

The Edge



hfma™ northern california chapter
healthcare financial management association

Fifth Issue - FY09-10

December 2009

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President's Message

Ken Jensen
Chapter
President
2009-2010



Here we all are, at the end of another year. In healthcare our battles are far from over, but as we go into the

New Year we should reflect upon our families and our blessings. As you well know, there will be challenges in the New Year, even without healthcare reform. Construction, equipment refreshment and the related financing, let alone trying to define "meaningful use" for stimulus money, will test our abilities to maintain our operations. Vendors will be challenged to meet their targets and goals given the financial restraints healthcare is feeling. Change has been our constant issue and we have survived. For me, it has been my involvement with HFMA that has provided insights into the issues of the day.

We have a few choices with what we face: we can just put our heads in the sand and fail, we can just hope things will get better, or we can be proactive and deal with the challenges head on. HFMA offers us a chance to educate ourselves about the issues

and possible solutions. In the New Year your Chapter plans to present educational opportunities that will assist with your understanding of the "old" environment of change. Look for programs that offer you a choice of affordable venues like the road shows or webcasts. There are opportunities to meet other folks who are dealing with similar issues. On January 24-27 there is the Region 11 Healthcare Symposium in Las Vegas where multiple chapters present current understanding and ideas for Compliance, Finance, Managed Care, PFS, Leadership and more. Early next year, your Chapter will have its Spring Symposium in Sacramento. I again encourage your participation.

As the year comes to an end, and we look back, I like to remember and acknowledge a few of those who have contributed so much in the past. Just to name a few so that we all do not forget, **Doc Barto**, **Jim Karling** and **Carl Hitchner** (who is no longer with us); over the years they have contributed to my and others' successes. Looking forward, I welcome a number of new members, including **Slauka Crouthamel**, **William Fleming** and **Robert Anderson**. So we have the "old" and the "new" which contribute to our Chapter.

I hope all of you have a joyous holiday season and I wish you the best in the coming new year.



HFMA Northern California Education and Events Calendar
Visit www.hfma-nca.org for details and to register online

January 8, 2010 PFS Road Show

Sutter Center for Health Professions, Sacramento, CA
\$35 for HFMA Members
\$45 for Non-Members
Group discount: \$10 off on registration fee per person for a group of 3 or more

January 20, 2010 Monthly PFS Forum

Free Teleconference. To join, email jaynek@ciriusgroup.com.

January 24-27, 2010 Region 11 Symposium

Caesar's Palace, Las Vegas, NV
Northern CA members get \$300 discount on registration fees. For details, visit the chapter website: www.hfma-nca.org.

February 5, 2010 A Morning with Medi-Cal: Billing and Follow Up Workshop

Washington Hospital, Fremont, CA
A Medi-Cal and Billing Follow Up workshop geared to the staff that handles Medi-Cal issues.

February 17, 2010 Monthly PFS Forum

Free Teleconference. To join, email jaynek@ciriusgroup.com.

March 25-26, 2010 HFMA Northern CA Spring Conference

Sacramento Marriott Hotel, Rancho Cordova, CA
Exhibit and sponsorship opportunities available. Contact Barry Brown at barry@rashcurtis.com

Healthcare Reform: Solution Must Include Uncompensated Care

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The current debate over healthcare reform is a much needed one.

Everyone, from politicians to the health care industry to consumers, all agree and recognize that access to affordable, quality healthcare is critical for the future well-being and prosperity of our nation. But in the debate over possible solutions, we also must look at aspects of our current healthcare system that, if left as they are today, could easily undermine all the good we are trying to achieve with this reform.

One of these areas is "uncompensated care," or the care that hospitals, by law, are required to give whether or not they are ever compensated by patients, insurers or the government for its true cost.

Everyone likely would agree that ensuring this type of access is a reasonable and fair-sounding proposition that contributes to the greater good. Indeed, countless numbers of people have received urgent and needed medical attention that they otherwise would not have received because of it.

Unfortunately, no one could have foreseen that providing this care without having any mechanism in place to fund it would eventually raise the costs of healthcare in the United States to incomprehensible levels that would threaten to cripple the health care system itself.

The numbers involved are simply staggering and impact the financial well-being of virtually every player in the healthcare delivery system. In 2008 alone, U.S. hospitals provided upwards of \$42 billion in care which went unpaid because of patients having insufficient or nonexistent health insurance. This situation is further exacerbated by the fact that many underinsured or uninsured Americans use the emergency room as a substitute for non-emergency care, which results in some of the most basic medical care being provided at the higher costs associated with an ER.

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California Hospital Association - Update

Steve Blake, California HFMA Liaison

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The CHA Board of Trustees met on December 17, 2009 and reviewed 2009 regulatory activity on Federal and State levels. Following is an update for some of the key developments pending or under review:

Provider Fee

A temporary hospital fee program to provide Medi-Cal supplemental payments to hospitals through December 31, 2010, was enacted in 2009 [AB 1383].

The provider fee approach is not uncommon. 21 states take full advantage of the federal match via implementation of a provider fee. CHA has taken this lead, embracing the following guiding principles:

- Hospitals must be permanently protected with respect to payment and the amount of the tax (i.e. the State cannot use this as a pretext to reduce its level of support in other areas)
- Hospitals should be paid by Medi-Cal at the highest level allowed under federal law.
- The State must be required to ensure that criterion 2 is met even when General Fund money is required (state maintenance of effort)
- All of the money generated from the hospital tax must be used solely to benefit hospitals.
- Only the voters can make changes to the program

Securing these principles is not assured and AB 1383 does not offer all of these safeguards to eliminate the risk. The additional federal revenue from this development promises to be approximately \$2 billion annually. It is anticipated the program is expected to cover 18 to 21 months ending December 2010. The CHA is continuing to seek longer term solution for the foregoing principles.

Maintenance of Effort [MOE]

Critical to the success of this program is the preservation of the State's contribution to care for the indigent. It is unacceptable for the State to take advantage of the provider fee to offset its already inadequate funding. A lot of legal analysis can be boiled down to a stipulation that this can only be accomplished with a ballot initiative on November 2, 2010.

The Association is prepared to move forward with a November 2010 ballot initiative to establish permanent protections in the event a future hospital fee is implemented. A decision on a specific initiative will be made in the coming months.

Equity for Net Contributors

By the nature of rules governing the application for enhanced matching funds, a smaller percentage of facilities will experience fees in excess of enhanced reimbursement. This has the potential for fragmenting industry support for the program. There has been widespread support for developing pledge agreements from providers who receive a net benefit to the California Health Foundation and Trust (CHFT). CHFT has designated a Government Health Care Program Grant Fund, designed to make awards out of these pledges to hospitals that do not receive an offsetting benefit to their fees. Pledges ranging progressively from 1% to 5% of the net gain to those hospitals that benefit are anticipated to accomplish this goal in 2010. The success of this program depends on widespread buy-in. CHA staff, Trustees and affiliated counsels stand ready to assist in presentation to hospital leaders and governing boards.

National Healthcare Reform

While CHA continues to support health care reform, several important issues need to be addressed in the Senate bill: the number of newly insured and readmissions policy are unresolved. It appears that the public plan was dropped early this week. Geographic variation proposals hold the potential to reduce Medicare revenues to California by \$2 billion and there are proposals to cut both Medicare and Medicaid Disproportionate Share Payments.

Medi-Cal 1115 Waiver

The Medi-Cal 1115 waiver is set to expire on August 31, 2010. It could be extended by CMS for several months. It is the intent of the Schwarzenegger Administration to make the next five-year 1115 waiver a broad waiver rather than a hospital waiver, bringing in other providers in an attempt to develop comprehensive systems of care.

Dissolution of Cal RHIO

This week Cal RHIO board voted to dissolve. The State is going to designate a new governance entity to preside over the development of a Health Information Exchange (HIE)

I would like to take this opportunity to wish all a happy and safe holiday... and a new year that promises to be as interesting as the last!

ZPICs - Zone Program Integrity Contractors

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Medicare's current auditing and enforcement agencies include: RAC, QIC, MSPRC, CERT, BCC, MEDIC, and QIO. Unfortunately, none of the existing audit agencies would look at ALL Medicare programs (Parts A – D) so Zone Program Integrity Contractors (ZPICs) were created. ZPICs will have comprehensive knowledge of all claims.

The main focus for ZPICs will be on Medicare fraud and abuse. ZPICs will have a direct link to CMS, OIG, DOJ, FBI or other law enforcement for further action. Here are the definitions and examples for fraud and abuse:

FRAUD: Intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and the individual makes known that the deception could result in some unauthorized benefit to himself/herself or some other person.

Examples:

- Making claims for non-covered services as covered services
- Upcoding
- Falsification of patient qualifying tests
- Billing for services or supplies not provided
- Falsifying Medicare claims
- Soliciting/Offering kickbacks

ABUSE: Billing for services that are not covered or are not correctly coded.

Examples:

- Improper billing practices (e.g. submitted bills to Medicare instead of primary payer or unbundling charges to get higher reimbursement)
- Routine waiver of coinsurance or deductibles
- Claims for services that are not medically necessary
- Excessive charges for services or supplies

There are seven ZPIC Zones by geographic area and California is in Zone 1. Zones 4 to 7 have been assigned to contractors and Zone 1's contractor should be announced by December 31, 2009.

The ZPIC auditor could ask for records as far back as six years. If intentional fraud and abuse is suspected – there is NO statute of limitations. ZPICs may look at the same record as RACs. Possible "triggers" for a ZPIC Review include:

- High cost or utilization of services or items
- Aberrant patterns outside the norm
- Insufficient documentation submitted with a claim
- Patient complaints

The Volunteer Hospital Association (VHA) provided a very informative webinar on December 2, 2009 and the HFMA Northern California Chapter has requested a joint venture webinar in January 2010 to provide the latest information after the Zone 1 contractor has been announced.

RAC Connolly Targets DRGs

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With much anxiety, the movement of RAC has started and the first to bring forth targeted DRGs is Connolly. Connolly Healthcare has announced the first issues approved for complex RAC review, so providers in several RAC Region C states could begin seeing medical record documentation requests at any time. Connolly is not yet reviewing for medical necessity.

Note that DRG-validation issues are approved for the following states: Alabama, Colorado, Florida, Georgia, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee and Texas. So is California next? Certainly food for thought and contemplation. I'm leaning towards... yes, we should prepare for and plan that RAC DRG targets will be coming to California in the near future.

The Connolly website has posted the twenty-four approved DRG validation issues which are listed here:

- **MS-DRG 163.** Major chest procedures with major complication/comorbidity (MCC)
- **MS-DRG 164.** Major chest procedures with complication/comorbidity (CC)
- **MS-DRG 165.** Major chest procedures without CC/MCC
- **MS-DRG 166.** Other respiratory system OR procedures with MCC
- **MS-DRG 167.** Other respiratory system OR procedures with CC
- **MS-DRG 168.** Other respiratory system OR procedures without CC/MCC
- **MS-DRG 207.** Respiratory system diagnosis with ventilator support 96+ hours
- **MS-DRG 255.** Upper limb and toe amputation for circulatory system disorders with MCC.
- **MS-DRG 329.** Major small and large bowel procedures with MCC
- **MS-DRG 330.** Major small and large bowel procedures with CC
- **MS-DRG 331.** Major small and large bowel procedures without CC/MCC
- **MS-DRG 372.** Major gastrointestinal disorders and peritoneal infections without CC/MCC
- **MS-DRG 386.** Inflammatory bowel disease with CC
- **MS-DRG 394.** Other digestive system diagnoses with CC
- **MS-DRG 432.** Cirrhosis and alcoholic hepatitis with MCC
- **MS-DRG 813.** Coagulation disorders
- **MS-DRG 871.** Septicemia without mechanical ventilation 96+ hours with MCC
- **MS-DRG 872.** Septicemia without mechanical ventilation 96+ hours without MCC
- **MS-DRG 981.** Extensive OR procedure unrelated to principal diagnosis with MCC

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CMS Clarification Regarding Practitioner Supervision Requirements

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Question: A hospital operates several off-campus provider-based department imaging centers. The imaging centers offer both CT and MRI, with and without contrast. The images are sent to the hospital's exclusive radiology group via teleradiology, which eliminates the need for radiologists to be on site. The radiologists are available by cell phone. Will this arrangement comply with the new rule?

Answer: To the extent radiology services require "direct supervision", such as the CT and MRI with contrast, the arrangement does not comply with the new rule. The radiologists must be physically present in the off-campus provider-based department and immediately available to furnish assistance.

CMS issued the final calendar year 2010 Hospital Outpatient Prospective Payment System ("OPPS") rule on November 20, 2009, which will go into effect January 1, 2010. The rule purports only to clarify certain physician supervision requirements for therapeutic and diagnostic services, but it will likely change the practices of most hospitals with respect to outpatient provided incident to the services of physicians. This bulletin offers key considerations for hospitals contracting with supervising physicians.

CMS clarified several practitioner supervision requirements for diagnostic and therapeutic services. Currently, there are four general levels of supervision:

- 1) General supervision means the product/service is provided under a physician's overall direction and control, but the physician's presence is not required.
- 2) Direct supervision means the physician is on-site and available to provide assistance and direction. The physician does not need to be in the room. Prior to this November's guidance, if a therapeutic service was provided in an on-campus provider-based department that required direct physician supervision, direct supervision was "assumed" by CMS. For off-campus provider-based departments, direct supervision required the physician to be "present and on the premises of the location."

3) Personal supervision means the physician must be in attendance and in the room during the performance of the procedure.

4) No supervision required (multiple reasons and codes).

CMS indicated in November's guidance that the standards for diagnostic test level supervision are not changed by the final rule. However, changes may be required in hospital practices to comply with the rule in connection with diagnostic tests that must be directly supervised by physicians.

"Clarifications" regarding direct supervision of services that go into effect in January 2010 include, but are not limited to, the following:

- **Only physicians** may supervise (directly) pulmonary rehabilitation (PR), cardiac rehabilitation (CR), and intensive cardiac rehabilitation (ICR);
- Supervising physicians and practitioners **need not be of the same specialty as the procedure or service being performed**, but must have, within their state's scope of practice and hospital-granted privileges, the ability to perform the service or procedure;
- Medicare **will not make a payment to a physician** under the MPFS for supervising hospital outpatient therapeutic services provided by non-physician practitioners or for direct supervision - the physician must directly provide services to the patient;
- While direct supervision may be "assumed" for on-campus provider-based departments, physicians **must be on-campus and immediately available** to furnish assistance throughout the procedure;
- "Immediately available" is not defined, but the guidance states the physician must be **able to intervene "right away,"** and should not be performing another procedure or service that he/she can't interrupt; and
- For off-campus provider-based departments, the direct supervision requirement means that the physician or non-physician practitioner must be **physically present in the off-campus provider-based department** and immediately available to furnish assistance and direction throughout the performance of the procedure.

Previous guidance suggested direct physician supervision in provider-based clinics would be assumed for on-campus providers, and would be met by the physical presence of a physician in off-campus departments. The addition of "immediately available" increases the level of supervision required. While CMS views this change as a "clarification," it will

likely cause a significant increase in the number of physicians needed for supervision purposes.

In order to comply with the new rules, hospitals will need to assess existing physician supervision for therapeutic and diagnostic services provided incident to the services of a physician, paying special attention to proximity to the main provider and the clarified requirements for direct supervision.

Compliance with the rule will require analyzing each provider-based location and service. In order to maintain adequate documentation of compliance, hospitals should consider memorializing its relationships with supervising physicians. Changes to medical staff bylaws and written supervising physician agreements are two options.

Considerations for Supervising Physician Contracts

- Identify agreements needed for compliance by assessing hospital provider-based operations by location and type of service (diagnostic or therapeutic). Due to the widespread use of teleradiology, we recommend a careful review of physician supervision at provider-based imaging centers.
- Once supervising physicians are identified, confirm that the physicians' location and availability will meet the requirements of the rule. For example, MRI and CT with contrast will require a physician to be physically present in the off-campus provider-based department. Physicians directly supervising services for off-campus provider-based departments can't be located off-site, or even in an office in the same building, if the office isn't part of the provider-based department.
- Clearly describe the role of a supervising physician for each level of supervision.
- Specify availability requirements for physicians, such as physician location, hours, and ability to respond.
- When adding supervision requirements to existing physician contracts, remember Stark and Anti-Kickback requirements. For example, the fair market value of the physician's supervisory services should be determined and documented.
- Confirm supervising physicians have the ability to perform the service according to state law and medical staff privileges.
- Specify the procedures for how hospital staff will contact the supervising physician and how the physician will respond.

Medicaid Integrity Program

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The Centers for Medicare & Medicaid Services (CMS) has contracted with Healthcare Management Services (HMS) - Audit MIC California to support the implementation of Section 6034 of the Deficit Reduction Act of 2005, which established the Medicaid Integrity Program (MW). One of the provisions of the contract is to audit the claims submitted by individuals or entities who furnish items or services for which payment was made by Medicaid (Medi-Cal), as well as the records supporting the claimed service. The objective of the audit is to determine whether the Medicaid claims and supporting documentation were paid in accordance with the California Medicaid laws and regulations, with special emphasis on Comprehensive Code Unbundling. Unbundling is when payment has been made for procedure codes for the same recipient, same date of service, and same performing provider, which should not be billed together because one of the procedures is considered to be an integral part of the more comprehensive procedure code.

Background

Section 1936 of the Social Security Act created the Medicaid Integrity Program (MIP) and directed the Centers for Medicare & Medicaid Services to enter into contracts to review Medicaid provider actions, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.

What are the Audit MICs?

Audit Medicaid Integrity Contractors (Audit MICs) are entities with which CMS has contracted to perform audits of Medicaid and Medi-Cal providers. The overall goal of the provider audits is to identify overpayments and to ultimately decrease the payment of inappropriate Medicaid claims. At the direction of CMS, the Audit MICs will audit Medicaid providers throughout the country. The audits will ensure that Medicaid payments are for covered services that were actually provided and properly billed and documented. Audit MICs will perform field audits and desk audits. Audits have begun in multiple CMS Regions and will be expanded to all States and Territories. The audits are being conducted under Generally Accepted Government Auditing Standards.

While the Medicare Recovery Audit Contractor program and the MIC program are similar, there are several key differences:

- The look-back period for RAC audits is three years but the MIC's look-back period depends on each state's guidelines.
- For RAC audits, providers have 45 days to produce medical record copies. But for the MIC audits this timeframe varies depending on state requirements. (*Title 22 sec. 51476 says that provider must make records available to DHCS or the attorney general's office on request "during normal business hours."*)
- RAC audits involve a maximum of 200 medical records, but there is no limit on the number of medical records in MIC audits.
- The RAC audits reimburse providers for the costs of copies required, but providers make the copies for MIC audits at their own expense.

RAC Connolly ... continued from page 3

- **MS-DRG 982.** Extensive OR procedure unrelated to principal diagnosis with CC
- **MS-DRG 983.** Extensive OR procedure unrelated to principal diagnosis without CC/MCC
- **MS-DRG 987.** Nonextensive OR procedure unrelated to principal diagnosis with MCC
- **MS-DRG 988.** Nonextensive OR procedure unrelated to principal diagnosis with CC
- **MS-DRG 989.** Nonextensive OR procedure unrelated to principal diagnosis without CC/MCC

What should you be doing in the meantime? You should form or have formed your RAC Committee. You should conduct some gap assessments via documentation and coding audits or reviews. Make sure that education is being provided to your coding staff but also to physicians and those who document in the medical record, whether it be a paper or electronic record.

Should you be proactive? Yes, you should be, and utilizing a RAC Committee is a good way to start. Make sure the key stakeholders are involved and kept informed. Review the Medicare Appeals Process with business office staff but also with clinical and coding staff.

Although the above DRGs have the potential for overpayments, there also could be underpayments in this list. Conduct your own internal probe audit on a sample of these DRGs. Again, good food for thought, be proactive and be prepared. Don't forget to check the website.

Healthcare Reform ... continued from page 2

To help offset these losses, hospitals and doctors need to charge everyone more for the services they provide. These higher prices then create a corresponding increase in the costs to insurance companies and other health care payment programs. They, in turn, pass these on to consumers and businesses that purchase their insurance coverage in the form of higher premiums. The result is a seemingly never-ending spiral in the escalation of health care costs.

We are now reaching a point where the hospitals providing the most needed care to some of the United State's most vulnerable populations are facing the very real prospect of financial collapse and closure because of the levels of uncompensated care they provide. Ensuring that those most in need of healthcare can continue to receive it while the hospitals that provide this care are adequately compensated so they can keep their doors open must be an element of the current debate on health care in this country.

Additional government grants and healthcare charity private funding are two possible options to ease the strain on hospitals. Public outreach to enroll more low-income Americans who qualify for subsidized coverage will also help offset some costs. There are countless charities that address illnesses and research cures for terminal and debilitating diseases, but without viable hospitals where the treatment is done, these charities can do nothing.

Joy Stephenson is founding and managing partner of Stephenson, Acquisto & Colman (SAC), a law firm that specializes in representing major California hospitals.

Turn it Up During a Downturn: How to Increase Team Productivity Despite Budget Cuts (Part 3 of 3)

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In the two previous issues of this three-part series, we talked about the importance of the following tips to increase your team's productivity despite budget cuts: **Tip #1: Improve productivity by learning how to improve team relationships and Tip #2: Teach your team how to do more with less.**

In this third part of our three-part series, we will explore tip #3: **Use stress reduction techniques to reduce fear and feelings of pressure.**

Talk with your team about what they're experiencing

From what we typically see with teams, it can be very helpful to check in with your team about how they're REALLY doing with their current situation. In other words - talk with your team about the current environment. They're all feeling different emotions, and ignoring those emotions won't make them go away. From a stress reduction standpoint, many people benefit from talking with others. Giving your team the opportunity to have a

safe place to talk about their fears and concerns might lower their levels of stress and/or change how they perceive their team - it often contributes to building camaraderie when team members feel that they're not alone.

One important aspect to consider is to be very intentional and solution oriented with these conversations - team members may become frustrated if every time they get together it becomes a venting session, with no productive outcomes. So, you might consider periodic team check in meetings, with a specific amount of time allocated to talking about concerns, then the rest of the time allocated to discussing how the team can support each other with those concerns and actually create specific next steps to do so.

Help your team members stay PRESENT

Help them remember that what they're dealing with is right now, in THIS moment, and this moment will change in the next moment! The reality is that most

of us can't predict the future - yet we spend a significant amount of time and energy worrying about the future, which creates significant stress. All we really have for certain is right now, in THIS moment - none of us know what our situations will be in five minutes, in a month, or in six months. Thus, by helping your team members stay present and grounded in "now" you are helping them to reduce their fears and concerns of what the future may bring.

Encourage your team to support each other with self-care

Self care means different things to different people - for some, it is going to an exercise or yoga class a few times a week; for others, it's daily meditation or prayer; for others, it's gardening in their yard or spending time with friends. It is different for everyone, but the important aspect of this is to help your team learn to support each other in each team member's own self-care, so that when they come to work they have a greater capac-

ity to be productive because they are rested, well nourished and present with each other. As you can imagine, this self-care approach yields very different results than teams who are stressed and feeling extremely pressured.

A couple of final thoughts as we wrap up this three-part series: You know your team best, so I encourage you to consider talking with your team about implementing the tips that your team feels would work best for their particular situation. When your team does start implementing the tips that they believe will have the most benefit, be sure to acknowledge and celebrate your team's successes - all of the changes they make related to their **positivity (relationships)**, as well as **productivity (output)** results!

While some of these tips may seem simple, the reality is that many of the teams we hear from aren't doing these things, because they are afraid to have these types of conversations with each other.

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HFMA NORTHERN CALIFORNIA - SPOTLIGHT ON A MEMBER

Wade Sturgeon
CFO
Carson Valley Medical Center
Years in Healthcare: 12
Years in HFMA: 12

“HFMA provides great networking and access to good education on relevant topics.”

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

It definitely chose me.

Tell us about yourself

Some things are better left unsaid. ☺

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

In the tropics with my beautiful woman on the golf course.

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

Bowling, softball, golf, travel

What’s the last book you read?

Hhhmmm...next question.

What would you do if you won the lottery?

All depends on how big the lottery was; anything from taking a long vacation, to taking care of my family, to retiring part time, to retiring full time. Definitely golf more!

What is your greatest achievement outside of work?

Other than my kids? I’ve won two state bowling titles: singles title in Idaho and All Events title in Washington. I’ve picked up a 7-10 split twice. I made the final table of a poker tournament that started with 661 people, taking 7th place.

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

Superman because he can do anything, has only one weakness and gets the girl in the end.

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

The Hangover

Who are your heroes?

My parents

The best advice I ever had was

At the end of the day, your family and true friends will always be there for you. Don’t make decisions in life wondering if they will be; they will always stand behind you and be there for you. Shoot for your dreams.

The best part of my job is

Knowing what I do directly impacts so many people in a positive way; whether it is the patients that have access to better or more services, or my employees who are assured future employment.

My favorite food is

I have to pick a favorite? Surf and Turf

My first car was

72 Olds Cutlass

My favorite car is

My 07 Chevy Silverado

Favorite quote

“Live for today”



Editor’s Note: The Spotlight On A Member section features any HFMA member in our chapter, new or old. If you would like to be featured, please visit the newsletter page of the chapter website (www.hfma-nca.org) to download the Spotlight On A Member questionnaire. If you would like to suggest someone for us to feature, please send an email to Terry Paff, Newsletter Committee Chair, at terry@rashcurtis.com.

Turn It Up During Downturn ... continued from page 6

The key to amazing shifts and greater success for your team truly could be 3 simple steps away!

So, I invite you to start the shift and begin talking with your team TODAY about how to start looking at your team’s current situation in a very different way! If you have questions or concerns about your specific team, you’re welcome to contact us and we’d be happy to share additional tips for your specific situation.

Cheryl Mann is a team development specialist and nationally-recognized speaker on this topic. Learn more at www.goalsinsight.com.



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“Positioned for Provider Success”

Wellness Challenge

Daisy Noguera

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On October 18, 2009 I walked a half marathon at the Nike Women's Marathon in San Francisco. I never thought I would be able to start a marathon, much less finish one! I always thought that marathons were for athletes.

I was inspired by the Wellness Challenge that **Dr. Packer**, our CEO, sent out to all the employees to join the Leukemia and Lymphoma Society Team in Training. I did not know what to expect when I joined. I only knew that: first, I wanted to work out more; second, I wanted to help people; and third, I wanted to have fun! I started my endurance training the early part of June.

The Leukemia and Lymphoma Society Team in Training is an excellent organization. They are very well structured and have the best coaches and mentors to work with. I participated in their nutrition clinic, injury prevention clinic and learned techniques on how to walk fast and keep going even when all I want to do is to stop.

We started training by walking three miles and went up to twelve miles. One half of a marathon is 13.1 miles. I knew I could do it after I walked eight miles. We did the technical training on Tuesdays and the endurance training on Saturdays. After each Saturday training I felt like a train had run me over. The recommendation is to have an ice bath after walking for two hours or more. I learned to love ice baths!

The training was one aspect of the marathon, but the fundraising was another challenge. I had to raise \$2,500 for the Leukemia and Lymphoma Society (LLS). I never did this before but the LLS also held my hands through this part. They gave me sample letters to use and ideas of who to contact. I want to thank many of my friends and colleagues for sponsoring me. Your donations helped raise over 14 million dollars for the LLS. I got to meet many of the honorees; they are the patients who are currently going through treatment or are in remission. They are the real heroes. The individual stories of patients are amazing!

The thing that I did not expect is the new friends that I made, both hospital employees and others in the community. I got to know **Sheri Shaw** and **Kim Fuji** a lot better. We walked each week and helped encourage each other. Sheri was like a mentor to Kim and me. She kept us on track and on schedule.

I did not know what to expect the weekend of the marathon - what an amazing event! The Leukemia and Lymphoma Society paid for two nights at a very nice hotel in downtown San Francisco which is very close to the start line. They planned an inspirational dinner



on Saturday where friends and family of the patients came to welcome us like we were rock stars. We had a nice pasta dinner to make sure we were well fed before our event and were given specific instructions to ensure we were all ready for our big day.

The day of the event was the best! Going up and down those hills in San Francisco was challenging, but we were trained and prepared for them. All the people who came out to cheer us on kept us going. All the LLS coaches were going up and down the course encouraging and pushing us along. The finish line was the best. I knew I was going to be able to finish but I did not know I was going to feel such a huge sense of accomplishment. To reach the finish line with my two team mates Sheri and Kim was the best feeling. The cute guys from Tiffany and Co. were there to greet us with a Tiffany necklace. This was the bonus!

The night of the event the LLS puts on a celebration party to thank all the participants and to make sure we keep

moving our body. All the body wants to do after a marathon is lay down and sleep. The best thing to do after a marathon is to have an ice bath and to keep ourselves active. The party was a lot of fun. The whole event was amazing and I am glad I did it.

I was able to accomplish my three goals of working out more, helping people by raising the money and I had lots of fun doing it! The extra plusses were the friends I made and the Tiffany necklace I received. I encourage each one of you to try something out of the ordinary in the name of wellness. It will be a life changing experience!



Membership News

Ramona Hernandez

Membership Chair

rhernandez@californiaservicebureau.com



Member-Get-A-Member: What It Is and How It Works

- Recruit **one or two** new members who begin their membership between June 1, 2009, and April 30, 2010, or former* HFMA members who reactivate their membership between August 1, 2009, and April 30, 2010, and you will win your choice of an HFMA apparel item (approximate retail value of \$25) or a \$25 Visa® Fuel Card.** Fuel cards can be used at the gas station of your choice or anywhere Visa debit cards are accepted worldwide.
- Recruit **three or four** new and/or former* HFMA members and you will receive a \$100 Visa prepaid card good anywhere Visa debit cards are accepted worldwide. You will also be entered into a drawing among all those recruiting three or four to receive a \$1,000 cash prize.
- Recruit **five or more** new and/or former* members and you will receive a \$150 Visa prepaid card. You will also be entered into a drawing among all those recruiting five or more to receive a \$2,500 cash prize.

Member-Get-A-Member Make A Difference Grand Prize

For every new or former* member you recruit, you will receive one entry into the drawing for the Member-Get-A-Member Make A Difference Grand Prize worth \$5,000. You will receive \$3,000 in cash for yourself and a \$2,000 donation in your name to the charity organization of your choice.

You will receive one entry in the drawing for each new member or former* HFMA member you bring in (or bring back).

**Sponsors will receive credit in the Member-Get-A-Member campaign for former members who reinstate (reactivate) their memberships between August 1, 2009, and April 30, 2010. Sponsors will also continue to receive credit in the Member-Get-A-Member campaign for new members who join (or have joined) between June 1, 2009 and April 30, 2010.*

*** Cards are issued by Citibank, N.A. pursuant to a license from Visa U.S.A. Inc. and managed by Ecount, a Citi company.*

Enhanced Student Membership

HFMA's student membership program has many benefits. In addition to preparing future leaders in healthcare financial management, it provides a pipeline for HFMA membership.

We currently have over 700 student members and 150 faculty members, many of whom are champions for student membership recruitment. Both faculty and students respond positively to HFMA materials and programs:

*"HFMA student membership provides access to supplemental educational materials and professionals available for networking."
HFMA Student Member*

*"Thank you. I plan to use HFMA materials with my notes instead of a textbook. It should provide very current information to my students."
HFMA Faculty Member*

To further expand student membership there are some changes that will occur in the next fiscal year, which begins in June, 2010. Based on the results of an e-student membership pilot program in 2008 and an

expansion in 2009, the HFMA Board has approved the change from traditional membership for students to an e-membership with no fee. With this change, student members will receive all materials in an electronic format.

WELCOME NEW MEMBERS!

- **David Keirns** - Principal Project Manager, Kaiser Permanente
- **Krista N. Touros** - Asst. Administrator of Finance, Sutter Health
- **Elizabeth Osborn** - Manager, Financial Planning and Analysis, Kaiser Permanente
- **Sarah S. Palko** - Manager, Triage Consulting Group
- **Lizette Razon** - Patient Accounting Manager, Sierra View District Hospital
- **Richard Sebbo**
- **Carla Ballou** - Director, Revenue Cycle, Mee Memorial Hospital
- **Lesley A. Anderson** - Student
- **Jennifer Clowers, CHFP** - Director Revenue Analysis & Reimbursement, Caritas Business Services
- **Jeffrey N. McLane** - Revenue Cycle Director, San Mateo Medical Center
- **Michael Brown** - Director Technology, Gaffey and Associates, Inc.
- **Virginia Downie** - Director Advisory Services, Deloitte
- **Amy G. Graham** - Senior Staff Accountant, Mammoth Hospital
- **Slavka Crouthamel** - Financial Analyst, Mammoth Hospital
- **Adam M. Main** - Business Development Executive, Siemens Healthcare
- **William Fleming** - Assistant Vice President, The Doctors Company
- **Laura K. Rehfeld** - Manager, Kurt Salmon Associates
- **Robert C. Anderson** - Chief Finance Officer, Mendocino Coast District Hospital
- **Dawn Weathersby, MS, RN** - Director Healthcare Product Management, Oracle Corporation

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Holiday Treat

Julekake

(pronounced yoo-lə-kah-kə or Norwegian Christmas Bread)

Recipe provided by Brian Marrs

Prep Time: 2 hours, 30 minutes

Cook Time: 50 minutes

Ingredients:

- 1/2 cup butter
- 2 cups milk
- 1/2 cup water
- 1 egg
- 8 cups flour, divided
- 2 packages rapid rise yeast
- 1/2 cup sugar
- 2 teaspoons salt
- 1/2 teaspoon ground cardamom
- 2 cups mixed diced candied fruit (preferably red and green cherries and pineapple chunks. I also like dates, but you can use raisins or dried cranberries)



Preparation:

Melt margarine with milk and water. In a large bowl, combine 4 cups of flour with dry ingredients. Add margarine mixture and egg and combine with an electric mixer. Beat until batter falls in sheets from beaters.

Stir in candied fruit. Gradually add remaining flour; knead dough until smooth and elastic, 6 to 8 minutes. Shape dough into a ball, and place in a greased bowl. Cover. Let rise in a warm place (80 to 85 degrees F) until doubled in bulk, about 1 hour.

Punch dough down and place on pastry board; shape into 2 loaves. Place each in a greased 9 x 5 x 3-inch loaf pan. Even better if you have a tree-shaped pan. Brush tops of loaves with milk. Cover and let rise until doubled in bulk, 45 to 50 minutes. Bake at 375 degrees F for 30 to 40 minutes or until lightly browned. Optional – drizzle with icing and sprinkle with sliced almonds and more candied cherries.

\$300 DISCOUNT ON HFMA REGION 11 REGISTRATION FEES

Available to Northern California Members Only

HFMA Region 11 Symposium
January 24-27, 2010
Caesar's Palace
Las Vegas, Nevada

| | General Registration | Northern CA Members |
|---------------------------------------|----------------------|---------------------|
| Early Bird Registration (by 12/31/09) | \$595 | \$295 |
| Regular Registration | \$695 | \$395 |

For details, download the discount flyer from the chapter website (www.hfma-nca.org)

For conference and hotel information, visit: www.hfma-region11symposium.org

Newsletter Comments

Is there a topic that you'd like to read about or get featured in the chapter's newsletter? Please send your suggestions to Terry Paff, Newsletter Committee Chair, at terry@rashcurtis.com. You tell us the topic, we'll go find the article.



In Appreciation

Thank you to our Corporate Sponsors for their continuing support of the Northern California chapter

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Job Opportunities

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



- Accounting Manager - Large Medical Group, San Jose (posted 12/28)
- Chief Financial Officer - SSM St. Mary's Health Center, MO (posted 12/17)
- Sr. Director of Finance - Mercy Hospital, FL (posted 12/17)
- HIM Manager - Bend, OR (posted 12/1)
- Consulting Manager - Regulatory - HFS Consultants (posted 11/23)
- Manager, Professional Coding Support Services in Northern CA - KForce Healthcare (posted 11/19)
- Manager, Compliance Regulatory and Operations Support in Northern CA - KForce Healthcare (posted 11/19)
- Director of Charge Capture Integration in Northern CA - KForce Healthcare (posted 11/19)
- Disbursements Supervisor - Salem Hospital, OR (posted 11/19)

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