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(Committee members not pictured – Christine Appicella, Paulette DiNapoli, James G. Fouassier, Esquire, Don MacDonald, Mike McGrath, FHFMA, Andrew Natkin, Justin Rooberg, Josephine Ross, Stephanie Welsher)

Metro NY HFMA Newscast Schedule

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I hope that everyone had a wonderful holiday season and I wish all of you and your families a happy, healthy, and prosperous New Year! I am confident that 2012 will be an excellent year for our Chapter and our members. The HFMA year is flying by and we have already accomplished a great deal. Before I turn the Presidential reins over to the more than capable hands of Palmira Cataliotti, we have a lot to look forward to over the next five months.

Our premier educational event, The Joseph A. Levi Annual Institute is right around the corner and it once again promises to be a tremendous conference. Meredith Simonetti, Maryann Regan and the entire Annual Institute Committee have put together a really impressive program for the 53rd edition which will be held on March 8th and 9th at the Marriott LaGuardia Hotel. In addition to the always popular CFO panel, this year’s conference will feature panel discussions with industry leaders addressing the Medicaid Redesign Team, Accountable Care Organizations, and Provider and Payer Collaborations. Keynote speaker Paul Keckley will address Health Reform, Deficit Reduction and the 2012 Campaign and Leslie Norwalk will provide insights from the Washington inner circle. Our motivational speaker Kent Rader will provide us with some much needed levity with his presentation at Friday morning's breakfast and the new OMIG, James Cox will give us insight into OMIG’s focus in the upcoming year. Please don’t forget to register for the AI on our website or by mail.

In addition to the Annual Institute, our educational committees have planned some outstanding upcoming seminars that will address cutting edge issues. On January 19th at Info Builders the Medical Group Management Committee will be hosting its seminar on 2012 Medicare and Medicaid physician reforms. The Patient Financial Services Committee will be presenting the 2012 Medicaid Snowflake Seminar (formerly known as the Medicaid Trick or Treat Seminar) at the LaGuardia Marriott. On February 3rd, the Finance Committee will be holding its ever popular Annual Reimbursement Update at the Uniondale Marriott. Also in early February, the Managed Care Committee will be presenting a new seminar on Managed Care Basics that will focus on contract negotiations, denials management and revenue recovery strategies. All of these sessions promise to provide the attendees with up to the minute information and tools to help them perform their jobs more effectively. Please register today on the website!

I am really excited that our Chapter has recently started a Linked-In forum. Under the diligent leadership of Susan Montana and Marty Abschutz, the Social Networking Sub-Committee has recently sent out invitations to join our Chapter's own Linked-In network. This platform will enable us to communicate virtually instantaneously. Once we are fully implemented, I envision our Linked-In network to be a primary resource for industry colleagues to be able to exchange ideas, network and share best practices. We also believe that building forums like this will enable us to attract the next generation of healthcare financial managers to our Chapter.

As always I want thank all of our Corporate Sponsors and our volunteers. Without you these wonderful educational opportunities afforded to our membership would not be possible. With the AI planning in full swing I would also like to give a special thanks to Kiran Batheja who handles all of the facility and food arrangements better than any events planner ever could, Jim Argutto who directs the entire Corporate Sponsor vendor booth operation and does an outstanding job with it, and our Registration Committee headed by Robin Ziegler and Diane Masi who dedicate their time and talents to make the challenging registration process run so smoothly.

If you have any suggestions or ideas with anything that we currently do or need to do in the future, please contact me directly at jcoster@jzanus.com. I promise you that your input will be taken seriously and that I will address any and all of your concerns directly. We will work hard to ensure that our Chapter continues to perform at the highest level possible. On a final note, please don’t miss the upcoming Chinese New Year's celebration on February 11th. This event promises to be a great evening filled with excellent food and drink, Chinese Dragon dancers and time with friends and family. I hope to see you there. Once again Happy New Year to all!

John I. Coster
Chapter President 2011-2012
“What is this LinkedIn?”

As I write this column, I am contemplating the suddenly cold and windy weather we are having. That signals a time to accomplish things indoors to me. One of the things the Social Networking Sub-Committee has accomplished, recently, is inviting every Metro NY Chapter member to join the Metro NY HFMA LinkedIn group. We have 136 LinkedIn members to date. John Coster discussed some of this in his President’s message. Here’s a little more detail.

First, let me say that the Metro NY HFMA LinkedIn group is not meant to replace any other form of communication. It is intended to be another outlet by which you can receive information on Chapter activities and what other members of the Chapter are thinking about. At the same time, it gives you an opportunity to tell other Chapter members what you are thinking about.

Among the features on the group site is the ability to start, join or read a discussion about topics that are relevant to the arcane world we live in: New York healthcare. You can start or vote in a poll – our first poll asks what your favorite part of the Joseph A. Levi Annual Institute is. In addition, we re-post articles and press releases from some national and regional sources, e.g., CMS, HFMA and Modern Healthcare.

Among the visions we have for the Metro NY HFMA LinkedIn group is for an exchange of ideas amongst members on topics of interest. It can be something as non-technical as, “Are you planning to attend the Annual Chinese New Year’s Celebration on February 11?” or as thought-provoking as “Should for-profit healthcare systems be allowed in New York State?” There will be very few limits on what you can post on topics relevant to Chapter members. There is also the ability for Committee Chairs to post a quick “Save the Date” for a seminar that is in the late planning stages. The Group will give you another vehicle to receive that information.

One of the things the Sub-Committee asked me to communicate is its willingness to listen to you, the Chapter membership, to understand what you would like to receive from being a member of the Metro NY HFMA LinkedIn group. We know that will be different for different people. That’s why we’re asking you. The Sub-Committee will act on all reasonable suggestions (keeping in mind we are all volunteers). You can send your suggestions to me at HFMA.Marty@gmail.com or post them as a discussion item on the Group site: http://www.linkedin.com/groups?gid=3960793. Our Sub-Committee members are: Susan Montana, Habanero, Inc. Chair, Michael Lamothe, Memorial Sloan-Kettering Cancer Center, Stephanie Welsher, Health/ROI, and me. If you have ideas you want to champion, let us know that, too.

If you want information about how to join the LinkedIn group, please send an e-mail to me with the e-mail address you use or will use to access LinkedIn.

We have included articles on some diverse topics this month, including electronic health records, ICD-10, how to reduce the number of No Fault denials and a new HFMA certification. I’ll see you along the way or on LinkedIn.
### 2012 IMPORTANT DATES

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<td>Info Builders</td>
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<td>January 24, 2012</td>
<td>Healthcare Provider Accounting Update</td>
<td>Free Webinar</td>
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<td>January 26, 2012</td>
<td>Medicaid Snowflake Seminar</td>
<td>LaGuardia Marriott</td>
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<td>February 3, 2012</td>
<td>Annual Reimbursement Seminar</td>
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<td>February 10, 2012</td>
<td>Managed Care Basics</td>
<td>Hofstra University Club</td>
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<td>February 11, 2012</td>
<td>Chinese New Year Celebration</td>
<td>Jade Asian Restaurant</td>
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<td>March 8-9, 2012</td>
<td>Annual Institute</td>
<td>LaGuardia Marriott</td>
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<td>March 30, 2012</td>
<td>Electronic Health Records - The Good, the Bad &amp; the Audits</td>
<td>Info Builders</td>
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<td>April 22-24, 2012</td>
<td>2012 Leadership Training Conference</td>
<td>Fort Lauderdale, FL</td>
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<td>June 25-28, 2012</td>
<td>2012 ANI</td>
<td>Las Vegas, NV</td>
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The Metropolitan New York Chapter of HFMA Proudly Welcomes the Following New Members!

By Paulette DiNapoli, Membership Committee Chair

MetroNY HFMA is pleased to welcome the following new members to our Chapter. We ask our current membership to roll out the red carpet to these new members and help them see for themselves the benefits of HFMA membership. Encourage them to attend seminars and other Chapter events. We ask these new members to consider joining a Committee to not only help the Chapter accomplish its work, but to expand their networks of top notch personal and professional relationships. See the list of MetroNY HFMA Committee Chairs, along with their contact information, listed in this eNewsletter.

Rick Sughrue
Principal & Founder, HealthIT360

Vanshdeep Sharma
Mount Sinai Medical Center

David R Becker
Senior Associate, Alvarez & Marsal

Joy Castro
Director of Care Management, SUNY UHB

Katherine E. Baxter
Revenue Cycle Consultant, Dell Health and Life Services U.S.A.

Brian P. Sweeney
Budget Director, NYU Langone Medical Center

Todd Fertig
Objective Health, McKinsey & Co.

Jennifer Duty
Huron Consulting Group

Michele Martinez
Project Manager, Montefiore Medical Center
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## Committee Listings 2011-2012

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CFOs Should Be Engaged with an EHR Initiative

By Lucy Mancini Newell

CFOs have an important opportunity to participate in activities surrounding an electronic health record (EHR) implementation in their organizations.

At the heart of any EHR initiative are clinical participation, advocacy, and leadership. CFOs should be among the initiative's leaders, given the likely continued financial pressures on health systems for some time to come. The CFO can help other members of the C-suite understand how an investment in an EHR affects and benefits the healthcare organization, both short term and long term.

EHR Implications for the C-Suite

Healthcare organizations historically have selected and implemented IT that readily provides an ROI and that lasts for a long time. An EHR is quite a different type of initiative because it is more of a concept than a single product or technology. No single software application or technology can create an EHR, which provides support to multiple clinical disciplines and directly affects every clinical workflow. Rather, an EHR requires a number of software applications (whether self-developed or from one vendor or a variety of vendors) and technologies to create the desired goal of automating the clinical environment to improve patient care and patient safety.

Achieving this goal is easier said than done. Implementing an EHR is a multiyear project that requires funding not only for the preparation and implementation phase, but also for its continuing use for many years to come. In addition, investing in process improvement as well as the training of physicians, other clinicians, and the IT staff who will support the EHR is invaluable. For these reasons, healthcare organizations should invest in an EHR as a multiyear project rather than as a one-time investment. Once an EHR project is budgeted, ongoing funding is critical.

Ultimately, the C-suite—and the CFO in particular—has an important role in the EHR journey. Because an EHR can have a strong impact on clinical operations, C-suite members—through their advocacy, leadership, sponsorship, and interest—contribute significant value to the initiative by demonstrating organizational understanding of the EHR's role in patient care delivery. Implementing technology as far-reaching as an EHR will inevitably be disruptive, so C-suite leaders can provide perspective to make the transition easier. Strong communication and an understanding of the impact the EHR will have on clinicians will smooth the way for issues that will require tough executive decision making to ensure the organizational transformation.

The CFO and the COO should be members of the organization’s EHR executive governance committee not only to witness the progress and challenges of implementing the EHR but also to provide organizational support and insights to pave the way for future success. The CFO and the COO also can help develop criteria for measuring progress, changes, and outcomes of the EHR initiative. Having measurement criteria is key to tracking EHR efforts and showing a tangible level of progress throughout the implementation and after the go-live. People are drawn to methods that show progress and keep them motivated.

What CFOs Can Do

Gartner, an IT research and consulting firm, in recent years has advocated use of the total-cost-of-ownership (TCO) model as an industry standard to assess IT costs, replacing the previously ubiquitous ROI. Because the organization will make a significant investment initially and long-term to support the EHR environment, CFOs might find it useful to use the TCO model to help all C-suite members understand the fiscal implications and monitor EHR investment. The better this model
is understood, the better able senior executives will be to make informed decisions during the budget process. An EHR cannot provide an immediate ROI; rather, the initiative requires a shift in thinking about the long-term investment of resources—people, processes, technology, money, time, and knowledge—needed to create a clinical environment that promotes better outcomes and ensures patient safety.

CFOs can also contribute to an EHR project by working with clinician leaders to develop meaningful metrics to benchmark targeted improvements. One caution is that metrics may be viewed by clinicians as potential tools for punishment or for negatively affecting the work environment. For example, if metrics show that labor savings can be realized by documenting patient information in real time, clinicians might be concerned that the CFO and other C-suite members might use this information to decrease staff.

In reality, the data can help increase an understanding of the dynamics and mechanics of patient care delivery. CFOs have a great opportunity to educate and integrate metrics while helping the governance committee and executive oversight committee benchmark EHR progress.

An EHR can create a more efficient and cost-effective way to provide patient care. First, the access to clinical information, shared across the health system or continuum of care at a single point in time, facilitates clinician decision making and prevents duplicate requests for services. Second, automating clinical documentation and standardizing patient care services allows costs and outcomes to be tracked readily. CFOs should help determine any other areas to track for improving efficiencies and effectiveness.

Finally, CFOs likely will face many challenges during the EHR journey, such as the following:

- Investment will be a multiyear effort and may continue indefinitely to remain current with technology.
- All processes will be scrutinized and require effort to update, standardize, and integrate into the selected EHR. (This effort can take from one to two years in preparation for EHR implementation.)
- Executive support, advocacy, and sponsorship will need to be maintained over a long period.
- Safeguarding against institutional fatigue will be ongoing as the organization continues to provide patient care while preparing, training, testing, and implementing the EHR.
- Incentives may be needed to ensure physician participation throughout all phases of the EHR initiative. (Some organizations provide financial incentives to physicians due to their lost productivity while others choose not to.)
- Instead of simply automating paper processes that are broken, effort and resources will need to be focused on rethinking the delivery of care and the interaction of clinicians with the EHR.
- Change is quite painful for professionals who have optimized their manner of productivity, so change management should be a cornerstone of any such undertaking.

**CFO Leadership Is Needed**

This remains an exciting time for CFOs to be a part of an EHR project. Remembering that EHRs affect every patient care process as well as clinicians reinforces the need for executive oversight and involvement. Although the initiative will strongly emphasize physician participation, this should be augmented by the leadership of the CFO and other C-suite executives. Because improving patient safety and providing efficient, high-quality patient care remain at the center of every health system's strategic business plan, it follows that an EHR project, with its ubiquitous impact, requires the involvement, sponsorship, advocacy, and oversight by C-suite executives. Moreover, a hospital can truly benefit from a multidisciplinary approach to its EHR initiative—one in which the CFO plays an integral role.

*This article originally appeared in HFMA's Leadership magazine ([www.hfma.org/leadership](http://www.hfma.org/leadership)). Used with permission.*
Past Presidents’ Dinner Dance

Photos selected by Marty Abschutz

Photos by Dennis Hodge

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Avoiding No-Fault Claim Timeliness Denials

By James G. Fouassier, Esq.

Let me skip the introductory sarcasm and smart remarks and get right into this one, because it's another dilly.

Some ten or eleven years ago, when the State Insurance Department enacted sweeping changes in the claims submission provisions of the no fault regulations (initially called Regulation 68 but then recodified as Regulation 65 or, more formally, 11 NYCRR Part 65) the rationale was the need to curb fraudulent health care claims. Provider claims submission periods were dramatically cut back from 180 days to 45 days. At the same time, almost like a quid pro quo, the time periods within which no fault payors were required to pay, deny or seek verification also were reduced.

For our purposes today two time periods are relevant. A no fault insurer is entitled to notice of an accident within thirty (30) days of the accident itself. Usually it’s the party or parties to the accident that notify their respective carriers (the regulation says “injured person”) but it need not be just those physically involved. The important part of this is that the carrier gets actual notice from someone within the thirty day period. The other time period is the provider’s notice of claim. As I said, this is the one shortened to 45 days from the date of service (or, for hospital care, the discharge date).

Recently the New York State Court of Appeals, our state’s highest court, ruled that a hospital’s notice of claim does not serve the same purpose as the insured’s notice of accident and that even though the hospital timely served its claim (within 45 days of discharge) the failure of the injured person to notify the insurance carrier of the accident within thirty days meant that the carrier need not honor the claim. Both the trial court and the intermediate appeals court upheld the hospital’s argument that complying with the 45 day claim notice also satisfied the shorter accident notification requirement, pointing out that the regulation does say that the NF-5 claim form may serve as notice of the accident. But the high court disagreed, finding that the 30 day accident notification requirement is meaningless if it can be satisfied by a timely claim submission months or years after the accident date. This would fly in the face of the purposes of the anti-fraud revisions to the regulations.

The Court also observed that the law clearly holds that an assignee “stands in the shoes of the assignor”, meaning that the provider, as assignee of the patient’s insurance benefits, gets no greater rights than the insured patient has. So if the patient fails to meet a condition of coverage (the timely notice of the accident) the hospital cannot get a greater right (the right effectively to cure the defect) simply by taking an assignment.

The case is New York & Presbyterian Hospital v. Country Wide Insurance Company, decided on October 13, 2011.

So, say good-bye to “no fault” insurance coverage, and the patient is personally responsible. Great. What’s a provider to do? Collect $50 a month forever?

Obviously the problem comes up in a growing number of cases where the patient or family, for reasons of their own, do not bother to notify their no fault insurer that an accident has happened. It is important to note that many
more general health insurers are taking the position that they will not pay bills that should have been covered by no fault if no fault coverage is disclaimed. So in a serious auto accident situation perhaps it's worth considering acting “on behalf of” the patient by notifying the no fault insurer yourself. Take a look at your admission and registration processes to see how practical (costly?) it would be to have a staffer fax or even email notification of the accident to the patient's (or driver's) no fault carrier when you get that information from the patient or a family member or friend. It may be worth doing this routinely, to preserve some source of payment so that your bills will be paid.

Yes; I realize that if a hospital gets the no fault claim to the carrier within 30 days of the accident date the NF-5 or equivalent also will qualify as a valid notice of the accident, but will that always happen? Not if the patient is seriously injured and stays in-house longer than 30 days. Yes; I also realize that when a patient is in-house that long then very often the claims of the physician providers will exhaust the $50,000 no fault first party benefits and there won't be anything left for the hospital anyway. At the end of the day it’s the usual cost-benefit issue that must be confronted when any revenue “fix” is contemplated.

This is the text of Regulation 68 respecting notice of the accident, as established in the language of the Mandatory Personal Injury Protection Endorsement requirements set out in section 65-1.1 of 11 NYCRR:

Notice. In the event of an accident, written notice setting forth details sufficient to identify the eligible injured person, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by, or on behalf of, each eligible injured person, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation.

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His opinions are his own and may not necessarily reflect those of the State University of New York or the State of New York. He may be reached at james.fouassier@sbumed.org.
Past Presidents’ Dinner Dance

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Approaching ICD-10 Strategically

By Kerry Johnson

If you haven’t developed an ICD-10 implementation plan yet, you better start now.

The debate on the implementation of ICD-10 is over! The final ruling for the implementation of ICD-10-CM/PCS (diagnosis and intervention coding) and the related electronic transactions standards (Version 5010) was released by the Centers for Medicare & Medicaid Services (CMS) in January 2009. The dates provided in the final ruling were extended from the original compliance dates in the Notice of Proposed Rule Making (NPRM) released in August 2008. The new dates for compliance are Jan. 1, 2012, for the Version 5010 electronic transaction standards and Oct. 1, 2013, for ICD-10 based upon industry feedback to CMS that more time would be needed than given in the original NPRM. Of note, the Version 5010 electronic transaction standards must be implemented first, as the existing standards (Version 4010/4010A) cannot support the ICD-10 code sets.

At the April 2009 American Health Information Management Association (AHIMA) ICD-10 Summit in Washington, D.C., many industry experts emphasized the importance of developing an implementation plan for these new data standards as soon as possible.

Types of ICD-10 Implementation

Summit participants also noted the importance of taking a strategic approach to the implementation of these new data standards, especially the implementation of ICD-10. The Deloitte Center for Health Solutions paper The Impact of ICD-10: Turning Regulatory Compliance into Strategic Advantage identifies three approaches that can be taken in implementing ICD-10: pragmatism, collaboration, and innovation.

Pragmatists will take a minimalist approach to implementation of ICD-10. Only absolutely necessary changes will be made to systems, and the use of crosswalks and data mapping tools from ICD-10 to ICD-9 and vice versa will be employed. Although there may be some short-term advantages to this approach, payers and providers will miss out on other advantages, Deloitte notes.

Collaborators will move past basic compliance by partnering with other organizations (whether payer or provider) to leverage some of the advantages of the enhanced ICD-10 code sets. They will reduce costs and position themselves to use the individual and aggregate data generated through the new code sets to enhance their understanding and improvement of claims adjudication and reimbursement, as well as enhance their knowledge about patient safety and care, utilization management, and improved documentation through the more granular nature of the ICD-10 data.

Innovators will gain the most strategic advantage. These organizations will take a strategic look at how they can use the ICD-10 implementation experience and subsequent data to their overall strategic advantage, and will account for this in their implementation planning activities. Their plan will include not only the compliance to meet the regulatory requirement, but also how investment in ICD-10 can position their organization for future opportunities.

Strategic Implementation Considerations

Organizations need to determine what approach they will take to ICD-10 implementation. Will they employ pragmatism, collaboration, or innovation? They should make a strategic business decision at the start, as the outcome of that decision will affect all other activity related to the implementation.

Whatever approach an organization decides to take, it should start its implementation plan immediately. In fact, many organizations are well on their way with their implementation plans. Considerable industry-generated resources are publicly available to assist with implementation planning, including such information as project task and timeline plans for the Version 5010 implementation (available from www.nchica.org), and ICD-10-CM/PCS planning checklist and training resources (www.ahima.org).

By now, discussions about this aspect of the ICD-10 implementation should have begun. Although the scope of the 5010 transactions portion of the mandate is somewhat more defined and contained in terms of who is most directly affected by this aspect for the implementation, it is the crucial initial step in the move to compliance with the CMS ICD-10 mandate. Those who are responsible for...
health information systems will be the most involved, including payers and health information and financial system vendors/developers.

However, healthcare organizations should be aware of what steps their payer systems, health information, and financial system software vendors are taking. Organizations should know which of their systems will be affected by the Version 5010 standards mandate and find out whether their vendors are committed to meeting the mandated timelines. Do the vendors’ implementation plans fit in with the strategic response the organization has committed to as part of its plan for compliance? Provider organizations should ask what the systems vendor’s plan is and request regular updates on its performance against that plan. The organization’s plan should be built around the ability to complete and deliver compliance on the Version 5010 standards.

ICD-10. By far, the largest piece of the CMS mandate is the implementation of ICD-10. Although the compliance date for ICD-10 is later than that for the Version 5010, organizations need to develop a plan now for the transition to the new code set. Only by developing the plan now will a facility be able to make a full and informed decision on the strategic response it will take to the implementation. Without a plan, organizations will not know what systems are affected in their organization, the extent of change management needed, education required, cost, contingencies for productivity loss, and accommodation for the fundamental changes to the data sets.

The key initial step in the development of the ICD-10 transition plan is the inventory of all systems (both electronic and paper-based) that currently use the ICD-9 code set and will be transitioned to the new code set. Strategically, this inventory should include those systems/functions that can benefit from the use of the ICD-10 code set. By producing an inventory of the systems, organizations will have a foundational understanding of the systems affected, the extent to which they are affected, who in the organization is affected, and the level of training required. At this point, the organization, in conjunction with system vendors, should also be able to estimate the cost of the implementation in their organizations. Of course, this cost will vary with the level of strategic response.

A strategic component of this planning phase is the need to examine what the organization would like to do with the ICD-10 dataset once it is in place. The most strategic organizations—the innovators and some collaborators—will fully implement the new code set and plan to use the enhanced data to better position their organizations in the healthcare arena. They will make as much use of the data as they can in the ICD-10 format and move away from ICD-9 as quickly as possible. Crosswalks and mapping to ICD-9 will be needed until grouping and reimbursement methodologies can make use of the data collected in the new code set. However, organizations that take a strategic approach should include in their plan the retirement of the use of the ICD-9 code set.

Organizations need to assess how their current vendor systems fit with their desired path for the implementation. If the provider’s vendors are not positioning themselves in the same strategic manner as the organization, the implementation plan might need to include the replacement of existing systems to meet the mandate and the organization’s strategic implementation.

The ICD-10 implementation plan should specify educational requirements. Clearly, the amount of training required will vary among staff members. For example, coding staff obviously need a much deeper understanding of the code set than senior administration does. However, senior administration needs to understand the impact the new code set will have on the organization in terms of data availability and comparisons, impacts on fiscal and human resources, and so forth. A detailed education plan is required, listing everyone who will need education and what level of training is needed. Consideration also should be given to the timing of the training. Senior administration needs some information now for budget planning. HIM staff might need some education now to help in selecting systems and determining their impact.

However, coding staff training should be scheduled closer to the compliance date. One AHIMA presenter at the summit recommended approximately 50 hours of training six to eight months before the compliance date. Strategic organizations should consider these recommendations carefully. First, if coding staff throughout the United States receive training at the same time, training programs are likely to be overwhelmed. Second, the recommended 50 hours of training should be considered a minimum training requirement for ICD-10 coders at acute care facilities. This recommended requirement is similar to that used in Canada, where in many instances, it was found to be insufficient. A recommended coder training approach is to provide in-depth ICD-10 training nine to 18 months in advance of the implementation, with a 50-hour refresher program immediately before the compliance date.

Critical to an organization’s operations is the reimbursement based upon the coded data. Organizations that strategically
implement ICD-10 should be aware of the impact the transition to the new code set will have on productivity and the revenue cycle, and should include in their implementation plan strategies to mitigate any negative effects on this cycle. One of the most effective strategies is to ensure that adequate levels of training are provided so coders will not be learning while coding. Other considerations include ensuring that there are minimal backlogs of coding at the time of switchover, new/updated systems are thoroughly tested before cutover, and physician documentation is complete in the records.

As noted previously, a highly strategic implementation of ICD-10 should consider how the new code set will be used in the organization. The greater specificity and flexibility of the new code set means organizations will have access to better data. Crosswalks, mappings, and translations are available, and will be necessary in the short term to make the transition and understand the data. However, strategic organizations should first understand how these tools are to be appropriately used, use them for a limited period (i.e., until there is sufficient data in the new code set to be effective), and move as quickly as possible to using ICD-10 data. It will take some time for the industry to collect sufficient data to recalibrate the grouping and reimbursement methodologies. Therefore, the use of the crosswalks, maps, and translations is necessary. However, strategic innovators should use these tools only as necessary and for as little time as possible to move to making the most use of the data collected in the new code sets and take advantage of the benefits of the enhanced data.

**Strategic Planning Success**

The consensus at the AHIMA summit was that CMS would be granting no compliance date extensions to any organization not able to meet those published in the final ruling. A strategic innovative approach to the implementation of the new code sets of Version 5010 and ICD-10 will position an organization to not only have an effective implementation/transition strategy, but also help it meet the compliance deadlines. An innovative approach will also provide an organization the strategic advantage of enhanced data for understanding its healthcare system and ultimately better provision of patient care.

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**Footnotes:**


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HFMA's Revenue Cycle Forum has aggregated four new tools on ICD-10, including a detailed overview, a sample superbill, a conversion timeline, and a preparation checklist. Visit the Revenue Cycle Forum at www hfma org/forums/pfs.
Past Presidents’ Dinner Dance

Photos selected by Marty Abschutz

Photos by Dennis Hodge
The cost of energy and world consumption continues to increase. Now is the time for hospital management to work with facility engineers, maintenance staff and others to explore innovative solutions and green practices to help manage operational costs.

A smart approach is to implement green practices incrementally by exploring what can be done in the short term (0-3 years), near term (3-8 years), long term (more than 8 years), and on a going-forward basis. To help anticipate areas within facilities to look at for savings and future areas of investment, we’ve assembled the following "50 Ways to Green Your Hospital."

By implementing some of these tips, hospitals can easily save between 10 and 25 percent annually on their energy bill. And even small changes can add significant budget savings to the bottom line. Let’s get started:

**Short term payback plan: 0-3 Years**
Quick changes and low or no cost facility areas to look at that can help yield instant savings. Often these tips will provide the biggest bang for your buck.

**Building Envelope**
1. Find and fix leaks (doors and windows)

**Lighting**
2. Install occupancy sensors
3. Retrofit existing lighting fixtures (T12 – T8)

**Motors**
4. Properly size to the load for optimum efficiency
5. Check alignment
6. Check for under-voltage and over-voltage conditions

**Pumps**
7. Operate pumping near best efficiency point
8. Modify pumping to minimize throttling
9. Adopt to wide load variation with variable speed drives
10. Use booster pumps for small loads requiring higher pressures
11. Repair seals and packing to minimize flows and reduce pump power requirements

**Controls/Automation**
12. Check schedules, setpoint and setbacks
13. Confirm HVAC/Refrigeration control strategies are correct/operational
14. Check/inspect/repair equipment for proper operation (fans, dampers, belts, filters, VAV boxes, etc.)
15. Use "free cooling" when using your chilled water system in cold weather

**Steam**
16. Fix steam leaks and condensate leaks
17. Inspect steam traps regularly and repair malfunctioning traps promptly

**Boilers**
18. Preheat combustion air with waste heat
19. Use variable speed drives on larger boiler combustion air fans with variable flows
20. Inspect and clean burners, nozzles
21. Close burner air and/or stack dampers when off
22. Automate boiler blow-down and recover blow-down heat
23. Use boiler blow-down to help warm the back-up boiler
24. Inspect door gaskets
25. Optimize boiler water treatment
26. Add an economizer to preheat boiler feedwater using exhaust heat- Recycle steam condensate

**Water and Sewer**
27. Recycle water, especially if sewer costs are based on water consumption
28. Use the lowest possible hot water temperature
29. Fix water leaks
30. Use water restrictions on faucets, showers and/or install self-closing type faucets in restrooms
31. Verify water meter readings

**Near-Term Payback Plan: 3-8 years**
You’ve looked at the easy stuff, now take a hard look. These suggestions are investments or changes that still have attractive payback, but take more time to investigate.

**Equipment Change Out**
32. Evaluate your chilled water system to specifically consider replacement of chiller(s) with more efficient models
33. Study gas-powered refrigeration equipment to minimize electrical demand charges
34. Assess new HVAC system
35. Replace boilers (higher efficiency, modular, etc.)
36. Consider installing: thermal storage systems, heat recovery systems

Operational Strategies
37. Determine optimum building automation/control strategies and implement –
38. Consider different utility purchasing options, rate analysis and/or buying utilities on the commodity market
39. Ensure high efficiency motors are matched to size/loads
40. Optimize compressed-air equipment for maximum efficiency through leak analysis and end-use requirements assessment
41. Study part-load characteristic and cycling costs to determine most efficient mode for operating multiple boilers
42. Consider more efficient options (don’t use the main heating boiler) for domestic hot water during the cooling season

Renewable Energy Solutions
49. Study the benefits of adding some renewable technologies such as: solar, wind, biomass

Ongoing

Maintenance
50. Engage in proactive maintenance for sustained performance

Making facility improvements of any kind can help hospitals achieve better performance and have a positive effect on budgetary resources. Of course, individual results and cost savings are dependent on each unique facility situation, utility costs and specific areas of investment. And while there could be higher initial costs, green design, upgrades and operations can help create cost savings that almost always pay for the added costs. But in the end, a green facility creates healthier and more resource-efficient models of construction, renovation, operation and maintenance – not to mention a more enjoyable and productive healing environment for patients and healthcare providers.

Steve Wey is Vice President, Trane New York / New Jersey. He has over 30 years experience in heating, ventilation and air conditioning (HVAC) and building automation. Steve holds a Bachelor of Science degree from John Hopkins University.

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Past Presidents’ Dinner Dance

Photos selected by Marty Abschutz

Photos by Dennis Hodge
How to Make the Most of an EHR Investment

By Bruce Henderson

Funding implementation of an electronic health record (EHR) system—and then finding the ROI—aren't easy. Here's how to accomplish both.

It's a classic chicken-and-egg conundrum. Beginning in 2012, hospitals will face aggressive deadlines to demonstrate meaningful use of EHR systems; however, many don't have the capital resources for the upfront investments in these systems, which offer only a promise of delayed financial reward and an unclear path to ROI.

Implementing EHRs is one of myriad competing priorities for health IT leaders and providers. And the daunting cost, steep learning curve, and uncertainty surrounding ROI have forced many hospitals to delay the project, leaving them behind the curve in EHR implementation, let alone the ability to demonstrate meaningful use.

According to the Healthcare Information and Management Systems Society (HIMSS), less than one in five hospitals has implemented a fully operational EHR system across the organization. For those behind the curve, government incentives for demonstrating meaningful use are now their call to order to reprioritize IT initiatives and accelerate EHR adoption. Yet, some health systems have a long road ahead. A recent PricewaterhouseCoopers survey of College of Healthcare Information Management Executives (CHIME) members found that half of hospital CIOs surveyed said they would not be ready to apply for those incentives when they become available.

Funding EHRs through Cost Savings

Advanced budgeting and an awareness of incentive eligibility will help providers manage costs. Organizations can start by applying EHR implementation to their strategic goals and capital plans. In some cases, EHR investment dollars may exist in other parts of the organization, outside of IT. For example, by scanning the entire organization’s processes, providers can identify fairly quick cost savings opportunities and use that money to kick start the implementation process. Such a project will be most effective if it is employed as an interdisciplinary team approach and involves staff beyond the office of the CIO.

Consider, for instance, the supply chain process, where costs can consume as much as 40 percent of total operating budget. By implementing relatively painless savings opportunities, such as restocking dated inventory items with the newest inventory placed in the back and the oldest inventory placed in the front, hospitals will be able to cut costs related to inventory expiration and inventory replenishment. Hospital supply chain managers can apply the newly found savings toward the hospital's health IT purchase while also making improvements in supply chain inventory management.

Providers can also identify cost saving opportunities by examining their current IT footprint. Now is the time to retire applications that no longer have use or consolidate redundant applications to eliminate maintenance fees. Other potential cost savings opportunities include consolidation of data centers and other cost reductions in hardware, as well as a review of niche and homegrown applications to determine if they can be replaced with more standard applications that require less support and fewer interfaces.

Quick hits such as these can not only provide ways to fund an EHR implementation, but also can provide lasting value as the hospital transforms its business to achieve greater efficiency of its clinical, operational, and administrative practices.

Healthcare executives may also recoup some of their organizations’ EHR investment dollars through incentive payments. As a general rule, providers will be eligible for incentive payments if they use government-certified EHR systems in a meaningful way. At a more granular level, they must comply with a new set of regulatory metrics designed to improve quality, manage disease, share data, and coordinate delivery of care (see the exhibit on the next page). As part of their EHR
investment strategy, it is important for providers to invest the time in understanding the EHR incentive program and how it relates to their practice or institution.

### Capturing the Elusive ROI

The ROI of an EHR system is not as easily calculated as some of the early healthcare IT applications, like tools for scheduling and billing that perform functions quickly and efficiently. Thus, it has been difficult for financial and information officers to justify the expense of EHR systems. The new government mandate is changing this way of thinking.

In planning for an EHR investment, the experiences of early adopters can help financial managers assess the potential ROI they may accrue in their own organization. The exhibit below shows common instances of ROI that can accompany a fully implemented EHR.

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Texas Health Resources, Arlington, Texas, is among early adopters that are achieving a variety of benefits as a result of EHR implementation. Texas Health, one of the largest faith-based, nonprofit healthcare delivery systems in the United States, has 12 acute-care hospitals and one long-term care hospital, with a total of 3,355 licensed hospital beds. In 2005, Texas Health embarked on an ambitious, systemwide project to convert its hospitals, outpatient clinics, and physician practices to an advanced EHR in an effort to drive standardization across its healthcare delivery system.

The EHR allows hospital staff to access patient medical information, track test results, view radiology images, and deliver coordinated care at most levels. It serves not as the driver, but as a lever for Texas Health’s hospitals to use to improve performance, whether quality or financial. Today, 11 Texas Health hospitals have implemented the EHR; the 12th will be online this summer, and by next year, all 13 of Texas Health’s hospitals will be using the system.

Texas Health as a whole is achieving a variety of benefits as a result of the EHR implementation.

- Medication errors have decreased an average of 54 percent, and estimated computerized physician order entry (CPOE) preventable adverse drug events have decreased an average of 33 percent.
- Unit clerk/secretary time spent on order entry and related activities has decreased an average of 72 percent, with a
subsequent impact on unit clerk workflows, job functions, and staffing.

* Transcription volumes have decreased and productivity has increased as physicians enter notes directly or use an electronic system for dictation. At one site, Texas Health saw a 44 percent reduction in average monthly transcription lines despite an increase in volume of annual charts coded and analyzed.

As a basis for measuring these performance improvements, Texas Health formed a value model realization program to ensure organizational commitment to obtaining value from the EHR. The program focuses on achieving value from the EHR rather than pure ROI, identifying the EHR's benefits and establishing improvement goals that can be achieved with EHR use, where possible. Using a value scorecard, Texas Health measures improvements across four areas:

* Efficiency
* Quality and safety
* Satisfaction
* Financial

For each of its hospitals that has implemented the EHR, Texas Health uses the value scorecard to conduct baseline performance studies pre-implementation and at one- and two-year post-implementation milestones. Key drivers for improvement include system reminders and alerts, evidence-based order sets, physician order entry, interaction checking, and other online tools to facilitate efficient and effective care delivery.

Although it is too early to calculate specific ROI dollars, Texas Health believes that its comprehensive EHR system and widespread adoption of this system is driving waste and redundancy out of the organization while making care more timely, efficient, and effective.

For those organizations that are beginning an EHR implementation, federal funding will be helpful in the development stages, but long-term sustainability of healthcare IT will rely on strategic initial investments and organizational acceptance to generate the kind of support that is needed to make the most of an EHR investment. Both are foundational building blocks to achieving sustainable improvements in clinical and financial performance.

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Footnotes:

a. HIMSS defines a fully operational EHR system as having complete automation of all clinical orders and documentation for all acute care services (20th Annual 2009 HIMSS Leadership Survey).
b. PricewaterhouseCoopers Health Research Institute (HRI), Ready or Not: On the Road to Meaningful Use of Health IT. HRI surveyed 120 CIOs and health IT executives who are members of the CHIME. In addition, HRI interviewed nine CIOs and health IT executives from health systems, health information exchanges, and regional extension centers.

**Excerpted from an article that originally appeared in HFMA’s Healthcare Cost Containment Newsletter (www.hfma.org/hcc). Used with permission.**
Past Presidents’ Dinner Dance

Photos selected by Marty Abschutz

Photos by Dennis Hodge
New Delivery Models Engage Consumers in Reducing Healthcare Spending

By Jeni Williams, associate managing editor of HFMA

As the nation moves toward value-based business models of care, a period of ‘disruptive innovation’ will reduce costs of care delivery and make access to care more convenient.

The move toward a value-based business model in health care ultimately comes down to one question: “Who is going to build a new, more convenient, safer, higher-quality health system?” Jason Hwang, MD, MBA, executive director of healthcare at Innosight Institute and coauthor of the book The Innovator’s Prescription: A Disruptive Solution for Health Care, asked participants in HFMA's 2011 Thought Leadership Retreat. The retreat was held this past October in Washington, D.C.

A process of disruptive innovation—in which a product or service takes root initially in simple applications at the bottom of a market, then relentlessly moves “up market,” displacing established competitors—will mark the move toward a value-based delivery model in health care, Hwang says.

Just as traditional department stores have given way to Target and Wal-Mart discount “superstores”—and just as these stores are now losing sales to Internet retail—multiple care delivery models are disrupting the traditional roles of payers and providers, Hwang said. These models provide the same level of quality or better than their more traditional counterparts, reduce costs of care delivery, and are making access to care more convenient.

However, Hwang said, “More affordable and convenient access to health care may not lead to lower overall spending on health care.” In the same way that American consumers spend more on computers and other IT devices despite the decrease in cost for such technologies, “If healthcare providers are delivering better value, that will erase consumers’ concerns about how much they are spending on health care,” Hwang said.

More Organizations Adopting Value-Based Approach

“Health systems that integrate finance and delivery functions have the organizational capacity to disrupt health care,” Hwang told participants at HFMA's Thought Leadership Retreat. He cited organizations such as Qliance—in which patients pay a monthly fee for primary care services directly to a Qliance clinic, without having to go through an insurance company—as examples of new delivery models that are engaging consumers in stabilizing healthcare costs.

For example, when Adventist HealthCare of Rockville, Md., launched a primary care medical home pilot in late 2009, it did so as a way of testing whether improved health management for employees with high-risk conditions could lead to better outcomes and reduced costs. At that time, 60 percent of the health system’s employee health costs were generated by just 6.3 percent of patients.

Adventist chose a select group of patients whose health would be closely managed by a primary care physician with the support of a personal health nurse. The results: In just one year, pilot participants’ per member, per month costs dropped 35 percent, from $1,981 in 2009 to $1,290 in 2010.

Evidence-Based Benefit Design Reduces Costs

James G. Lee, FHFMA, FACHE, executive vice president, CFO for Adventist, noted that healthcare workers use 13 percent more healthcare services than the average American worker. Adventist's primary care medical home approach is an example of evidence-based benefit design that can reduce costs, enhance care, and improve quality of life, he said.

“As an industry, we can make a difference in lowering healthcare costs. We need to be advocating for some of these changes,” Lee said.
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A World of Difference In Receivable Management Services
National HFMA Offers New Certification Program

By Art Cusack, PhD, FHFM A
National HFMA Board of Examiners

Today's healthcare reimbursement environment is growing increasingly complex. The demands on revenue cycle staff to achieve higher levels of performance are ever present. The HFMA National Board of Examiners has created a new certification to advance revenue cycle staff's proficiency and technical expertise. This new opportunity to become certified is called the “Certified Revenue Cycle Representative” (CRCR).

The program began as a continuing education course at several local chapters. Its value was recognized by the National Board and has been expanded and validated over the last year to create a second HFMA nationally sanctioned certified program in addition to the Certified Healthcare Financial Professional (CHFP). The overall goal of the certification is to gain a broader understanding of the entire revenue cycle.

Understanding the importance of revenue cycle proficiency to the success of healthcare organizations, the CRCR program is offered not only to HFMA members, but non-members as well. The exam is composed of 150 multiple choice questions that must be completed within three hours. Individuals and organizations may purchase the program at a cost of $400.00 per candidate. The exam fee includes access to the online study guide for one year, the exam, and exam retakes over the one year period if necessary. All candidates that successfully pass the exam will be able to print out the certificate online.

In order to maintain the certification both members and non-members are required to pass a 75 question, 90 minute recertification exam every two years. The biannual recertification exam fee is $150.00.

The exam covers seven topic areas that include:

- Compliance
- Patient Access
- Claims Processing
- Account Resolution
- Cash Handling
- Financial Management
- Operations of Revenue Cycle Departments

The CRCR will help you to validate your skills and knowledge, enhance your credibility in the industry, and support your career growth. As a certified member I can tell you that it will also improve your confidence and confirm your commitment to professional development. For more information and to sign up for the exam go to: http://www.hfma.org/crcr/

Art Cusack is the Executive Director for the Long Island Family Health Centers.
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