accuse you of selfish motives.

Do good anyway.

If you are successful, you may win false friends and true enemies.

Succeed anyway.

The good you do today may be forgotten tomorrow.

Do good anyway.

Honesty and transparency make you vulnerable.

Be honest and transparent anyway.

What you spend years building may be destroyed overnight.

Build anyway.

People who really want help may attack you if you help them.

Help them anyway.

Give the world the best you have and you may get hurt.

Give the world your best anyway.

The world is full of conflict.

Choose peace of mind anyway.

-Anonymous

Happy New Year, wishing you all the best!

Susan



making connections

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Special points of interest:

- Mitigate Financial Risk
- Eligibility Verification
- Chapter News and Events
- Region 10 Information
- Help Wanted

Using a Frontline Offense to Mitigate Your Financial Risk in Today's Sick Economy

By Bruce Nelson, Vice President, SearchAmerica, a part of Experian

It is a usual day at a hospital. A new patient enters an Emergency Room needing care for a broken arm. The treatment process begins... the registrar admits the patient, a nurse preps the receiving room, an X-ray technician readies the equipment, and the financial director sighs as he sees the hospital's finances plunge. Why? In today's economy, every patient entering their facility is more and more likely to be discharged feeling better, but leave the hospital in a weaker financial state than when they entered.

An ever growing number of today's patients are responsible to pay for a portion of their care. Many need financial assistance, charity, or a payment plan, or they may simply default on their financial obligation. The number of underinsured patients is rising rapidly to an estimated 25 million adults in the United States, an increase of 60 percent since 2003 according to a recent study by PriceWaterhouseCoopers. The result is a rise in self-pay patient population, who have become a significant piece of a hospital's revenue cycle. These individuals are often unable or unwilling to pay the high deductibles associated with their plans, leaving the hospital with increasing bad debt. Coupled with decreased financial giving and elective surgeries, the outlook is grim.

However, even in the worst of times the hospital's mission remains the same -- to care for those in need of medical treatment within their communities. Despite its financial woes, hospitals must remain viable to serve its mission.

The economy of today has resulted in capital resources vaporizing and investment income turning negative. This means budgets are stretched and many hospitals are looking to their front-end staff and systems to buffer their organization from today's financial crisis. The following are a few steps that financial executives can take to better financial health that apply to any economy, without significant cash outlay:

Step One: Diagnose or Prequalify the Patient

With today's frequent changes in insurance coverage (due in part to rising unemployment) and medical identity theft, hospitals need to be vigilant in attaining the most recent and accurate information on every patient.

First, hospitals need to be sure the patient is who they claim to be, and the provided coverage (if any) is valid. Then, they must understand the patient's ability to pay their bill. It may be a question not of *if* they can pay, but *when* or *how* they can pay. Knowing this information at registration establishes a mutually agreed upon relationship and can protect the

hospital from undue risk.

Non-emergent medical treatment now requires the hospital knowing its financial risk in serving this individual and then mitigating this risk as much as possible

Step Two: Deliver a Personalized Financial Treatment

The hospital's frontend should have a suite of payment options available that protect the hospital from accumulating bad debt. These may include pre-payment at registration (cash, credit card, or a medical care credit card plan issued by a third party), hospital approved payment plans, charity programs, and government assistance programs, among others. Especially for self-pay patients, appropriate options should be made available to ensure payment using one or multiple options.

Teaming with medical staff, frontend personnel should be able to offer patients approximate costs of proposed treatments, especially those that can be delayed or are elective. This information can change the necessary financial relationship and options available. It also empowers the patient to make educated choices on elective or optional components of their care.

Step Three: Act Quickly

Aging of accounts will worsen in recessions. Collection policies and procedures should be directed at carefully segmented patient populations defined according to a patient's ability to pay their bill and its balance. In addition to frontend collections, some suggestions have included offering incentives for pre-paying or early payment of medical bills to maximize cash balances in the short term. Often the first medical bill to reach a patient may be the first one paid, hospitals should see this as a race and beat other providers to the finish line.

There is no magic to surviving in today's economy, avoiding layoffs and the other cost cutting measures. However the hospitals frontline can minimize risk and improve cash balances if used properly. It is time to equip frontend staff with the technology and processes to identify patients quickly, assess their financial capabilities, and trigger a financial plan made to fit each unique patient.

If a hospital falls into poor financial health, its mission cannot be fulfilled. It is important to the community it serves to be diligent in protecting its financial health.



Gaining Visibility and Control Over Your Collection Agencies

By Steve Levin, President, Connance, Inc.

How to Adequately Compare Your Collection Agencies' Performance

Hospitals increasingly rely on third-party collections agencies to work patient accounts. Today, day-to-day management of these relationships is cumbersome and unproductive as hospital resource time is consumed with auditing and reconciling vendor invoices and files. Limited visibility into vendor activity and inconsistent reporting make performance reviews across vendors virtually impossible.

As patients today are directly shouldering a greater share of healthcare costs than ever before, hospitals need to gain visibility and control over their self-pay collections in order to maximize cash flow. By better managing agencies, hospitals can realize more cash with greater oversight while substantially reducing administrative burdens. In addition, hospitals need to make sure they continue building stronger relationships with their patients by being able to make sure they continue building stronger relationships with their patients by being able to supervise agencies' daily activities.

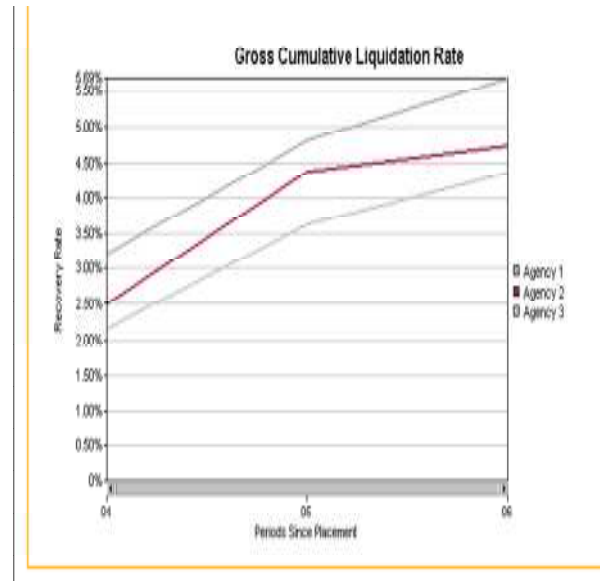
Step 1: Consider New Approach

Innovative companies in other industries, such as telecommunication companies and multiline financial institutions, have embraced technology to improve collection agency management. Using three or more primary and secondary collection agencies, these companies don't rely on alpha splits and account balance size to simply place accounts. Instead, they use technology to manage the placement, reconciliation, and auditing activities – all activities that tax scarce internal resources. These creditors have realized consistently increased cash yields from any single agency, reduced clerical costs, improved handling of exceptions in the collections process, enhanced customer satisfaction with their agencies, and the ability to optimize their portfolio of agencies. Their agencies also experience improvements including less clerical activity, fewer administrative calls and better creditor engagement.

The technology solution for collection agency management establishes a single placement platform that sits between the hospital and its agencies and collection resources. The best platforms include a database and a rules engine that captures the hospital's work requirements. The database maintains an inventory of accounts

being worked by all vendors and receives daily updates on recent activity by the hospital and the vendor. As a result, the central database has all the information needed by hospitals to analyze performance. The rules engine continually analyzes the database to find activity that should be flagged for review.

How do my agencies liquidation rates compare?



Step 2: Evaluate Your Options

When choosing agency management technology, hospitals should evaluate their current agency management issues and then compare the features and benefits that existing solutions can offer. Some factors to consider follow.

A single platform for all of the hospital's agencies. All agency activity (including early out and late stage collection agencies, attorneys, and debt buyers) should be centralized to compare agency performance consistently.

A full reporting suite. A framework for consistent reporting across all collection agencies is necessary to support account audit and reconciliation requirements and to conduct agency performance comparisons. Daily reports of agency activities can provide insight into the number of letters sent, calls made, and "promises to pay" taken, which allows hospitals to respond quickly to changing agency dynamics and performance.

Ability to execute the hospital's business rules. A system that offers automatic rules-based workflow allows hospitals to monitor and control compliance to their business rules.

Gaining Visibility and Control Over Your Collection Agencies (Continued)

Ability to change agencies quickly. A more robust, comprehensive system enables users to change vendors quickly and with minimal business disruption.

Quick and easy installation. Implementation of an agency management system can be done on a small scale. Many web-based solutions don't require investment in hardware and software upgrades, have reasonable installation fees, and are predominantly pay-as-you-go.

Limited maintenance. Web-based systems simplify maintenance and software upgrades. They have limited requirements for internal resources.

Regulatory compliant. The system should ensure full regulatory compliance with the Health Insurance Portability and Accountability Act.

A platform for future analytics. The system should be able to accommodate analytics to achieve maximum financial performance. Analytics ensures that each account is sent to the collection agency most likely to maximize collections on that type of account.

Step 3: Implement and Compare

Once you have selected the technology that is right for your organization, ensure executives and managers are taking control of patient revenue by better managing the collection agencies.

The hospital CFO should monitor and compare current and trendline performance of the collection agencies and evaluate performance on gross and net liquidation rates to get a complete view of the true relative value of each vendor.

The revenue cycle executive should access information necessary to manage the vendors, not just audit them. The executive can find the collection sweet spots for each of the collection agencies by comparing performance on different classes of accounts. The revenue cycle executive should make more informed decisions with respect to assignment timing and recall decisions, optimizing internal resource costs against vendor demonstrated performance. Over time, the executive should quickly identify true underperformers and replace with a new proven vendor, already connected to the agency management network, who has a demonstrated strength in the desired area.

The day-to-day manager of a hospital's vendors should monitor service level agreements, rapidly reconcile invoices and inventory, and broadcast new information to all vendors at once.

Providers that are adopting new agency management technologies will be more efficient and effective, know where performance is slipping and be able to respond quickly. Their personnel will sleep better at night knowing what the agencies are and are not doing with their patients.

American Hospital Association Survey Report Details Impact of Economic Downturn on Hospitals and Patients

A report released by the American Hospital Association on November 19, based on a survey of more than 700 hospitals, shows that hospitals nationwide are being severely impacted by the current economic downturn. Of the hospitals participating in the survey:

- 60 percent are anticipating cuts in administrative costs
- 53 percent are anticipating reductions in staff
- 27 percent are anticipating reducing the services they offer

40 percent are seeing reductions in admissions, while at the same time experiencing an 8 percent increase in uncompensated care

As a result of the impact on the debt market:

- The surveyed hospitals are experiencing interest payments an average of 15 percent higher than the previous year
- 56 percent of the hospitals are delaying renovations or plans to increase capacity
- 45 percent of the hospitals are delaying purchases of clinical technology or equipment

39 percent are putting off plans to invest in new information technology



Eligibility Verification: Once Is Not Enough

**By Ray Shealy, Vice President and General Manager,
RelayHealth**

Hospitals and healthcare providers are facing significant financial challenges, and ranking high on the list is orchestrating the collection of insurance coverage. More of the costs for services and procedures are being billed directly to patients, and if they don't pay, then it becomes bad debt. Adding to this burden are higher service costs, increasing numbers of the uninsured and underinsured, and rising pressures to boost charity care. The ability to meet revenue goals has never looked so grim.

To cope with these economic challenges, many hospitals are seeking ways to improve their financial position by enhancing patient eligibility verification. Eligibility verification is the one process from which all other revenue cycle functions should flow. When captured with a newly available level of detail, this data provides the basis for efficient claim submission and the accurate bill estimation that is needed to support increasing consumer requirements for information about healthcare costs.

The Bare Minimum

Hospitals often limit themselves to the bare minimum of eligibility verification transactions because, until recently, it simply didn't pay to run multiple eligibility checks on all but the highest-charge patients. Online eligibility queries are often billed on a per-transaction basis, and manual verifications, involving phone calls to insurers, consume excess time and manpower. To prevent these problems, hospitals often rely on what little coverage information a patient can provide pre-service or at point of service. It's not surprising that 80percent of accounts receivable staff time is spent re-working claims.

Patients frequently do not know the name of their current health plan, let alone coverage details such as deductible amounts, co-payments and year-to-date met totals. They also may not have reliable forms of personal identification, leaving providers with no vital information. Combine these issues with common health benefit changes and coverage lapses, and it becomes clear that once is not enough when verifying patient benefits eligibility.

Best Practices

New web-based technologies enable hospitals to make eligibility verification a top priority through automated workflows and flat-fee pricing. Revenue cycle best practices, compiled over years of real-world experience, show that in order for hospitals to effectively collect from patients and third-party payors, eligibility verification must occur at

multiple times. When an automated verification system is combined with unlimited eligibility queries, it becomes possible to check eligibility pre-service, then multiple times until final resolution of the claim. Here's how eligibility verification can best be achieved:

1. Pre-Registration Scheduling

The earlier patient identification and eligibility is verified, the more smoothly the subsequent patient accounting process will go. Pre-registration is often the hospital's first opportunity to capture all the critical patient information necessary to produce a clean bill for the right payor. Registrars should begin by verifying the identity of the patient, address, health plan benefit coverage and self-pay status.

Here, "verification" means objective verification, and not relying primarily upon patients' statements. Automated, web-based eligibility verification technologies prompt registrars to request backup documentation from patients and externally verify data through real-time eligibility queries.

Standardized computer display screens with normalized payor responses create a user-friendly data source, minimize typographical errors, and support higher quality data capture. The increased accuracy and thoroughness of information gathered using newly available technologies significantly improves point-of-service collections by providing more detailed benefit eligibility data regarding co-payments, co-insurance, deductibles and year-to-date met estimates. This externally verified data will also limit opportunities for fraud and reduce back office workload and staff frustrations.

2. Patient Registration

The face-to-face registration process provides the registrar with another opportunity to verify all critical data. If a pre-registration benefit eligibility verification check was performed, this is an additional opportunity to correct any discrepancies between the information provided by the patient and data returned from the health plan verification queries.

Patients should be queried for any missing data, and a standardized process to collect patient liabilities should be performed. To maximize the effectiveness of upfront collections, bill estimation software can be incorporated to provide patients with an accurate picture of their ultimate financial liability and support access staff efforts to collect appropriate deposits towards the services to be delivered. This newly available technology also supports pricing transparency initiatives that providers find increasingly critical.

Eligibility Verification: Once Is Not Enough (Continued)

3. Time of Service Quality Assurance Review

Shortly after services are delivered or while a patient is still in-house, health plan benefit eligibility should automatically be checked again, especially in the absence of significant coverage found during pre-registration or registration. With a flat-fee model for eligibility verification queries, the hospital can ensure that it has the most up-to-date information without incurring additional transaction costs.

This is important because patient circumstances such as diagnosis, treatments or length of stay may change, or previously unknown supplemental or primary coverage may be located from a spouse or other responsible party's health benefit plan. Similarly, Medicaid applications may have been approved in the interim. Repeated eligibility verifications increase the likelihood of identifying patient coverage and reducing claim errors.

4. Billing

Before a final bill is produced, it is often useful to verify all critical patient data once more. This is the time to reconfirm patient employment and insurance information, include any month-end changes and identify pending or newly approved Medicaid benefits. This final verification ensures that more complete and accurate claims are submitted to the correct payor. In turn, claims can be paid more quickly and cash flow can be significantly improved.

Success

One Ohio health system has reaped success from implementing new eligibility verification technology that allows them to perform an unlimited number of real-time eligibility verifications that identify whether a patient is covered by private insurance, Medicaid/Medicare or is truly self-pay.

Cincinnati's Mercy Health System (Mercy) is identifying an additional \$500,000 each month in gross charges of Medicaid coverage for patients prior to claim drop (3 day hold) after patient discharge. The health system has also experienced the benefits of batch processing capabilities allowed by the technology's flat-fee pricing structure.

Quarterly, Mercy runs a batch of all self-pay accounts up to one year-old (including primary and secondary balances) using a new generation of eligibility verification services and has identified an average of \$380,000 in eligible charges each quarter. In addition, through a new bill estimation tool supplying more accurate data, they were able to improve pre-service collections by \$1,700,000 over a year's period and reduce full time employees.

Yet another benefit of identifying charity care earlier through the improved collection strategies for Mercy has seen a \$1,300,000 increase in post-service collections from self-pay patients in 2006. Mercy is also utilizing new technology that assists access team members in performing proactive financial counseling and screening of patients for potential charity funding sources when a patient is uninsured. This enabled Mercy to provide an additional \$350,000 in charity care funding for patients in the first month of usage. Most impressive is the fact that Mercy has been able to increase Medicaid payments by \$1,800,000 in their first six months of using these new technologies.

Mercy demonstrates the immense value that can result from a consistent application of a new generation of eligibility verification technology throughout the patient access continuum. As technology continues to make more accurate and complete patient and payor data available, the ability to access that data multiple times without incurring escalating costs becomes essential to an efficient, sustainable revenue cycle that supports better customer service and significantly enhances the hospitals' bottom lines.

CALL OUT

You need multiple eligibility checks when:

You are experiencing front-end eligibility rejections from your payors.

Services have been added that may impact how the bill is presented.

Newborn babies of Medicaid mothers are not covered until after the birth, and pre-service eligibility checks the mother but will not check on the baby.

Pre-service eligibility verification does not occur on every encounter.

When the patient has a long hospital stay, benefits may have changed or been exceeded.



Chapter News and Events

Idaho Success Story

By **Michelle Marcum, CHFP**

On the evening of December 17, 2008 snow boots, hat and gloves on (and laptop in tow – would not want to miss out on any work opportunities), I made the journey from Boise to Pocatello. Not wind nor sleet nor snow (not to mention sub-zero temperatures at my destination) would keep me from my call to duty. I was to be on site at Portneuf Medical Center at 8:00 am the next morning. As one of the elite certified members of the Idaho Chapter, I had the honor of serving as proctor for four ambitious members that took on the challenge of taking the HFMA certification exams.

So now that I have arrived at the designated test location the next morning, it is no longer about me. Their highly competent IT staff had everything ready, well almost. There was a little glitch on the HFMA office side which was quickly resolved and we were ready to go. Though each participant was anxious about the process and nervous about their success, spirits were high as they began their testing.

I am very proud to announce the great success this group had. I asked each of them to provide some comments which I will share with you here:

John Wilker (whom I believe may have coerced his fellow test takers) successfully completed both section of the exam, setting a great example for his team. John had this to say, "Great experience. Be sure to study lots. Pretty straightforward material and study guides."

Don Herbert also passed the entire exam and shared these comments, "the testing process was straightforward with no surprises. I think that any healthcare financial professional, at any stage in their career, will find rewards in the certification process. The study material appropriately prepared the candidate to be successful on the exam."

Holly Parkinson successfully completed the Patient Financial Services Specialty section of the exam. She had this to share, "I did learn a lot from this, and it clarified some things for me as well."

Shirley Lawson successfully completed the Core section of the exam. Her advise is, "to study BOTH sections, not just one! Testing process was easy and very accommodating to a busy schedule, no trick questions that I could find. Having the flexibility to take the test locally is an incredibly efficient option."

I want to congratulate this group. They took on this challenge amid their transition to new hospital ownership, which is challenging enough on its own. I feel their accomplishments were outstanding. Shirley and Holly assured me they would be back to complete their goals.

I also want to thank all of them for their great hospitality and the thanks they expressed to me for assisting in the process. It was truly an honor and I was happy to be a part of it. As I made my way back to Boise, I felt that it was well worth the trip. I felt rewarded, almost like I had passed the test all over again.

I thank them for allowing me to share their experience with you. I hope reading about their experience and success will encourage more of you to consider taking this step in your career.

HFMA has excellent study materials and the process is as user friendly as it can be. In reflecting back, I think anyone of these members will tell you it was not as difficult as they had feared it would be and that it was well worth the effort. The Idaho Chapter has some options for assisting you in obtaining the study materials. If any of you have questions or want to discuss certification, please contact me at 208-367-6572; michmarc@sarmc.org or Norlina Harvel, CHFP at 208-785-3849; cfo@bonnergen.org.



New Member Spotlight



Please join us in welcoming our newest Chapter Members!

Melissa Davies, St. Luke's Regional Medical Center, Boise, ID

Ryan Messerly, PFS Director, Montpelier, ID

Welcome! We look forward to seeing you at our next meeting!

Updates from Tricare

Gastric Bypass Surgery—An Update on What's Covered

Laparoscopic bariatric surgical procedures and adjustable gastric laparoscopic banding are covered TRICARE benefits. A TRICARE beneficiary who is interested in having gastric bypass surgery to lose weight for health reasons needs to meet one of several conditions to be eligible for the surgery.

If ordered by the surgeon, the beneficiary may undergo a pre-surgical psychological assessment, a specialized appointment for patients being considered for gastric bypass surgery. This typically involves a psychological evaluation and brief psychological testing. This specialized patient care service is part of a multidisciplinary approach. Prior authorization is required for the pre-surgical psychological testing.

If it is determined there are no psychological contraindications to surgery, gastric bypass, gastric stapling or gastroplasty (to include vertical banded gastroplasty) may be covered when one of the following conditions are met:

1. The patient is 100 pounds over the ideal weight for height and bone structure and has one of the following associated medical conditions: diabetes mellitus, hypertension, cholecystitis, narcolepsy, Pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders and severe arthritis of the weight-bearing joints.
2. The patient is 200 percent or more of the ideal weight for height and bone structure. An associated medical condition is not required for this category.
3. The patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery (a takedown).

In determining the ideal body weight for morbid obesity (using the 1999 or most current Metropolitan Life Table), TriWest applies 100 pounds (or 200%) to both the lower and higher end of the weight range. Payment will be allowed when the patient meets all requirements for morbid obesity surgery, including the ideal weight within this determined range.

Facilities

Network providers should only use network facilities for gastric bypass procedures. Requests for non-network facilities may result in higher out-of-pocket expenses for the beneficiary. If TriWest receives a request for a non-network facility, TriWest may contact the patient and suggest a network facility as an

alternative.

Exclusions

TRICARE will not reimburse providers for nonsurgical treatment of obesity, morbid obesity, dietary control or weight reduction. Excluded procedures include:

- Biliopancreatic bypass (jejunioileal bypass, Scopinaro procedure CPT procedure codes 43645, 43845, 43847 or 43633).
- Gastric bubble or balloon
- Gastric wrapping/open gastric banding (CPT procedure code 43843)
- Unlisted CPT procedure codes 43659 (laparoscopy procedure, stomach); 43999 (open procedure, stomach); and 49329 (laparoscopy procedure, abdomen, peritoneum and omentum) for gastric bypass procedures.

You should contact TriWest Healthcare Alliance at 1-888-TRIWEST (888-874-9378) if you have a question on whether a beneficiary is covered for one of these procedures.

For further information, please refer to the TRICARE Policy Manual, Chapter 4, Section 13.2 at

www.tricare.mil.

Two TRICARE Provider E-Seminars Updated

TriWest Healthcare Alliance has recently updated the Medical/Surgical Provider E-Seminar and Behavioral Health E-Seminar. Developed with busy providers and their staff in mind, these E-Seminars contain the same content as our live Fall 2008 provider seminars.

TRICARE Provider E-Seminars allow you and your staff to learn about TRICARE and TriWest in the comfort of your own office, home or any location with Internet access. In addition, the E-Seminars are a good way to educate new staff about TRICARE and for experienced staff to get a refresher between live provider seminars in their area.

The Medical/Surgical presentation is 67 minutes long, and the Behavioral Health session is 64 minutes long. If you can't complete the E-Seminar in one setting, you can pause it and finish it later.

You will need headphones or speakers to take an E-Seminar. Viewing the entire E-Seminar is necessary to receive credit for taking the training. It is important to complete the online form

Updates from Tricare (Continued)

at the end of the E-Seminar. You also will need your Tax Identification Number(s) (TIN) to complete the online form.

The Medical/Surgical and Behavioral Health E-Seminars cover the following topics:

- TRICARE Overview
- TRICARE Programs and Benefits
- Clinical Programs
- Referrals and Authorizations

- Consult and Treatment Reports
- Claims and Reimbursement
- Electronic Data Interchange (EDI)
- Provider Resources

You may begin a seminar immediately as no pre-registration is required and there is no waiting. Just click on the "Begin the Seminar" button below where you can choose the E-Seminar you would like to take. At the completion of the seminar, take the time to follow additional instructions to receive credit for taking the course.



HFMA Membership

HFMA National's On-line Membership Directory

Have you visited HFMA National's On-line Membership Directory lately? Here's the link: <http://www.hfma.org/login/index.cfm>. When you select "HFMA Directory", not only can you search for members of our chapter, you can also search for all of your HFMA colleagues by name, company, and location - regardless of chapter! Using an on-line directory instead of a printed directory ensures that you always have the most up-to-date contact information.

While accessing HFMA National's On-line Membership Directory, you may view your current contact information and make edits to your profile. You can also view any products you have ordered, events you have registered for, your CPE credits, your Founders points, and more!

It is vital that HFMA has your correct information, so please take a moment to review your record now. By doing so, you will ensure that HFMA continues to provide you with valuable information and insights that further your success.

Region 10 Information

After taking a 1 year break, the REGION 10 EDUCATION EVENT is back by popular demand. Region 10 is glad to once again host this great educational opportunity.

The Region 10 Conference will be held at the new Renaissance Glendale Hotel & Spa on February 25 – 27, 2009. This facility has just opened and features:

- 2 Story Spa with outdoor treatment rooms
- 2 swimming pools, hot tub and state-of-the-art fitness center
- Wireless high speed internet throughout the hotel, conference center and in each guest room
- A location next to Westgate City Center which is a vibrant development of restaurants, retail and entertainment venues plus the Jobing.com Arena (home to the Phoenix Coyotes of the NHL) and University of Phoenix Stadium (home of the Phoenix Cardinals of the NFL, the Tostitos Fiesta Bowl and the 2008 Super Bowl)

View this great location at www.renaissanceglendale.com



Region 10 Conference

February 25-27, 2009

Mark your Calendars to “winter” in Arizona at the Renaissance, Glendale Hotel & Spa (*visit www.renaissancehotels.com/PHXGR to see this new hotel, Westgate entertainment area, etc.*)

You can expect to attend great educational sessions, network with your colleagues in the Mountain states and play golf if you wish.

Conference Sponsors

MOSS ADAMS LLP



Career Opportunities!



HEALTHCARE FINANCIAL PROFESSIONAL / CPA

A growing, dynamic healthcare consulting firm seeks an individual to join our team as a Reimbursement Consultant. Responsibilities include assisting in audits and with monitoring and implementing regulatory changes within cost reports, analyzing and resolving issues for governmental appeals, actively participating in analyzing data and developing recommendations and action plans within defined procedures and practices, and acting as a significant information resource for our clients. Successful candidate will be confident, productive, and able to work well independently. Minimum of 3 years of accounting or finance experience, preferably working with third party reimbursement and/or health care decision support, effective written and verbal communication skills, time management, follow-through, organizational skills, and excellent computer skills. We offer a challenging work environment, a high level of professional interaction and strong earning potential. Please forward resumes in strictest confidence to:

hr@theybargoup.com

Mail: Human Resources
The Rybar Group
1495 Dauner Rd
Fenton, Michigan 48430
Fax: 810.750.6733
Web site: www.theybargroup.com

VICE PRESIDENT, CHIEF FINANCIAL OFFICER

Reporting to the President/CEO, the Chief Financial Officer is a key member of the executive team providing exceptional financial leadership, guidance and discipline. Plan, direct, manage, and coordinate the financial policies, practices, and supporting activities to accomplish the organization's vision, mission and goals. The CFO is the chief advisor to the CEO, Board and staff on financial matters and primary contact for investors and financial community.

- Make a vital contribution to the strategic planning and organization growth process. Participate in the development and implementation of strategic plans to support sustained growth and profitability to meet immediate, medium, and long-term goals.
- In collaboration with senior management, develop systems where finance, business development, contracts, and clinical operations work together to facilitate timely and appropriate billing, streamlined communications, and shared relevant information.
- Establish financial objectives, policies and operating plans, both strategic and tactical; provide reports outlining the financial position as to income, expense, liabilities and earnings based on past, present and projected future business.
- Actively participate in Board meetings and make presentations with regard to financial updates, operational results, forecasts and future strategy. Coordinate with the Board on issuance of all debt and propose investment strategies.

FOR ADDITIONAL INFORMATION, CONTACT SUSAN CHAPMAN 425-455-2041

Chapter and Vendor Information

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2008 – 2009

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