



## CHA Update

Laura Zehm, HFMA's representative on the CHA Board provides an update on the Governor's revision to the 2008-2009 Proposed State Budget  
**Page 2**

## Health Regulatory Updates

Gloryanne Bryant provides highlights on the proposed IPPS rule and CMS Updates. Cindy Rudow provides updates on Medicare and Medi-Cal.  
**Page 2 - 4**

## Selling Bad Debts

When should you consider selling bad debts, how to go about such a transaction and when would you know if you're getting a good deal?  
**Page 5**

## Improve Healthcare Building Environments to Improve Staff Satisfaction

"A positive building environment can play an important role in how healthcare delivery personnel feel about their jobs"  
**Page 7**

## Chapter News

Yearly change-over of Region 11 Executive-Elect, 2008 Joint Fall Conference and Recap of the Managed Care Event in Sacramento  
**Page 8-9**

## Membership News

New Chapter Members, Members on the Move  
**Page 10**

## President's Message

Chuck Acquisto  
Chapter President  
2008-2009



What an honor it is to be the President of Northern California Healthcare Financial Management Association for 2008-2009. I have to thank the most recent past Presidents **Jack Ruzic** and **Christine Sarrico** for their leadership as well as mentoring.

The Chapter is hoping to build upon the amazing successes of the 2007-2008 chapter year that led to HFMA of Northern California earning six Yerger Awards from National: two Yergers for the PFS Revenue Cycle Committee Road Shows (2006-2007; 2007-2008); a Yerger for Northern California Membership; a Yerger for the Spring Conference; a joint Yerger with Southern California for the 2007 Fall Conference in Lake Tahoe; and a joint Yerger for the Region 11 Symposium in Las Vegas. In addition to the Yergers, the Chapter captured the following prestigious awards: the Henry Morgan Award (Education) as well as Silver

Certificates for Membership and Certification. Christine Sarrico will feature these awards in an upcoming article, but a special "tip-of-the-cap" for their outstanding contributions in achieving these National Honors goes to **Aimee Arata, Steve Thompson, Ramona Hernandez, Cynthia Denton, Mary Ackley, Terry Paff, Deborah Knight, Kim Miranda, Jayne Kroner, Cindy Rudow, Dan Dreblow, Peter Hugenroth and Brian Marrs.**

The Chapter's winner of the Membership Drive, with the prize being a trip for two to Hawaii, is **Mich Riccioni**, CFO at St. Joseph Health System - Sonoma County. For those who missed this year's opportunity, the Chapter will award another Hawaii trip in 2009 as we push renewal and new membership in the late winter and early spring next year. To illustrate the Membership Drive's prize effects, the Chapter experienced an increase of 156 renewals/new members over the close of the 2006-2007 Chapter year.

Perhaps the most exciting venture for this coming year is the Chapter's new website. I first want to thank the Board, who gave approval to move forward with the project. I also want to thank **Jayne Kroner** and **Mike Laidlaw** who, along with your President, comprised the Website Committee. FutureTech Consultants from Georgia, who designed the award-

winning Georgia website as well as other HFMA websites, were selected to re-design the website to bring the Chapter into the 21<sup>st</sup> Century. The goal is to make your Chapter website interactive as well as a portal that each member will bookmark for its ease and educational content.

With the rising costs of travel, coupled with companies and hospitals slashing expenses, it is imperative that our website be able to meet the needs of all of the Northern California members. Look forward to the opening of the Chapter Website in July with an announcement to be made to all members via electronic mail.

Finally, the Chapter's success hinges upon the many great volunteers and leaders who step up to bat for HFMA of Northern California. Two recent shining examples of Chapter Volunteers stepping are **Daisy Noguera** from Community Hospital of Monterey Peninsula and **Eula McKinney**; both are representing our Chapter on the Region 11 Symposium Committee. I want to encourage all members to get involved with a Chapter and/or State and Regional committee to make your membership in HFMA that much more valuable to you and the Chapter itself.

Have a safe and wonderful summer.



## CHA Update - Proposed State Budget Cuts and Impact on Medi-Cal

Laura Zehm

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HFMA Representative on the CHA Board

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There is a slew of information about the Governor's May Revision to his 2008-2009 Proposed State Budget and the impact on Medi-Cal Payments. I am sure you have all seen much of it. I will attempt to narrow it down to the key points.

### How much are the cuts?

CHA reports that the May Revision of the 2008-09 State Budget includes up to \$232 million in *new* cuts. This is on top of the more than \$1.3 billion in Medi-Cal reductions to all health care providers that were enacted earlier this year and are scheduled to take effect on July 1, 2008.

### What gets cut?

- \$22 million for inpatient services provided at hospitals that do not contract with the Medi-Cal Program through the California Medical Assistance Commission (CMAC). This represents a 10% rate cut. There is language in the proposal that describes a rate to be applied to hospitals that have no contract with either CMAC or another Medi-Cal managed care plan that is based upon the average CMAC rate for a region less 5% (the so called Roger's Rate). CHA estimates that in most cases this rate is less than half of what hospitals would have received from Medi-Cal with their cost-based weights.
- \$54 million in cuts to some public hospitals through the Safety Net Care Pool.

*Continued on page 4*



## Proposed IPPS Rule FY 09 - Some Highlights

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The Inpatient Prospective Payment System (IPPS) proposed rule for FY 2009 was released in April and there are some noteworthy items being addressed and recommended. This article will touch on **some** of the proposals that hospitals and finance staff need to watch for in the "final rule" come early August.

### MS-DRGs

The MS-DRGs do not contain but a few proposed changes, starting with the separate payments for ICD pulse generator replacements from ICD lead replacements. However, this results in a proposed payment increase for ICD pulse generator replacements of 30%. Some MS-DRGs specific to implantable cardiac defibrillators and pacemaker system insertions may result in a slight payment increase.

### POST ACUTE CARE TRANSFER POLICY

This is often called the PACT rule, which results in IPPS MS-DRG payment being adjusted lower if the payment is transferred to a post-acute level of care, included SNF, Rehab and Home Health within three days of discharge. The proposed rule recommends that the three day Home Health timeframe be expanded to seven days after discharge. The hospital discharge process is multifaceted and is influenced by a number of factors, including patient preferences, family availability, insurance coverage, and access to post-acute care treatment options. The PACT rule is operationally challenging for hospitals to comply with while maintaining accuracy, so let's watch this closely.

*Continued on page 3*



## Medicare and Medi-Cal Update (or MACs, RACs, MICs and ZPICs - Who's in Charge of the CMS Acronym Department?)

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HFMA held a national audio webcast on May 27, 2008 entitled "Challenges to Providers from Federal and State Health-care Regulatory Enforcement Initiatives." Here are a few of the highlights:

- CMS has declared the Recovery Audit Contractor (RAC) program "successful" so there will be a national RAC program next year (at least 90 days) after California transitions from NGS to Palmetto GBA, which is currently scheduled for August 18, 2008 via MAC, the Medicare Administrative Contractor.
- CMS has launched their first national strategy to combat fraud & abuse in the forty-one year history of the Medicaid program via the Medicaid Integrity Contractor (MIC). The first contractor task order went to Booz Allen Hamilton and they will concentrate on Region III & IV (East Coast). They will start on the East Coast and then work their way to the West Coast.
- CMS Medicare Reform Initiative, which re-shapes MACs and the Program Safeguard Contractors (PSCs), will be replaced by Zone Program Integrity Contractors (ZPIC) with a more aggressive fraud fighting mandate. Five out of seven ZPICs will be assigned to "hot spot" areas such as California, Florida, New York, Illinois and Texas.

*Continued on page 4*

*Proposed IPPS Rule ... Continued from page 2*

### BEHAVIORAL OFFSET

A lot has been said about the MS-DRG behavioral adjustment or "offset". The proposed rule for FY 2009 includes documentation and coding adjustments. This is a statutory adjustment which reduces the national standardized amounts by an additional -0.9 percent in FY 2009 on top of the -0.6 percent adjustment applied to the standardized amounts in FY 2008, yielding a combined reduction of -1.5 percent. Note that P. L. 110-90 also specifies that to the extent the documentation and coding adjustments applied in FY 2008 and FY 2009 result in overpayments or underpayments relative to the actual amount of documentation and coding-related increases, the Secretary will correct the overpayments or underpayments in fiscal years 2010-2012. With many hospitals and healthcare systems implementing "Clinical Documentation Improvement Programs", it will be interesting to see what the CMS Case Mix Index reports will look like for FY 2008.

### HOSPITAL QUALITY MEASURES

The proposed rule would add forty-three new quality measures for payment determination in FY 2010. Of the proposed measures, only ten have been adopted by the HQA (Hospital Quality Alliance).

### HOSPITAL ACQUIRED CONDITIONS

FY 2008 CMS adopted eight conditions for which it would no longer pay a higher diagnosis-related group rate. This begins in FY 2009 if the conditions were the only MCC/CC and not present on admission. These also are referred to as "Present on Admission" conditions or POAs. Those eight conditions are:

- Object left in during surgery;
- Air embolism;
- Blood incompatibility;
- Pressure ulcers;
- Falls and trauma;
- Catheter-associated urinary tract infections;
- Vascular catheter-associated infections; and
- Surgical site infection – mediastinitis after coronary artery bypass surgery.

CMS proposes to expand the POA list and include **nine additional conditions** when the payment policy takes effect on

October 1. The nine proposed conditions are:

- Surgical site infections following elective procedures;
- Legionnaires' Disease;
- Glycemic control;
- Iatrogenic pneumothorax;
- Delirium;
- Ventilator-associated pneumonia;
- Deep-vein thrombosis/pulmonary embolism;
- *Staphylococcus aureus* septicemia; and
- *Clostridium difficile*-associated disease.

CMS also is proposing that the POA indicator of "U", meaning that the medical record documentation which is insufficient be treated like an "N" (not present on admission) indicator. CMS proposes to not pay a higher DRG payment amount when the medical record documentation is insufficient or "U" because it believes this will foster better medical record documentation.

### CHARGE COMPRESSION

CMS proposes cost report changes to separate out supplies with higher charge mark-ups from implantable devices with lower charge mark-ups into two cost centers on the Medicare cost report. Under this proposal CMS would be allowed to calculate two cost-to-charge ratios that more accurately reflect the costs of these items

These are *only some* of the proposals for FY09 under IPPS, other proposed topics include: Value-Based Purchasing, Capital Payment, and Emtala. It is recommended that hospital Finance, Reimbursement, Cost Reporting, Quality, Risk, and Health Information Management department management closely review the comment statements from the AHA, Boston Scientific, and other healthcare organizations before the final rule comes out in order to be better prepared.

Sources: Cardiac Rhythm Management, Boston Scientific Corporation, IPPS Highlights, April 2008; Federal Register at: <http://www.cms.hhs.gov/AcuteInpatientPPS/IPPS/list.asp#TopOfPage>; CMS-1390-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Proposed Rule (Vol. 73, No. 84), April 30, 2008; Premier, Inc IPPS FY09 Comments.

## CMS Open Door Forum June 12, 2008 – The Short and Sweet of It

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- NPI: On Inpatient claims, it is estimated that > 99% of providers are reporting NPI.
- Artificial Heart Device NCD: Since the mid 1980's, artificial heart devices were not covered by Medicare. There is a new NCD, since May of 2008, and these devices will be paid, provided that the patients are enrolled in the specially approved clinical study. Only two centers currently are performing these device implants under the approved study however.
- ACE demonstration: applications are still being accepted through August. There is competitive bidding for bundled payment for hospitals and physicians on cardiac valve procedures and joint replacement procedures. Only four states (Texas, Oklahoma, New Mexico and Colorado) are participating in the demonstration. Incident to services: A caller requested clarification on Transmittal 82 from Feb 2008. CMS officials said there would be more clarifying language forthcoming, probably in the form of a transmittal. They did say the doctor must be in the provider based department, but not necessarily in the same room. The caller gave the example of a cardiac rehab department, which is located on the same campus, but in an adjacent building from the "incident to" provider. How does the transmittal deal with this? This is an example of CMS officials not understanding how these ancillary departments are set up. So, stay tuned...
- Signature stamps: FAQ 9149 deals with acceptable signatures for clarification of terminal illness in the hospice setting, and the stamps are not acceptable. A caller asked whether this impacted all other settings. No one at CMS was able to answer this question.
- A LOT of callers' questions were not answered because no one from that topic or area was in attendance to address the question. Most of the of time was spent exchanging contact information.
- Next call is July 17, 2008

*CHA Update ... continued from page 2*

- \$48 million in reductions to the Disproportionate Share Hospital (DSH) program
- \$12 million in payment reductions in the Medi-Cal managed care program
- \$96 million in losses as a result of changes being proposed to Medi-Cal eligibility and benefits. This is a particularly troubling component of the Governor's proposed budget since it will remove many working poor and uninsured from the Medi-Cal system.
  - Requires enrollees to submit paperwork four times annually to retain eligibility for Medi-Cal services, eliminates dental and other benefits for adult Medi-Cal beneficiaries. The Administration estimated that half a million Californians would lose coverage.
  - Substantially restricts Medi-Cal eligibility for low-income patients with children, which would decrease the number of parents covered by Medi-Cal by approximately 430,000 by August 2011. The restrictions include a reduction in the maximum income level to 61 percent of the poverty line (\$10,736 for a family of three in 2008). Requires that family's principal wage earner works less than 100 hour per month.
  - Reduces the services provided to certain legal immigrants.
  - Requires unauthorized immigrants to re-apply for Medi-Cal monthly to receive emergency services.

**What is CHA doing about this?**

CHA and other statewide associations sued the state to reverse the ten percent cuts that are effective in July of this year. CHA has proposed to the state a solution for the two Medi-Cal payment delays and are working for adoption before the first scheduled payment delay in June. It is working to block the proposed cuts that are contained in the May revision. CHA also has prepared a Media Statement, Talking Points, for hospitals and a Code Blue media kit and is working through the Hospital Councils to schedule hospital meetings with local media about this issue.

**What can you do about this?**

Work with your Hospital Council and CHA to inform your communities about this issue. As an example, **Steve Packer MD**, our CEO, **Pamela Smith Martin**, our Hospital Council representative, and I met with the editor of our local newspaper using the Code Blue presentation prepared by CHA.

Please email or call me at (831) 625-4915.

*Medicare and Medi-Cal Update ... continued from page 2*

HFMA's Northern California Chapter hosted "Hot Regulatory and Legislative Issues" on June 6, 2008 in Sacramento. Representatives from Valley Health Plan, California Hospital Association (CHA), Department of Insurance (DOI), Department of Managed Healthcare (DMHC), and the Medi-Cal Managed Care Program provided various updates. An important "take away" from the program was a notice to providers who render services to Medi-Cal funded programs: **check-writes of June 19, 2008 and June 26, 2008 will be deferred to July 2, 2008.**

**MESSAGE FROM THE EDITOR**

"Out with the old, in with the new."

As we welcome the new chapter year, we decided to give our chapter newsletter a little make-over. You may have noticed that our newsletter has a new look and layout. It also carries a new name - *The Edge*. The changes are steps towards our goal of making the chapter newsletter an invaluable source of information for all members by featuring articles that will keep you abreast of industry news and issues, thus giving you the "edge" at work.

This is a work in progress and we welcome your suggestions and contributions. If you want to submit an article for publication in the newsletter, please send an email to [terry@rashcurtis.com](mailto:terry@rashcurtis.com). We want to hear from you about healthcare issues and trends, and news features that are of interest to the members.

In closing, I would like to welcome all the new members of the Newsletter Committee. Your ideas and contributions have and will continue to change *The Edge* to make it more dynamic and valuable to our members.



*Terry Paff*  
Newsletter Committee Chair

# Selling Bad Debts - Making the Decision

*Scott Abram*

*Director of Collections for Kaiser Permanente*

You've received the calls, emails and mailings from vendors who solicit your interest in selling bad debts. There are many well-known companies who specialize in purchasing receivables, and bad debt accounts in particular.

The concept of selling bad debts is relatively new to healthcare, but it is a long-standing practice in other finance and capital markets such as credit cards and personal loans. Hospital CFOs and revenue cycle leaders have been sheepish about selling debts, and for good reason; it's a new concept to us and there is an element of the unknown that makes us tread cautiously. And besides, bad debts are generally written off so they don't relate to our Days Revenue Outstanding calculation (or as most of us call it, A/R days outstanding). That, beside cash, is our major performance metric for revenue cycle. But bad debt

recovery remains an important source of cash, especially when we're managing millions if not hundreds of millions in bad debts. So when should you consider selling bad debts? How would you go about such a transaction? And most importantly, when would you know if you're getting a good deal? To be an effective and progressive leader in the modern healthcare finance and accounting field, it's important to understand this alternative to bad debt management and to formulate a strategy for engaging bad debts sales when appropriate.

## **Issues and Concerns about Selling Patient Accounts**

Perhaps the most significant issue that first arises when considering the sale of patient accounts is the loss of control. Once you sell the accounts the purchaser owns them and can do whatever they want to collect those debts. This

can be rather scary for CFOs, revenue cycle and other administrative leaders who worry about their organization's image in the community. And typically, the conversation is quite short because this concern alone is often enough to quash the entire concept. But there is a solution to this issue and it's quite simple: don't relinquish complete control. It's possible to include a provision in the sales agreement that will allow you to recall accounts that you've sold just like you do now with debts you've placed with your collection agencies. More about this important feature later, but I mention it now because most people would never consider selling accounts due to the control issue. But like most problems, there is a solution.

## **How It Works**

Bad debt purchasers aren't stupid or reckless. On the contrary, they

have deep analytical skills and often create proprietary software and algorithms to evaluate the liquidity of a given portfolio to determine its value and craft purchase proposals that include a reasonable margin. They are in the business of buying accounts for a price that is less than they can recover, and which not only covers their cost, but provides a net gain on their investment. We should expect nothing less from a shrewd and respectable business partner. They operate a profit-based business and they accept a certain degree of calculated risk in purchasing a portfolio, which is important to keep in mind. Bad debt purchasing agents generally assess the liquidity of a portfolio and will speak in terms of 'basis points' or what they think the portfolio is worth. One basis point is equal to 100<sup>th</sup> of one percent and can generally be converted into pennies on the dollar

and/or fractions thereof. Once general terms of a transaction are agreed, the Purchase Agreement defines the transaction and legally binds the parties to the agreement so it's important to know what you will agree to in such a transaction and how to craft a Purchase Agreement that meets your needs. But we're getting ahead of ourselves.

### Reasons to Consider Selling Bad Debts

Selling bad debts could be a good strategy for you if you need an immediate injection of cash to your organization. It will be 'found' money and can be done relatively quickly. In essence, selling bad debts accelerates the recoveries that you would expect to trickle in over the course of months or years. But that acceleration comes at a slightly discounted value. Other less obvious advantages include the elimination of regular reconciliations of your bad debt inventory and will dramatically simplify cash projections from bad debt sources. Even if you decide not to execute a sale of your bad debts, the examination of your portfolio's value is useful and the process will send a clear message to your collection agency partners that you have high expectations for maximizing the liquidation of your inventory of bad debts.

### How to Get Started and Formulate a Strategy

The first thing to do when considering the sale of your bad debt portfolio is to assess its value. This can best be done by preparing a Net Present Value (NPV) calculation of your bad debt portfolio. There's probably a NPV button on that fancy HP calculator that you use all of the time, but you've never had a reason to press it until now. It's wise to segregate your bad debt portfolio into aging categories and identify the historical recovery rate for each aging bucket. Collection agencies typically provide very useful actuarial reports that will serve this calculation well. It's

also useful to compare the NPV to the expected recovery rate if you were to do nothing and continue to receive monthly recoveries from your collection agencies. The resulting NPV will be the base from which you can assess whether the proposal that you'll receive seems reasonable, given your knowledge of the historical recovery rate.

Notwithstanding a detailed dissertation on NPV, suffice it to say that knowing the value of your portfolio in terms of NPV is the key to assessing proposals for purchase and having a logical calculation of value that can allow you to sleep comfortably at night after a decision to accept or reject an offer to purchase.

Your bad debt portfolio is likely already at collection agency(ies) and selling it means that you will be recalling all or part of it from the agency. Your collection agencies are your business partners and you should treat them as such, with respect and professionalism. So, you should advise them of your intent to offer the portfolio for sale and invite them to participate in the bidding process even if purchasing receivables is not one of their current offerings.

Next, develop a Request for Information or Request for Proposal and be sure to include:

- A general description of your organization, the general nature of the bad debts and expected outcomes
- Philosophical requirements relative to the organization
- Healthcare industry expertise of potential purchasers
- Technical specifications for the format and content of an electronic file of the portfolio

Most potential buyers will want to apply their valuation techniques to the portfolio before making an offer. This will require you to prepare an electronic file of the portfolio with all of the data

elements necessary for bidders to assess value. Those data elements are basically all of the demographic and transaction data that you have, less things like detailed notes from collection activity. Prior to submitting the data file to potential bidders, you must execute a Confidentiality Agreement, Business Associates Agreement and a Non-Disclosure Agreement or a document that suits all of these concerns.

Once you've evaluated the responses from the bidders, assessed their proposals and selected a winning bid, the next task is negotiating terms of the transaction. It's important to remember that you are the party offering the sale and it is you who should direct the negotiations. The Purchase Agreement must be carefully crafted to include or exclude certain items and other important terms of the sale such as:

#### *Whether you will sell the accrued interest*

The value of your bad debt accounts can be significantly larger than the gross principal balance if you include interest in the sale, but you will likely be required to attest to the accuracy of the interest calculation.

**Terms for recalling accounts** – This is where you address your concerns about losing control of the accounts. You may include a provision in the Agreement that allows you to buy back accounts at an agreed rate (such as your historical recovery rate) or to recall sold accounts and replace them with accounts of similar age and value. You may hold some accounts in reserve and exclude them for the sale for this very purpose.

#### *Flow-forward agreement*

Besides purchasing the existing portfolio, the purchaser may offer to buy debts on an ongoing basis as you write them off to bad debt rather than send them to a collection agency. Or you may send

them to a collection agency and then sell them after a short duration in collections. It's worth exploring if you are satisfied with the purchase price and the overall process. You also might expect slightly better purchase rates from the buyer when a flow-forward process is in place.

#### *How to handle accounts with government or other coverage discovered after sale*

You should give consideration for how you want to handle accounts where insurance coverage is discovered by the purchaser after the sale, particularly when government coverage is involved. If you do not want the purchaser to bill third parties with your Provider ID and Tax ID, you may wish to arrange to recall/replace or buy them back.

#### **Conclusion**

The sale of bad debts should not be mysterious or perceived as a scary venture. It should be considered as a viable alternative to bad debt management. It is important to understand what selling debts is all about, how it works, and when it's right for you. It's also important to realize that the offer of sale is a process and you should treat it as such. You need to be willing to go through the process and *not* execute a sale if it doesn't make good business sense for you. At the very least you will end up with a much clearer understanding of your bad debt portfolio's worth and be more likely to project cash flow from recoveries. And, if you formulate a strategy and know what you want out of the transaction, you will be able to control the process. Once you know what you want and how you want to arrange the transaction, you will be surprised at how selling bad debts may be a wise strategy.

## Improve Healthcare Building Environments to Improve Staff Satisfaction

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In healthcare settings staff satisfaction and retention are critical to patient care and hospital outcomes. In fact, the continuing shortage of qualified nurses has been found to play a role in the commission of medical errors, according to a recent Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) study (1). Therefore, maintaining job satisfaction to retain healthcare personnel is a continuing, important goal of healthcare organizations.

Given that working conditions comprise a major factor in job satisfaction among RNs (2) as well as all healthcare providers, a positive building environment can play an important role in how healthcare delivery personnel feel about their jobs. Providing these supportive positive working conditions, including building layout, temperature, lighting, noise, and Indoor Air Quality (IAQ) can therefore contribute to the ability of medical personnel to perform their work well and maintain high morale.

To create and maintain building environments that support the highest possible levels of healthcare delivery – as well as overall professional staff satisfaction – focus on efficiently providing indoor comfort and proper Indoor Air Quality (IAQ).

IAQ affects healthcare staff satisfaction in several ways. Improving IAQ, including proper air exchange, air flow and filtration, can contribute to lower rates of nosocomial infections, which results in longer patient stays and higher work loads for already stressed staff. Better IAQ also benefits hospital personnel by helping to reduce their risk of contracting infections such as tuberculosis.

For proper IAQ, hospital ventilation and filtration systems must meet strict standards. Look to guidelines set out by the Centers for Disease Control (CDC), the American Institute of Architects (AIA), and the Joint Commission on Accreditation for Healthcare (JCAHO).

### Temperature and Humidity

When regulating temperature and humidity, priorities must address patient health and

healing, as well as staff working conditions. For example, in the operating room, set temperatures to suit the procedure being performed and materials used, including the personnel involved. Surgeons and support staff often need to concentrate for long hours wearing layers of protective clothing and sub-optimal temperatures can lead to significant discomfort and sweating.

Consider that different spaces may also warrant specific requirements. Patient rooms will generally require warmer temperatures than surgical suites. Ensure that the design and control of healthcare HVAC systems will allow both the precise, and customized, temperature control throughout the facility.

### Noise and Light

In addition to air quality, temperature and humidity, noise also can directly affect the hospital atmosphere, impacting both workers and patients. High noise levels can add to stress. Building equipment, including HVAC systems, should be selected and designed for minimal noise output.

Poor lighting has been linked to patient depression and medication errors (Designing, 2004). Hospitals can incorporate technologies, such as highly efficient fluorescent lighting, to achieve proper conditions for staff while saving energy. Lighting systems can be integrated in overall building automation environmental management solutions to provide centralized control as well as improve energy management and efficiency.

### Centralized Monitoring and Reporting

In launching the industry's Critical Hospital Systems Dashboard, Trane has provided hospital administrators and engineers with a tool that will not only save time and money by providing detailed environment of care documentation for Joint Commission reporting, but also allows hospital staff to continuously view, monitor, track, trend and report environmental conditions in all critical areas from a single location. The Dashboard provides an immediate alarm signal if any critical parameter is exceeded so that staff may take immediate action to correct the situation.

### Quality Staff and Environment

Improving patient outcomes can be a direct benefit of raising job satisfaction and lowering turnover among healthcare professionals. Creating healthy, efficient, and comfortable hospital buildings is an integral element of achieving staff satisfaction and retention – worthy of ongoing attention, investment, and improvement.

For more information, contact: Pete Hugenroth, TRANE, Rocklin, California, by phone: 916-577-1119 or email: [pmhugenroth@trane.com](mailto:pmhugenroth@trane.com).

### References:

- (1) Tarkan, Laurie. "Nursing Shortage Forces Hospitals to Cope Creatively". *The New York Times*, January 6, 2004.
- (2) "Designing the 21<sup>st</sup> Century Hospital: Serving Patients and Staff." Summary based on a conference convened by the Robert Wood Johnson Foundation (RWJF) and The Center for Health Design, June 3, 2004, in Washington, D.C.

## Easy-to-Use, Online Hospital Financial Performance Tool

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Monitoring the health of the state's 355 general acute care hospitals has been a difficult task, with much of the important data unavailable in a usable format. The goal of California HealthCare Foundation's California Hospital Financial Performance Dashboard which debuted in June 2007 was to bring greater transparency to the issue of hospital financial health and provide more ease of access to hospital finance data for key industry stakeholders.

The interactive, easy-to-use tool, updated this month with 2006 audited annual data from the California Office of Statewide Health Planning and Development, includes individual hospital financial performance, as well as aggregate performance in multiple categories, such as hospital systems, geographic regions, counties, and legislative districts.

The tool allows users to export entire data sets. Data includes patient volume, payer mix, profitability, and capital strength, among many others.

Find the dashboard at:

<http://www.chcf.org/topics/hospitals/index.cfm?itemID=131619>



## A Weekend in Newport - Golf, Education and Networking (September 13 - 16, 2008)

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As the summer months are starting to materialize, a lot of thought is given to the various activities that we can enjoy with families and friends. It is a time of picnics, baseball games and other festivities.

Let us not forget, as the summer months start to wane, the annual Fall conference which will be held at the Hyatt Regency in Newport Beach. This location is close to a lot of the Southern California amusement activities, such as Disneyland, Knotts Berry Farm, the Hollywood Wax Museum, or just a leisurely stroll down the beach.

Families will appreciate the allure of the amusement attractions and Newport Beach. In addition, there will be a special pre-event opportunity to play golf at the world renowned Pelican Hill Resort and Golf Club. This weekend also will include a CFO Roundtable and a full day of educational sessions geared to the CFO and staff.

As we know, it is not all about the fun and social settings; we are also offering a renowned panel of experts and keynote speakers at this annual event. Each year, the conference grows in sophistication and depth of programs. The key note speakers include Steven Ford (son of Gerald and Betty Ford), Jeanne Scott, a self proclaimed "Talking Head in Chief" who always provides her wonderful and candid view of the political environment.

Not to be forgotten will be a presentation by David Link, Deputy Commissioner of the Department of Insurance and Cindy Ehnes, Director of the Department of Managed Care.

Sunday will offer Pre-Conference workshops covering areas from payment for non-contracted Hospital Emergency Room Services to MS-DRG's and their impact on the Case Mix Index.

Monday and Tuesday sessions will offer three unique tracks covering Patient Financial Services, Financial Operations, and Managed Care. We will have representatives from the new Medicare Administrative Contractor (Palmetto), covering how to effectively manage and plan for the RAC audits, Medicare Performance Tracking and Incentive Program and much more.

We all look forward to seeing you there.

## What's Cooking in Sacramento - Hot Regulatory and Legislative Issues

William McCammon  
Sr. Revenue Analyst  
Hill Physicians Medical Group and  
Brian Marrs  
Lead Sr. Financial Analyst  
Kaiser Foundation Health Plan



One of the most challenging aspects of healthcare these days is dealing with an ever shifting landscape of legislative rules and policies, industry innovations, political power plays, and budgetary constraints.

The Managed Care Committee stepped in several years ago and created the "Morning with DMHC" meeting. The purpose was to bring in key individuals from the newly created State Department to talk about what the department was doing and provide a Q&A session. That was expanded to bring in various State government offices as well as various Healthcare Associations (especially CHA) to provide insight, information, and the "low down" on the latest regulatory and legislative issues coming our way.

As in years past, the Committee focused on pulling speakers who could address some of the hottest topics in healthcare today. With the State budget in trouble, complex rules and guidelines, and a burgeoning population for starters, Medi-Cal has surfaced as one that can't be left on autopilot.

In order to assist our attendees we kicked off our conference with Greg Price, CFO Valley Health Plan & Director Managed Care for Santa Clara County. Greg jumped in with both feet and provided an overview of Medi-Cal from the trenches – the challenges and opportunities we face.

In order to provide some insight from the government's perspective, our concluding speaker of the day, Willie Anderson, COHS, GMC, Expansion & Other Contracts Section, Medi-Cal Managed Care Division, provided a general overview of Medi-Cal. Based on the number of members who stayed around after the conference ended for an informal Q & A session with Willie, indicates that we addressed a topic of concern for HFMA members.

The balance of our conference was rounded out by speakers from both the State government, including the Department of Insurance ("DOI"), Department of Managed Healthcare ("DHMC") as well as California Hospital Association ("CHA").

- Department of Insurance, DOI – David Link, Senior Health Policy Advisor and Deputy Commissioner, provided a summary of regulatory and enforcement issues currently under review by the Division.
- Barbara Glaser, CHA, provided a detailed review of the various bills and legislation currently with the State Legislature that will impact the Healthcare community (a summary of these bills can be found on a PDF report now on the Chapter website).
- Gary Baldwin, Senior Counsel, Office of Provider Oversight, Department of Managed Healthcare, provided an organizational overview of DMHC Offices and how they can help each of our organizations.

*Continued on page 10*

## The Region 11 Executive: Voice of the Region Chapter Leaders

Walton K. Luke,  
 FHFMA, MBA  
 Principal, L.H. &  
 Associates, LLC  
[wluke007@aol.com](mailto:wluke007@aol.com)



### The Yearly Change-over

On June 1<sup>st</sup> of every year, the eleven regions of HFMA nationally changes their Volunteer Leadership. On that day I changed my role from Region 11 Executive-Elect for 2007-2008 to the Region 11 Executive for 2008-2009, assuming this new role from Vicki Morgan, Past President of the Southern California Chapter and Region 11 Executive for 2007-2008. Mickey Duke, Past President of the Nevada Chapter is now the Region 11 Executive-Elect. Each of us have always been mentored through these very challenging positions from our predecessor, and each of us bring our own unique perspective in trying to make these roles effective and representative for the seven chapters in our region.

On this day, we also changed over the seven Chapter Presidents for Region 11, and I welcome:

**Alece Hon**, Scripps Memorial Hospital  
 San Diego Chapter

**Greg Moga**, Outreach Services Washing-  
 ton~Alaska Chapter

**Traci Kobayashi**, Sh Consulting, LLC  
 Hawaii Chapter

**Barbara White**, Legacy Health System  
 Oregon Chapter

**James Cummings**, JMCummings &  
 Associates  
 Southern California Chapter

**Chuck Acquisto**, Law Offices of Stephenson,  
 Acquisto & Colman  
 Northern California Chapter

**Mike Seeley**, Seeley Healthcare Consulting  
 LLC  
 Nevada Chapter

Together all of us will face our new challenges with enthusiasm and resolve to getting things done for our Chapter members in Region 11.

### The Role of Region 11 Executive

We all know how challenging the role of Chapter President has become, but few of us understand the role of the Region Executive. First of all, we have to be elected by the Chapter President-Elects during the Fall President's Meeting (I was nominated and elected two years ago by Jack Ruzic, Northern California Chapter President 2006-007 at the meeting held in Kaanapali, Maui). We have to be a member in good standing (yes, that means I pay my dues as well), a Chapter Officer for at least 2 years (I am a Past-President of the Northern California Chapter 1999-2000), and not serving concurrently as a chapter officer (nobody in their right mind would even consider doing that given the amount of time spent doing both roles).

There are a number of duties that the Regional Executive is required to perform:

- Regional Executive Council - At least five times a year, the eleven Executives have a conference call with a member of the National Board, plus HFMA Staff, to discuss specific agenda issues. In addition, we have face-to-face meetings at ANI, Chicago, Illinois with the National Board at our National Offices and at LTC. The key to these meetings are representing the needs of the chapter leaders and members in each region, be it Chapter Balance Scorecard (CBSC) issues or regional concerns for the chapters (or in our case, the Region 11 Symposium.)
- Best Practice Assessments—At every regional meeting, we solicit best practices from any chapter in our region then we discuss the success of that practice for common goals so that any chapter from another region could gain from improved performance. There is also the concern of chapter improvement activities and follow-up with the Chapter Presidents or President-Elects on what they might be doing differently.
- Annual Chapter President's Meeting—Each year the Chapter President-Elects led by the Regional Executive-Elect, review different sites and vote on attending in August/September of any year, a Fall Presidents' Meeting. Last year, when we held our Fall Presidents Meeting at the Sun Valley Resort in Sun Valley Idaho, we voted on this year's meeting at Turtle Bay Resort on the North Shore of Oahu on August 16-18, 2008.
- Leadership Training Conference (LTC)—In April of this year, we all attended LTC in San Antonio, Texas; in April of 2009, LTC will be held in Fort Lauderdale, Florida.

The Region 11 Chapters will hold a Presidents' meeting there and discuss face-to-face, any issues of concern, as well as hold individual Chapter meetings to plan for the on-going year. In addition, the Region Executive acts as a Course Coordinator for various training sessions, including leading group interaction or focus sessions.

- Fall President's Meeting—Each of the eleven Regions have chosen different sites within their region to have these meetings; one region will hold their meeting on the Royal Caribbean Adventure of the Seas ship, while two of us will hold ours in Hawaii, and another at Fisherman's Wharf in San Francisco, California.
- Regional Planning—For the past eleven plus years, the Region 11 Symposium has been held in January in Las Vegas, Nevada at Caesar's Palace. The Region Executive, in this case me, will conduct not only a Chapter Presidents' meeting on Symposium issues that covers operations, finance, sponsorship and general concerns, but also HFMA issues on CBSC or region specific issues. Each chapter in the region shares education hours based on attendance by a chapter member as well as sharing of revenues from the success of the event, which then funds the activities of the Region 11 Executives when HFMA National does not pay for their expenses of Volunteer Leadership.

### Closing—The Region 11 Symposium

The role of the Region 11 Executive changes yearly depending on the different priority issues involved. For my year, as the Chapter Balance Scorecard re-emphasizes education hours and the economy impacts how many Healthcare professionals can actually attend this conference, we face the reality of looking at how we operate the Region 11 Symposium to continue its success; the issues of "continuity of Volunteer Leadership" and "Succession Planning" are now priorities as we move to a new year.

The Southern California Chapter in the past has taken a very active role in running the Symposium. We thank them for their intense involvement but hope that we have not "burnt-out" their Core Volunteers. Our concern, as we move forward, is to continue involving key Volunteer Leaders into the "Core Leadership" from all of the seven chapters and prioritizing our focus on continuing this successful event. I am thankful to have these seven Chapter Presidents and their President-Elects to work with in continuing my role as the Region 11 Executive.

*What's Cooking ... continued from page 8*

As a reminder to all attendees and HFMA members, the various Power Point presentations and supporting documentation can now be found on the Chapter website. For those of you who weren't able to attend, we recorded the conference and hope to re-broadcast via teleconference in the coming months.

A review of the feedback surveys shows another informative and successful conference. We appreciate all the excellent feedback and suggestions and we will be taking these ideas into account as we lay the groundwork for next year's conference.

A special thanks to all the committee members for their time, effort, and ideas in bringing this conference together.

## Message from the Membership Chairperson

*Ramona C. Hernandez*

*Northern California Membership Chairperson*



As your new Membership Chairperson, I will do my very best to assist in getting our members more involved in committees and networking. I hope that each and every member is getting all the awesome benefits from their HFMA Membership.

If you have not already joined a committee, now is the time. If you enjoy leadership, we have something for you! If you like networking opportunities, we have lots of them! Joining a committee or committees has countless benefits.

If you need any assistance with membership, or would like to refer a new member to HFMA, please feel free to contact me at (510) 860-7442 or email [rhernandez@californiaservicebureau.com](mailto:rhernandez@californiaservicebureau.com)

I certainly look forward to working with all of you, and to another awesome year!

### MEMBERS ON THE MOVE

**Aimee Arata**

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**Deborah Knight, CHFP, CPAM**

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**S. Andrew Rybolt, CPA**

Vice President & CFO  
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### WELCOME TO ALL NEW MEMBERS!

- **Rachel H. Bell** - Director, Protiviti
- **Sandra L. Byrd** - Business Office Manager, Modoc Medical Center
- **Jonathan F. Casey** - CFO, Episcopal Senior Communities/Lytton Gardens
- **Dean Christman** - Vice President RLPS, Commerce Bank
- **Terrie Crampton** - Area Wide Operations Manager, Sutter Health
- **Patricia Hom** - Director Financial Management, St. Mary's Medical Center
- **Cole Hooper** - Account Executive, MedeFinance, Inc.
- **Linda Hurley** - Director, Macia Gini & O'Connell LLP
- **Chelva Kumar** - CFO, St. Louise Regional Hospital
- **Susan M. Lynn** - Sr. Financial Analyst, Sutter Health
- **Terrylee Neal** - Reimbursement Analyst, UC Davis Medical Center
- **Nina V. Pacheco** - Hospital/HP Compliance Officer, Kaiser
- **Wayne Pan** - Consultant, L.E.K Consulting
- **Eric Pifer, MD** - Chief Medical Information Officer, El Camino Hospital
- **Anthony Pizzuto** - Senior Consultant, Siemens Medical Solutions, USA
- **Joelle Pulver** - Moss Adams
- **Donna Sheel** - CFO, Lassen Medical Group, Inc.
- **Penny Spike** - Manager, Catholic Healthcare West San Mateo
- **Forrest B. Stamps** - VP Business Development, AuditLogic
- **Herb Suvaco, Jr.** - Vice President, Commerce Bank
- **Katherine A. Vanderveen** - Executive Director, Kaiser Permanente
- **Rodney M. Wallin** - VP Business Development, AuditLogic
- **Mary Warrack** - Compliance and Safety Officer, Tehachapi Valley Healthcare District

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Ramona Hernandez  
rhernandez@californiaservicebureau.com  
(415) 475-4595



## Job Opportunities

Visit the chapter website (<http://www.hfma-nca.org>) for details and a complete listing of job openings

- 🔍 Vice President of Business Development - MedAssist (posted June 25)
- 🔍 Reimbursement Manager - Washington Hospital (posted June 11)
- 🔍 Audit Manager - CHAN Healthcare Auditors (posted June 11)
- 🔍 Decision Support Analyst - Doctor's Medical Center (posted June 4)
- 🔍 CDM Analyst I/II - Stanford Hospital & Clinics (posted May 12)

## Northern California Chapter Board of Directors

**Chuck Acquisto - President**  
**Kenneth Jensen - President-Elect**  
**Jayne Kroner - Secretary**  
**Kathleen Cain - Treasurer**

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Aimee Arata	Brian Marrs
Barry Brown	Terry Paff
Dan Dreblow	Cindy Rudow
Maria Dryden	Jack Ruzic
Ramona Hernandez	Christine Sarrico
Peter Hugenroth	Steve Thompson

## Newsletter Committee

**Terry Paff - Committee Chair**  
**Walt Luke - Co-Chair**

Mary Ackley	Jayne Kroner
Geli Argao	Frank Fedor
Gloryanne Bryant	Brian Marrs
Kathleen Cain	Kim Miranda
Ramona Hernandez	Cindy Rudow
Arlette Kendall	Steve Thompson
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