

Industry News

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President's Message



Kathleen Cain
Chapter President
2010-2011

Step It Up

Last column I proudly announced the number of Yerger awards won by our Chapter and presented at the Annual National Institute (ANI). Now the real work is underway for the current year. Our Chapter is on a path to be eligible to receive a Shelton award for five years of continued improvement. This is a coveted award and not given lightly. We need to focus on strategy and execution as well as communication. Each of you is key to our success and we want to keep you apprised of our progress. Each edition of The Edge will contain the most recent Chapter Balanced Scorecard, the document that National utilizes to track chapter progress towards goals.

We're measured primarily on the following items:

	CURRENT	GOAL
Membership	833	981
Education Hours	306	11,004
Certification Exams Taken	0	12

The largest challenge the Chapter has traditionally faced is education hours. If each member got *just one more hour* than last year, we would exceed our goal. We realize many organizations have limited the opportunity for travel and education. The **Fall Conference** is quickly approaching on September 19 to 21 and we are again offering a hefty \$300 rebate towards the registration. Plus, we offer multiple venues at little or no cost. As an example, the third Wednesday of each month is a **Revenue Cycle Forum Chat** held during the lunch hour from 12:00 to 1:00 PM. It's an interactive conference call and deals with current hot topics or questions from the participants. You can register at the Chapter website www.hfma-nca.org. The Chapter website also lists many other free webinars on various topics.

How can you help us towards our goals? Do the following:

- Recommend a friend or co-worker to join the Northern California chapter
- Attend an educational event
- Take the certification exam
- Tell everyone "We want the Shelton"
- Step It Up!

SAVE THE DATE!
HFMA Northern California
Spring Conference
March 24-25, 2011
Sheraton Grand
Sacramento, California

HFMA Northern California Education and Events Calendar

Visit www.hfma-nca.org for details and to register online

August 31, 2010
Morning with Medi-Cal: Billing and Follow Up Workshop
9:00 am - 12:00 PM
El Camino Hospital, Mountain View, CA

September 8, 2010
CFO Panel on Health Reform and Impacts on Physician Relationships
1:00 - 2:00 PM
Webinar

September 15, 2010
Monthly Revenue Cycle Forum
Free teleconference

September 19-21, 2010
California Fall Conference
Long Beach, CA
<http://www.hfma-cafallconf.org>

September 23, 2010
PFS Road Show
8:30 AM - 2:00 PM
Kaiser Foundation Hospital, Modesto, CA

October 1, 2010
11th Annual Northern California Chapter Golf Tournament
Tee time: 11:00 AM
Rancho Solano Golf Course, Fairfield, CA

October 15, 2010
PFS Road Show
8:30 AM - 2:00 PM
Washington Hospital, Fremont, CA

Computer Assisted Coding (CAC) - Technology Comes to the Needs of Healthcare

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Computer Assisted Coding or “CAC” as the industry refers to it, offers some very impressive benefits IF you know what it is you are looking for and know what it should bring to the table. There are many varieties of CAC technologies and applications available to hospital HIM departments, physician offices and all those settings in which the coding function is performed. For several years now the American Health Information Management Association (AHIMA) has been studying and continues to study the benefits of this technology. AHIMA has defined CAC as the “... use of computer software that automatically generates a set of medical codes for review, validation and use, based upon clinical documentation provided by healthcare practitioners.” This article will share some of the differences in CAC technology, the benefits and provide some ideas of why you should consider looking into this in the very near future.

Those of us who work in healthcare know that in order to process the patient services into payment or reimbursement we need to have the encounter, visit or hospitalization, coded either with ICD-9-CM (International Classification of Diseases 9th Revision Clinical Modification), CPT (Current Procedural Terminology) codes or a combination of these code sets. A given fact is that it is the coded data that also suggests the quality of care provided for patient populations **and** drives severity of illness, risk of mortality data, research, contracting, and the list goes on and on. The significance of high quality coded data is paramount, but equally important is the clinical documentation the coding is based upon. The documentation linked to the codes and the resulting payment is under greater regulatory scrutiny which requires defensive auditing and monitoring to be in place.

Hiring trained, skilled and productive HIM coding professionals is a challenge, and this challenge is compounded by the lack of these professionals. It is expected that the shortage of these skilled professionals will significantly increase with the implementation of ICD-10, which is on October 1, 2013. The coding process can be very time consuming and expensive in and of itself, with overtime and contract coding services needed to address backlogs and demanding turn around times as well. But we can utilize CAC to narrow the gap in this area.

Computers today do “assist” in the coding process and there are software applications that allow the coding professional to find information without the use of the ICD-9-CM code book or in conjunction with the coding book. This process does require the detailed reading of the medical record documentation, both handwritten and electronic, although handwritten has the challenges of legibility. Knowledge of anatomy, physiology, disease process, pharmacology and medical terminology are just a few of the competencies required. Electronic health records can aid in the legibility issues of documentation, but we still have limited trained staff and the time-consuming process of actually reading the medical records and assigning accurate code(s).

CAC is achieved by Natural Language Processing, or NLP, which is a type of artificial intelligence that allows the computer to read the “text” of an ICD-9-CM or CPT code assignment. Then the computer

Continued on page 3

Update on California Hospital Association Activity

Steve Blake, Trustee for California HFMA Chapters

On July 15-16, 2010, the CHA Board of Trustees met for review and update on California Hospital Association Activity. Many topics were covered, most significantly:

- Affordable Care Act [ACA]
- Status for the California Provider Fee
- Section 1115 Medi-Cal Waiver
- International Studies and Missions in Healthcare

Affordable Care Act [ACA]:

The enactment of the Patient Protection and Affordable Care Act (ACA) this March (CMS issued supplemental proposed rules on June 2) has set the stage for a series of changes to healthcare regulation over the next decade. This defines the landscape for CHA’s federal advocacy for years to come and its leadership role to help hospitals and caregivers adapt to new delivery system approaches and payment structures. CHA is taking a proactive role working with CEOs and lawmakers to help California develop a model for the future that is fair for providers and the patients they serve.

Guest Speakers Bruce Merlin Fried (Partner – Sonnenschein Nath & Rosenthal LLP) and Herb Schultz (Regional Director Region 9 U.S. Department of Health and Human Services) provided their analyses of the sweeping changes on our horizon. To recap, some of the key elements are:

- Insurance Reform [2010 to 2014]
- Long term policy on Geographic Variation [2011-2012].
- Creation of Accountable Care Organizations (ACO) [2012].
- Value Based Purchasing [VBP] – quality and efficiency measures [2013]
- Expanded eligibility for Medicaid [2014]
- Cuts to Medicare and Medicaid DSH payments proposed [2014]
- Initiation of state Exchanges [2014] and universal expansion [2017]

Mr. Fried highlighted the core focus – that emphasis on quality is expected to be the key driver for cost reduction. The government estimates \$1.2 trillion in achievable savings, \$200 billion from hospital providers. Emphasis on primary care, reduction in hospital errors, acquired conditions and readmissions are expected to yield significant savings. Additionally, there is a belief that reimbursement cuts are sustainable if the uninsured population becomes covered.

Insurance reform focuses on perceived abuses, eliminating denial of pre-existing conditions, banning rescissions and regulating loss ratios.

Geographic Variation (i.e. the elimination thereof) was postponed pending further study but remains a future threat to California revenues.

Accountable Care Organizations will be primary care based and fee for service, relying on shared savings incentives to encourage innovation in the delivery of care. Hospital Council of Northern and Central California and the Hospital Association of Southern California [HASC] are working on demonstration models. The bar on corporate practice of medicine presents a significant challenge that most other states do not contend with.

Continued on page 3

Computer Assisted Coding ... continued from page 2

“engine” will have programmed algorithms, edits, and logic to allow it to interpret and assign the code or codes. CAC can also provide a validation and an audit trail by identifying (highlighting) where within the medical record the computer found the text that is represented by a code(s). CAC is also achieved through structured input technology which is the process of having a menu with clinical terms that the provider can select from. Often, structured input is seen in the physician setting. In addition, some CAC technology also develops and emphasizes the actual content of the text and documents. Improving the clinical documentation content can greatly impact the assignment of the code(s). Overall CAC works best with electronic medical record text versus handwritten documentation.

Imagine if you will a 12 day hospital stay; imagine now the amount of documents from the hospitalization: nursing notes, physician reports, etc., and the coding process which requires the reading of much of these documents. The coding professional then has to apply knowledge and skill to interpret the correct assignment of ICD-9-CM codes. How long do you think this will take? 10 minutes, 15 to 20 minutes, or longer? Sure, the complexity of the patient’s medical condition may also impact how long it would take. Now think of the computer that can read the same medical record text and interpret diagnosis, signs/symptoms and assign the ICD-9-CM codes ready for validation in a matter of seconds. The amount of time that this saves is enormous, and with the accuracy of computer coding being in the 95-97th percentile, the validation work of the professional coder would be expedited.

Healthcare has additional pressure and concern with the increase in regulatory auditing, like Recovery Audit Contractors. The use of

CAC can provide an audit trail within the medical record text of where the code was based. This can drastically assist providers and institutions in defending their coded data and reimbursement. This will also aide in the internal audit process and monitoring.

CAC technology is not a threat to HIM or the coding staff but provides a greater use of the coding professionals’ skills and knowledge by eliminating the time-consuming steps of reading and determining the code(s).

In summary, the benefits of CAC include:

- Reductions in overtime for coding staff – financial savings
- Reduction in use of external coding vendors – financial savings
- Achieving Discharge Not Final Coded (DNFC) goals
- Improvement coding related workflows
- Decrease regulatory and compliance risks

So check out some of these technologies and start with a visit to the ProVation Medical, A-Life Medical, Dolby, Lynx Medical, MedQuist and 3M websites, and you will begin to gain greater knowledge and understanding about each of these new technology approaches to clinical documentation, coding and data quality. This is not an all inclusive list, of course. Be sure to also read over the AHIMA Practice Brief on this subject as well. The ultimate benefits of CAC technology are to help healthcare improve coding productivity and accuracy in many settings. ☒

Resources: AHIMA: Delving into Computer-assisted Coding (Practice Brief) 2004; ProVation Medical; A-Life Medical, Dolby, MedQuist, Lynx Medical; 3M™ Corporation

Update on CHA Activity ... continued from page 2

Additional initiatives [VBP, Cuts, Eligibility and Exchanges] are still being defined and can be counted on to be key sources of substantial changes in the delivery of healthcare.

Mr. Schultz introduced himself and the role of HHS Region 9 in the development of new delivery approaches. He expressed confidence in the ability of California providers to “step up” to the challenges and offered the services of his department to assist in that role.

California Provider Fee

Adjustments to the model, a narrative description and payment justifications have been negotiated with the state this week. In addition to the changes required in managed care, other minor adjustments will be made. In aggregate, the changes are designed to minimize the impact on the original model, however, in the aggregate, the reduction in matching revenues (net of fees) can be as much as 23%. In addition to amendments in law and modifications to the State Plan Amendment filed by the state with CMS, an independent actuary retained by the state must certify the actuarial

soundness of the managed care rates. The certification must include an acceptable allocation of managed care payment increases to hospitals.

The initial payment for the first quarter of the program (April 1, 2009 through June 30, 2009) will be processed as soon as possible after CMS approval. Thereafter, each subsequent quarter will be processed in rapid succession with expected completion by December 31, 2010.

Section 1115 Medi-Cal Waiver

The Department of Healthcare Services (DHCS) is working on a new Medi-Cal demonstration project waiver to expand coverage to the uninsured; improve coordination of healthcare to seniors and persons with disabilities; and obtain new federal financing to strengthen the state’s safety-net hospitals. DHCS issued a concept paper that builds upon the existing delivery system while providing the foundation for implementing healthcare reform over the next 36 months. The current fiscal crises in California casts doubt on the state’s ability to achieve this purpose as it seeks to expand coverage with no additional general fund contribution.

International Studies and Missions in Healthcare

Barry Arbuckle, Ph.D., President and CEO MemorialCare Health System, Fountain Valley, presented the Walker-Sullivan Fellowship Report providing both quantitative and qualitative analyses of healthcare delivery around the world complete with slides and anecdotes that put the data in perspective. Clearly the level of expenditure (% of GDP or other measure) is not the only factor in mortality or longevity. Culture and lifestyle contribute challenges that money can’t cure.

Chris Van Gorder, FACHE, President and CEO and Brent Eastman, M.D., Corporate Senior Vice President and Chief Medical Officer Scripps Health, San Diego provided a Special Report on “Mission Haiti.” Their firsthand and very moving accounts of the tragedy and loss of life, as well as the care and hope they were able to deliver under extremis, exemplified the best of what members in our industry have to offer when we rise to the challenge. ☒

More details on developments and other activities can be found on the CHA Website at <http://www.calhospital.org>.



Creating a User Friendly Physician Environment

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Over the past 30 years of practicing medicine in Northern California, I've seen a lot of changes. First was the introduction of the new restructured payment system from Medicare and Medi-Cal with stringent utilization controls and fixed base payments. Then came the era of managed care and physician contracting, which perpetuated competition and more of the same. Both of these changes were designed to reduce healthcare spending. Unfortunately, what they accomplished was setting up a system of "discounted care" based on a set of perverse financial incentives, which started the economic divide between insurers, managed care organizations, healthcare systems, hospitals, healthcare providers and patients in need of medical services. The results of these efforts as to their financial impact is open to debate, as healthcare spending in the United States continues to escalate. The impact on insurer-hospital-physician-patient relationships is much more of a concern because the resulting conflicts in priorities, inequities, disparities and inefficiencies lead to an eroding system of patient care. Now with the advent of Healthcare Reform, newly introduced models of care and healthcare initiatives with such terms as Meaningful Use, Comparative Effectiveness, Accountable Care Organizations, Bundled Payments, Value Based Care, Performance Profiling, Pay for Performance and other cleverly titled programs are further compromising the physician ideal. Those who can afford to do so have retired, some have left practice in pursuit of another career, some have taken paid positions, some have tried to diversify their offerings and others begrudgingly just go along with the flow. So what are we going to do?

For the most part physicians are good people. Sure they have their idiosyncrasies

and personality quirks, but in the end their primary interest is best patient care. To start off with, we need to look at physicians (as well as other healthcare professionals) as a precious resource in short supply and do what we can to help them. We need to recognize that these changes are having a significant effect on physicians' practices. Growing interference from outside agencies, public reaction, and accountability imposed upon by suspect physician rating systems, the increasing costs of doing business, and the reduction in revenues for services provided have led to growing levels of stress, frustration, and dissatisfaction. In some cases this has resulted in burnout, depression, and more serious consequences interfering with both their public and professional lives.


"Utilizing a physician champion, who has the right skill set to meet with physicians and present relevant and meaningful information that is appropriate from the physician's perspective, can be extremely influential in getting physicians to appreciate what needs to be done and how they can help do it."

From an organizational perspective the first step in the process is to improve physician relationships. Listen to their concerns, recognize their priorities and adjust accordingly. Conversations with physicians need to be open and honest, sharing mutual concerns and objectives, developing trust and respect for each other's needs. Administrative leaders need to have effective communication and facilitation skills and be sensitive and responsive to physician concerns, not just tell them what they would like physicians to do. Utilizing a physician champion, who has the right skill set to meet with physicians and present relevant and meaningful information that is appropriate from the physician's perspective, can be extremely influential in getting physicians to appreciate what needs to be done and how they can help do it. This includes issues around utilization manage-

ment, compliance with best practice standards of care, participation in committee activities, and responsiveness to documentation needs in medical records. In some instances it may be necessary to create such a position or be willing to pay physicians who are willing to serve in this capacity when taking time away from their office. When looking for physician involvement always keep in mind two things: one, they are investing their time and two, the question, "what's in it for me?" It's all about motivation and incentive to change.

A second phase is to provide physician support. Some of this may revolve around finance, contract negotiations, business opportunities or practice management. Some of it may involve emotional support. Many organizations have implemented a Physician Wellness Committee designed to work with physicians to help them adjust to the stresses of their environment. Other organizations may offer similar support services through the Medical Staff office, Human Resources, or Employee Assistance Programs (EAP). Some organizations have contracted with outside agencies to assist in physician coaching and counseling or provide customized in-house training programs on specific topics of interest. Early intervention programs like these have the best opportunities for success.

In the end it's all about cultivating positive relationships. We need to understand physicians' concerns, regard them as a precious resource, and try to work with them in a collegial supportive manner. Recognize their value and reward their efforts. There is no "cookie cutter" approach, but following the suggestions listed below will lead you in the right direction.

1. Listen
2. Share information
3. Discuss objectives
4. Be responsive
5. Provide skilled leadership intervention
6. Engage a physician champion
7. Provide support
8. Provide recognition and respect 

Compliance Planning: Preventing Waste, Fraud, and Abuse

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FACHE*

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Services*

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While most acute care hospitals have instituted a compliance plan and many have a compliance staff, there are more healthcare organizations that do not have such a plan; and they may be at risk in the event of potential fraud or abuse action against them.

Under the Affordable Care Act (ACA) of 2010, the Secretary of Health and Human Services (HHS) working jointly with the Health and Human Services Office of Inspector General (OIG) must promulgate regulations for an effective compliance and ethics program which may include a model compliance program within two years of enactment of ACA. The following are excerpts and summaries from the OIG website and its guidance on developing an effective compliance program.


The OIG has adopted zero tolerance toward waste, fraud, and abuse in Medicare, Medicaid, and other HHS funded programs. The OIG believes that by implementing an

effective compliance plan, a provider can create an environment of awareness and understanding that will enable the provider's staff to identify potential fraud and abuse and to report such activities without fear of retribution. The OIG believes that through a partnership with the private sector, significant reductions in fraud and abuse can be accomplished. Compliance plans offer a vehicle to achieve that goal.

While a compliance program will not provide immunity from criminal, civil or administrative prosecution, it may be considered as an extenuating factor in negotiations with the Office of Inspector General if a provider is being charged with fraud or abuse. "The OIG suggests that the comprehensive compliance program should include, at a minimum, the following elements: (1) written standards of conduct for employees; (2) the development and distribution of written policies that promote the organization's commitment to compliance and that address specific areas of potential fraud; (3) the designation of a chief compliance officer or other appropriate high-level corporate structure or official who is charged with the responsibility of operating the compliance program; (4) the development and offering of education and training programs to all employees; (5) the use of evaluation techniques to monitor compliance and ensure a reduction in identified problem areas; (6) the development of a code of conduct and the use of disciplinary

action against employees who have violated internal compliance policies or applicable laws or who have engaged in wrongdoing; (7) the investigation and remediation of identified systemic and personnel problems; (8) the promotion of and adherence to compliance as an element in evaluating supervisors and managers; (9) the development of policies addressing the non-employment or retention of sanctioned individuals; (10) the maintenance of a hotline to receive complaints and the adoption of procedures to protect the anonymity of complainants; and (11) the adoption of requirements applicable to record creation and retention."

The OIG will not accept compliant plans and programs that exist on paper but are not earnestly implemented or enforced. In addition to education and training programs, policies, and notices, a successful compliance program should require the thorough monitoring of its implementation and regular reporting to senior executives and members of the Board of Directors. Periodic training of the Board of directors and senior managers should also be part of the compliance program.

The OIG offers fraud alerts and periodic updates in addition to guidelines for implementing an effective compliance program. Information about compliance, sanctioned individuals, and reports and audits are all available on the OIG website at: <http://oig.hhs.gov/>. 

HFMA NCA FINANCE EDUCATION EVENT

*The Northern California HFMA Finance Committee presents a CFO panel discussion
broadcasted via live internet video streaming/webinar*

Health Reform and Impacts on Physician Relationships

Wednesday, September 8, 2010 | 1:00 - 2:00 PM PST

\$25 registration fee per facility

For additional information and to register online, visit www.hfma-nca.org

**Recommended for
CEOs, CFOs,
Controllers, Senior
Finance and Accounting
Executives, Contracting,
Managed Care and
Reimbursement
Executives, Business
Development Leaders,
and staff interested in
leadership perspectives**

In a panel format, we will hear first-hand from the speakers on how their healthcare organization is preparing for the impacts of healthcare reform. We will explore topics such as:

- Preparedness for value-based payments such as bundled payments, outcomes-based tiered contracting and Accountable Care Organizations (ACOs)
- Data and reporting readiness to support cost and outcomes measures
- Perspectives on future reimbursement trends
- Physician alignment strategies and support for reform-based planning initiatives

The session will also include time to answer your questions related to reform preparation in these areas.



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Quality as a Strategic Differentiator

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Read more of the content from this article at <http://www.hfma-nca.org/Newsletter/>

Over the past few decades, the concept of hospital quality has evolved from an ambiguous perception to a measurable and important element of a hospital's value. This shift supports a broader trend toward reimbursement for the outcome of care provided, rather than the quantity. To be fully paid in the future, hospitals must demonstrate their quality outcomes—at or above national levels—and their agility in moving to a payment structure that rewards value.

These trends mean quality is becoming a strategic lever for hospitals. This opportunity warrants a significant change in thinking for organizations that have historically regarded quality as an element of risk management, of compliance or as a payor reimbursement requirement. Hospitals with robust quality improvement programs will use their quality position to improve contracting positions, to attract the best nurses and physicians, and to compete effectively for patients.

High-Performance Organizations

Differentiation on quality is very difficult to achieve...only a small percentage of hospitals are in the top stage of quality development.

Organizations that value quality as a strategic asset make the continuous quest for quality advancement part of their culture. These high-performance organizations

develop tailored quality plans and define elements of quality care unique to their individual patient populations and organizational strengths. These high-performance organizations have gone through four stages in creating a quality improvement culture and building their quality strategic asset.

EXHIBIT 1: FOUR STAGES OF QUALITY FOCUS

Stage 4: Expanded Quality Definition	<ul style="list-style-type: none"> • Metrics specific to the hospital and population
Stage 3: Improvement Targets	<ul style="list-style-type: none"> • Robust, multi-level metrics defined by the hospital • Internally and externally defined
Stage 2: Quality Improvement Plan	<ul style="list-style-type: none"> • Continuous improvement metrics • Predominantly based on external metrics
Stage 1: Limited Focus on Quality	<ul style="list-style-type: none"> • Minimum set of externally-defined compliance metrics

Five Steps to Advance Quality Today

Creating a quality strategic differentiation strategy requires hospitals to move beyond nationally accepted metrics and create quality indicators specific for their populations and situation.

After an organization has assessed its current stage of quality focus, it can develop a quality advancement strategy. There are five steps in establishing quality as a strategic differentiator. Each step advances a hospital's quality position with an increased quality focus, depth of commitment and level of achievement. Hospitals must have robust, challenging plans to move forward from each step to the next.

Step 1: Set a Quality Vision

Step 2: Emphasize the Role of the Board

Step 3: Charge the Care Team and Create the Infrastructure

Step 4: Measure, Adapt, Publicize

Step 5: Refine Goals and Measures

Summary

In the future, there will be significant benefits for hospitals that advance their strategic quality position. Hospitals with advanced quality strategies will be well positioned to participate in the development of future care models and accompanying reimbursement structures. Furthermore, as the public focus on outcome quality increases, these hospitals will be able to tangibly demonstrate their superior care. This will attract patients as well as the best physicians, nurses and staff to the hospital.





Past Masters and Commanders Return to the Quarterdeck

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Northern California Chapter Past Presidents (L-R):
 Jack Ruzic, Frank Fedor, Christine Sarrico and
 Chuck Acquisto



Top: Past meets present. Christine Sarrico (FY 2007-08) and current President Kathleen Cain; Middle: Jack Ruzic and Ken Jensen; Bottom: Kathleen Cain, the chapter's fearless leader, steers the boat onto calmer waters.



Top row, middle photo: Gary Lampi, Frank Fedor and Jack Ruzic; Above: Vince Acquisto and Gary Lampi enjoying wine and h'ors d'œuvres inside the cabin.



On August 6, 2010, ten Northern California Chapter past and future presidents spent several hours before the mast battling strong winds and incomparable views from the bay in the service of their chapter.

The afternoon began with lunch and a business meeting aboard the Cat Ballou in Sausalito to discuss how to retain the active involvement of the chapter's past presidents. The experiences of the most successful chapters show that they find a way to retain the active involvement of past presidents well past the time their terms end. Several ideas surfaced as to how past presidents could serve as mentors to incoming committee chairs and co-chairs, and share experiences and contacts to maintain a high level of service to chapter members.

The ideas and discussions continued to flow across the bay as the sailing began. This of course, is one of the main attractions of HFMA: sharing ideas and having fun with friends in the service of our industry. Special thanks to **Kathleen Cain, Terry Paff, Ken Jensen, Bernadette Mills-Jensen, Chuck Acquisto, Vince Acquisto, Jack Ruzic and Gary Lampi** for sailing aboard, what all hope was only the first of many future sailing trips and other activities, to promote the involvement and goodwill of our former chapter leaders. ☙



Above: Terry Paff, Chapter Secretary, takes his turn in steering the boat. Below: Past Presidents enjoying lunch before the boat ride.



HFMA NORTHERN CALIFORNIA - SPOTLIGHT ON A MEMBER



MATT MORGAN

Director, Financial Services, Community Hospital of the Monterey Peninsula

Board Member, HFMA Northern California Chapter

Years in Healthcare: 13

Years in HFMA: 10

What are your personal and/or professional benefits realized from HFMA?

It's been a great opportunity to meet good friends and enhance current and prospective business relationships. My professional network is largely HFMA-based. I can pick up the phone and call someone I know from HFMA and get an answer or at least pointed in the right direction - that's invaluable.

How did you end up in Healthcare? Did you choose it or did it choose you?

People choose healthcare, seriously?

Tell us about yourself

I'm a happily married man and proud father of two young girls (6 and 3). I'm the oldest of four, with family roots in Southern California. I'm also very active in my church.

There's no right or wrong answer, but if you could be anywhere in the world right now, where would you be?

Anywhere tropical - warm water and warm weather.

What do you like to do for fun in your spare time?

I play two-man beach volleyball most Saturdays, love the water - liquid or frozen forms both work for me. Shoot pool, listen to tunes, play fantasy football. I very much enjoy playing with my kids too. I try to get outside with my wife and kids whenever possible.

What's the last book you read?

"The Girl Who Played with Fire" by Steigg Larsson. Currently reading "Lamb" by Christopher Moore.

What would you do if you won the lottery?

Quit working - buy property in a warm climate and in the mountains. Adopt beach/ski bum status. Play more golf.

What is your greatest achievement outside of work?

Having a family.

If you could be a superhero, who would you be and why?

The Silver Surfer - he flies through space on a surfboard.

What's the best movie you've seen in the last three years?

That isn't a cartoon? I don't know. It wasn't the best movie but I thought Avatar was an amazing spectacle.

Who are your heroes?

Jesus Christ, my Dad, JFK, MLK

The best advice I ever had was

"Deliver good numbers and you earn the right for people to listen to you."

The best part of my job is

It changes all the time; there are always fresh challenges to tackle and unique problems to solve. Is my boss going to read this? I mean, my boss.

My favorite food is

Fish tacos

My first car was

1963 VW bug



My favorite car was
1964 Ford Galaxie 500

Favorite Quote
"A good plan today is better than a perfect plan tomorrow" - Patton

"If two people agree all the time, one person is not necessary." - Unknown



HFMA Triathlon “Partners” Results

*Dan Dreblow
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Six months ago, **Jim Strong**, the CFO from Sutter Coast in Crescent City, and I were discussing my triathlon stories. Jim had heard enough and Jim said that he was ready to accept the challenge and join me at the Solana Beach Triathlon. Registrations were made and Jim ordered all of the necessary training information.

His wife, **Susan Strong**, was very supportive and even purchased a bicycle to participate in Jim’s training rides. Susan is the stronger swimmer, so I told Jim that Susan

may turn out to be the most capable triathlete of the three of us. Susan didn’t disagree.

Our plans changed dramatically when Susan learned that she had a health issue to deal with, requiring continuous medical treatment. The triathlon was forgotten and Jim focused on the well-being of his wife.

This was my first experience with someone sharing their personal journey through the use of a blog. It quickly became clear that Susan is an amazing woman by taking on this health challenge with confidence and good humor.

Jim’s role as a loving husband was also well communicated by Susan. Jim has “set the bar” very high for any husband that wants to be supportive of his wife. In many ways, Susan’s blog reads more like a love story than a healthcare journey.

The Solana Beach Triathlon was held earlier today and I completed the event. Usually I am very self-absorbed. I even always say a prayer in the ocean, for my safety during the event. Running into the ocean with hundreds of other racers is intimidating.

But today was different. My prayer was that things would go well for Jim and Sue such that next year, both would be able to join me for the triathlon. Jim and I tried to recruit other HFMA members to join our informal club; without success. As a result, we have a “Partnership” rather than a “Club.”

With Susan’s addition next year, our group would finally qualify to be described as a “Triathlon Club”, as well as being the answer to my “Ocean Prayer.” ☒

Opportunity to Connect with a Diverse Group of Colleagues

*Mori Moriuchi
Regional Director
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Regardless of the size or your organization, the scope of your position, or your personal and professional background, when faced with budgetary constraints and organizational changes, how can you – a healthcare leader – maintain a competitive edge? And how do you address staff diversity and the changing needs of our patient populations?

The Asian Health Care Leaders Association (AHCLA) is an association that seeks the solutions to those questions - to share what works and to cope with these challenges. Working in collaboration with asso-

ciations, such as the American College of Healthcare Executives, the American Hospital Association and the Institute for Diversity in Health Care Management, AHCLA is engaged in relationships with organizations that are committed to pursuing the increased representation of diversity in healthcare executive management. AHCLA is open to all individuals at every phase of their career development interested in advancing diversity and workforce development in healthcare.

AHCLA can also help organizations such as HFMA who are committed to valuing diversity in healthcare by helping drive the necessary changes in workforce development and leadership. By serving as one of the definitive organizations for diversity, AHCLA will promote and enhance healthcare delivery, especially to under served and under recognized populations. AHCLA will create a unique value by providing exposure to senior healthcare leaders, professional development opportunities, and involve-

ment with ongoing efforts to improve quality, transparency and consumer driven care.

On October 7, 2010, AHCLA is providing an exceptional forum to address these issues with the goal of advancing attendees’ professional goals - “Creating Your Unique Career Path,” a half-day interactive program at the Westin San Francisco Market Street.

Keynote speaker, **Don Tamaki**, a Partner with Minami Tamaki LLP, will explore the topic of providing quality healthcare to diverse populations. Sponsored by HCA, the afternoon will delve into innovative approaches to advancing your career including tales from the trenches followed by a session with local search firms who will focus on practical tactics for career advancement. ☒

For more information about connecting with local and national leaders from diverse backgrounds, visit <http://asianhealthcareleaders.org> or to register for this one-time opportunity, <http://www.eventbrite.com/event/463667843>.

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Welcome New Members!

- ◆ **Matt Absher** - Director, Reimbursement Programs, California Hospital Association
- ◆ **Jeffrey Edgar** - Business Analyst II, Sutter Health
- ◆ **Osahon Ekhaese** - Director of Revenue Cycle - GSAA, Kaiser Permanente
- ◆ **William E. Farrant** - President, BACTES
- ◆ **David W. Fichter** - Senior Financial Consultant, Medical Pay Solutions
- ◆ **Andrea L. Ganzinotti** - Revenue Cycle Analyst, Bakersfield Memorial Hospital
- ◆ **Aaron Hammon** - Business Development Associate, MedeAnalytics
- ◆ **Doug Hart** - AVP, Marketing and Communications, MedeAnalytics
- ◆ **Heather M. Heise-McDuffie** - Regional Accounting Manager, Sutter Health Sacramento Sierra Region
- ◆ **Penny A. Jadwin** - Vice President, Columbia Healthcare Analytics, Inc.
- ◆ **Ankit Jain** - HCIT, Patni Americas, Inc.
- ◆ **John K. Jensen**
- ◆ **David Jones** - Director, Aspen Healthcare Metrics

- ◆ **Rose Kish** - Solution Consultant, Lawson Software
- ◆ **Jennifer Moore** - Revenue Cycle Analyst, Children's Hospital Central California
- ◆ **Jamie A. Mumford** - Healthcare Advisory Associate, PricewaterhouseCoopers
- ◆ **Denise Munoz** - Logistics Administration, Cirius Group, Inc.
- ◆ **Daniel J. Nardoni** - Budget Manager, Washington Hospital Healthcare System
- ◆ **Rahul Nawab**
- ◆ **Mitchell A. Pierce** - Director General Accounting, John Muir Health
- ◆ **Louis J. Pirnik** - Ernst & Young LLP
- ◆ **Janet Doherty Pulliam** - Controller, Muir Medical Group IPA, Inc.
- ◆ **Pinaki Ray** - President and CEO, ExpenseRX
- ◆ **Roy Robbins** - Board of Trustee Member, Natividad Medical Center
- ◆ **John Ruffner** - MedAmerica
- ◆ **Saadiah Ryan** - Assurance Senior, Moss Adams LLP
- ◆ **William J. Shelton** - Chief Financial Officer, American CareQuest Inc.

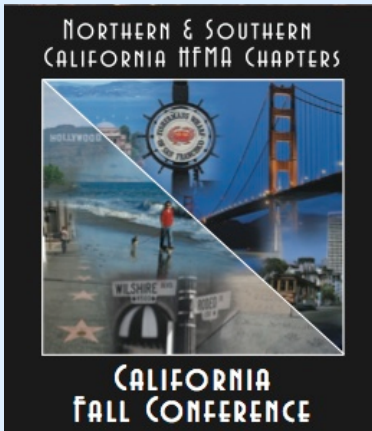
- ◆ **Paul Snyder** - Vice President, H-Card, LLC
- ◆ **Mark Sithi** - Manager, Triage Consulting Group
- ◆ **Charles Tuchinda** - Chief Innovation Officer, Hearst Business Media
- ◆ **Richard Waller** - CTO, VisiQuate, Inc.
- ◆ **Emily White** - Manager, Triage Consulting Group

Welcome Members Who Transferred In!

- ◆ **David Hall** - Finance Manager, Catholic Healthcare West
- ◆ **Christopher Jordan** - Director of Sales, California Service Bureau
- ◆ **Christopher M. Kelly** - Vice President, Bank of the West
- ◆ **Michael D. Rowe, FHFMA, CPA** - Senior VP of Finance, Kaiser Permanente, Northern CA Region
- ◆ **Michael N. Tesfay** - Senior Consultant, Navigant Consulting, Inc.
- ◆ **Tammy S. Trovatten** - Reimbursement Analyst, Sutter Health Support Services

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Available to Northern California Members Only!



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Hyatt Regency Long Beach
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<http://www.hfma-cafallconf.org>

- Current members of the HFMA Northern California Chapter can avail of the \$300 rebate. The full conference price must be paid at the time of registration. Pre-conference workshops are additional fees and are not covered by the rebate.
- Non-members may qualify for the rebate by becoming an HFMA member within the Northern California Chapter.
- HFMA Northern California Chapter will issue the rebate check. Please allow two weeks for processing.
- For additional information, call (925) 828-4532 or send an email office@hfma-nca.org.

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Job Opportunities

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



- 📍 **Systems Analyst II - Patient Business Services** - Community Hospital of the Monterey Peninsula, Monterey (posted 8/29)
- 📍 **Head of Decision Support** - UCSD, San Diego (posted 8/20)
- 📍 **Registration Supervisor** - Washington Hospital, Fremont (posted 8/20)
- 📍 **Senior Accountant** - Bay Area (posted 8/12)
- 📍 **Patient Accounting Manager** - Contra Costa County, Martinez (posted 8/5)
- 📍 **Director, HIM/EMR Implementation Opportunity** - Arizona (posted 8/5)
- 📍 **HIM Manager** - Mercy San Juan Medical Center, Carmichael (posted 7/28)
- 📍 **Business Office Supervisor** - St. Joseph Health System, Santa Rosa (posted 7/21)

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