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OBJECTIVE

Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to healthcare financial professionals and as to serve as a forum for the exchange of ideas and information.

EDITORIAL POLICY

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The President's View . . .

Mary T. Taylor

It's pretty incredible that we are almost at the end of the 2010! This has been a challenging year trying to keep abreast of the Healthcare Reform regulations, which was the main focus of our 34th Annual Institute held this past October. Kudos to the Institute Committee Chair, Deb Shapiro and Co-Chair Howard Krain along with all the committee members who out did themselves this year! They added an additional full day of education, had 492 attendees, over 40 vendor display booths, designed a new Institute website, with all the presentations uploaded and created an abstract database for use by all committee's for future education programs. I would also like to thank our sponsors for their support, and encourage them to join our Sponsor Sub-Committee in order to gain additional value from our events. Thanks to all the speakers who gave excellent presentations and valuable information & updates on many topics including Healthcare Reform. Save the date for next year's Institute: October 12-14, 2011 at the Borgata in Atlantic City. See our website at www.hfmanj.org for more details.

Mark your calendars for our yearly **January Quarterly session, entitled *"No Margin for Error"*** by the HFMA NJ Patient Financial Services and Patient Access Committees, **which will be held on January 11th** at the Woodbridge Hilton. This is our largest quarterly event, don't miss it!

Our Education and Member Services & Networking Committees are hard at work putting together webinars, half-day sessions and social events to continue our education.

Other events include:

- December 14th, a **free** lunch webinar on "Vendor Management" a Case Study of what it is and how it creates value.
- January 18th, "Use IT or Lose IT: Complying with HIPAA/HITECH and Electronic Health Record", a joint conference with NJHIMSS and NJHFMA at the Holiday Inn in East Windsor.
- February – Medicare Cost Report
- March 8th, Quarterly CARE Education sessions
- April – a two day event on HealthCare Reform
- April – Managed Care Program
- May 12th – The Chapter Annual Golf Outing at Fiddler's Elbow

And many more on the drawing board, so read our weekly NJ HFMA PULSE email communication and check the website for dates and details: www.hfmanj.org

I strongly encourage all of you to ***Step Up*** and join a committee, get involved, share ideas, learn and have fun! As a member of HFMA NJ, the opportunities our committees offer are endless, with shared talent, networking, best practices, excellent education and lifetime friendships. Visit our website for information on education events, hot topics and committee listings showing contacts and meeting minutes.

Finally, on behalf of the Officers and Board of Directors, we wish you a Happy, Healthy Holiday season and the best for 2011.

Respectfully,

Mary T. Taylor, MBA, FHFMA

From The Editor . . .

Elizabeth G. Litten

Dear Readers,

In the spirit of the season, and inspired by this issue's cover photo, I'm skipping my typical letter and instead am giving you a song and the chance to win a holiday gift. The clever reader who is first to correctly identify Santa and his hospital affiliation will win free attendance at an upcoming Quarterly Meeting. Email your guesses to Laura Hess at njhfma@aol.com. The winner will be selected by random drawing from all the correct answers received on January 3rd. May you all enjoy a happy and very healthy new year!

Santa Baby, slip a putter under the tree, no not for me
You've been an awful good boy
Santa baby, and hurry down the chimney tonight

Santa baby, some popcorn and a Yankees jersey, too, pinstripe blue
I'll wait up for you dear
Santa baby, and hurry down the chimney tonight

Think of all the fun I've missed
Think of all the CFOs that I haven't kissed
Next year I could be oh so good
If you'd check off my Christmas list
Boo doo bee doo

Santa honey, I wanna yacht and really that's
Not a lot
I'll keep it in the bay by you dear
Santa baby, and hurry down the chimney tonight

Santa cutie, there's one thing I really do need, the deed
To one of your two hospitals dear
Santa cutie, and hurry down the chimney tonight

Santa baby, I'm filling my
stocking with bonds and checks
Sign your 'X' on the line
Santa baby, and hurry down the chimney tonight

Come and trim my Christmas tree,
With some decorations bought at Tiffany's;
I really do believe in you
Let's see if you
Believe in me
Boo doo bee doo

Santa baby, forgot to mention one little thing, a claddagh ring
The kind that Irish guys wear
Santa baby, and hurry down the chimney tonight

Hurry down the chimney tonight
Hurry down the chimney tonight

Cheers,

Elizabeth G. Litten

The 2010 Annual Institute

by Deborah Shapiro

If the 34th Annual Metro Philly/NJ Chapter Annual Institute, held at the Borgata Casino Hotel and Spa on October 20 – 22 was a recipe, it would go something like this: Take 2 co-chairs (**Deborah Shapiro** and **Howard Krain)** who are somewhat less than sane, 10 months of planning, a gung-ho Institute committee, 9,000 emails, 800 tracking spreadsheets, 37 education sessions, great food, fabulous fun – mix it all up and you get 2.5 days of an unbelievable event!

Tuesday Night – October 19, 2010: It feels like moving day, but it's really packing day. Five hundred and fifty bags – sponsored by BESLER – to be packed with the conference CD and schedule, an Audiobook, "Life", provided by our Friday keynote, Dr. Bruce Weinstein, portfolios by Blue Marsh, a white paper by A.M. Best (both Breakout Education Sponsors), and a booth bingo card. Among **Mary Taylor, Mike Alwell, Joann Higman, Deborah Shapiro** and our photographer, **Ben Martin (www.bpmartinphotography.com)**, we get those bags stuffed and ready to go. A moment of hilarity ensues when we discover, at the bottom of the fourth box of bags, that Besler had provided pens, sticky note pads and marketing material to be stuffed as well. As we had already completed about 400 bags…well, let's just say they had more bits and pieces to hand out at their booth than they expected! We troop off to dinner at Izakaya (best sushi EVER!) and join a number of other Institute goers at B Bar for a nightcap.

Wednesday – October 20, 2010: A full day of education planned. Over the course of the next 2.5 days, we scheduled 31 break out sessions, 5 keynote speakers, and 1 CFO panel. Oh boy! The line starts at the Registration Desk before 8 AM and all are grateful to our coffee sponsors for making sure we have sufficient caffeine to start off – and keep us going throughout – the day. As people register, in addition to the conference bag, they receive a token and instruction sheet for the charity auction and Roarin' 20's Bootlegger Banquet taking place in the evening.

Signage for the various events is placed, the vendor slide show is running in the pre-Event Center area and the day begins! With four tracks to choose from – Audit/Compliance, Finance, Reimbursement, and Patient Financial Services – the conference attendees are confronted with a plethora of excellent choices for every classroom hour in the day. **Mary Cronin** is owed a huge round of applause – she brought all the copies of the sign in sheets, CPE certificates (prepared by **Lew Bivona)** and session evaluations that are to be used during the conference. Without her, no one would have been able to get up to the 14.5 CPE and ACHE credits available over the course of the event! Our intrepid room volunteers – including **Jim Beutel, John Brault, Curtis Brooks, Terri Brown, Tony Consoli, Tracy Davison-DiCanto, Howard Krain, Fred Molinari, Michael Ruiz De Somocurcio, Deborah Shapiro, JaneAnn Sheehan, and Mary Taylor - keep things moving along** throughout all the breakout and general sessions. **Laura Hess**, the Chapter administrator, helps conduct the flow of activity throughout and acts as general sergeant-at-arms during the course of the event – when she isn't manning the FOCUS booth shared with delegates from HFMA National.

Lunch was fun – we have vouchers to the Borgata Buffet with an unbelievable selection. With two hours between the morning and afternoon sessions, we have more than enough time to eat, check email, and get ready for more education! The afternoon flies by – with a much needed snack break complete with fruit and energy bars to keep us going - and

continued on page 8

continued from page 7

it is time for the grand opening of the Vendor Fair with the charity auction benefiting the Metro Camden Habitat for Humanity. Our theme for the evening is the HFMA version of "Boardwalk Empire" with flappers, gangsters, ballroom dancers, boardwalk games, vintage photo booth for dress up, and a wonderful band. A delicious dinner buffet is served and the attendees are able to walk among the 45 different booths that have been erected that afternoon. We even have an area set aside for an Internet café where the truly diehard could check in at the office! **JaneAnn Sheehan** has worked hard to coordinate the event with the charity raising just shy of $1,000 for the organization. The Chinese auction included items donated by vendor sponsors such as a Blu-Ray DVD player, restaurant vouchers, hotel vouchers, and sports tickets. We also had a sports memorabilia silent auction for select Yankees, Phillies, Giants and Jets items. Special thanks go to **Tony Consoli** for manning the Steiner Sports table for the evening and coordinating with Steiner for the wonderful selection of auction items.

A great time is being had by all. As a surprise, we wheel out a cake 'Mafia style' with the Lapis Luna band playing "Happy Birthday" in honor of **Mary Taylor** and **Mike Alwell**, our chapter President and President-Elect, respectively. Who knew that both Mary and Mike planned it so that the Annual Institute would take place over their birthdays?! [Just kidding!] The cake is delicious and adds just the right festive note to the evening. We won't mention what the bar bill was – but thanks to our drink

continued on page 43

The Hazards of Pharmaceutical Disposal: Rising Issues of Concern for Healthcare

by Suzanne M. Avena, Afsheen A. Shah & Jeffrey S. Brown

Suzanne Avena

Afsheen Shah

Jeffrey Brown

The presence of pharmaceuticals in our nation's waterways arising from a variety of sources, particularly hospitals, has brought the topic of pharmaceutical waste disposal to the forefront of environmental and public health issues. New science indicates that the prior practice of discharging waste pharmaceuticals down the drain, while generally accepted and legal, is contaminating our waterways. Although harmful chemicals can enter water sources through various means (*e.g.,* excretion, unused or expired medication being placed in the trash), hospitals and healthcare facilities tend to flush or pour unused products directly into sinks or other drains. From there, these products flow into sewage treatment plants or septic systems which have been discovered to be improperly equipped to remove all pharmaceuticals, resulting in these medications filtering into our waterways. Thus, regulatory agencies are now seeking to enact stricter environmental laws governing the disposal of pharmaceuticals.

Hazardous wastes are defined and regulated under the Fed-Hazardous wastes are defined and regulated under the Federal Resource Conservation and Recovery Act (RCRA) and New Jersey statutory analogs. However, there is a lack of definitive regulations at either the federal or state level with respect to the proper disposal of certain solids and many chemicals which are classified as 'pharmaceutical wastes' but deemed non-hazardous. This can also include controlled substances. Regulatory agencies fear that absent a cohesive and coherent policy governing disposal of pharmaceutical wastes, uncertainty regarding the appropriate methods for disposal will lead to a further contamination of waterways. As a result, the Environmental Protection Agency ("EPA") and New Jersey Department of Environmental Protection ("DEP") are actively reviewing existing policies governing the disposal of pharmaceutical wastes, as well as other hazardous and potentially hazardous chemicals, particularly as they pertain to hospitals and healthcare facilities. Furthermore, in some cases where it has been determined that drinking water is imminently threatened, prosecuting agencies have already been requiring certain institutions to implement such practices in advance of the anticipated revisions to existing law.

Wastes typically disposed of by healthcare facilities consist of pharmaceuticals and contaminated packaging. Pharmaceutical and personal care pollutants can consist of both hazardous and non-hazardous materials. They include an expansive and varied category of chemical substances ranging from prescription to over-the-counter medications, nutraceuticals, hormones, anti-depressants and biopharmaceuticals, among others. Proponents of change to the existing laws contend that although priority should be given to the management of hazardous pharmaceutical waste, this should not preclude implementation of adequate procedures for the disposal and management of non-hazardous pharmaceutical waste.

Current Gaps in Regulations for Disposal of Pharmaceuticals

As mentioned, RCRA controls the management and disposal of hazardous pharmaceutical wastes and ensures they are managed in an environmentally sound manner. Under RCRA a waste is considered 'hazardous' if specifically listed as such by the EPA or if it exhibits one or more of the specified characteristics required to render it as hazardous under its provisions, such as ignitability, corrosivity, reactivity and toxicity. However, RCRA regulations have not been updated since being enacted in 1976. As a result, many pharmaceuticals of concern, such as hormones, antibiotics, antidepressants and other controlled drugs and trace chemotherapy waste, are not covered by its provisions.

Complicating the matter is the disposal of controlled sub-

continued on page 11

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continued from page 9

stances which is governed by the federal Controlled Substance Act (CSA). The CSA consolidates numerous laws regulating the manufacture and distribution of prescription drugs such as narcotics, opiates, stimulants and chemicals used in the illicit production of controlled substances. Entities registered under the CSA, may dispose of harmful controlled substances through several permitted means, including reverse distribution, returning unused products to manufacturers or destruction in accordance with applicable state law, which usually includes on-site witnessed destruction, including flushing.

Disposal by use of reverse distribution companies is aided by companies that track manufacturer return policies and facilitate a return of any unused or expired drugs for potential credit from the manufacturer. The EPA has approved this method of disposal for close to three decades through Letters of Interpretation. However, not all products are eligible for credit and those which cannot be returned are frequently thrown away or flushed. Additionally, since most long term care facilities are not CSA registrants they are not eligible to return pharmaceuticals to manufacturers or utilize reverse distributors.

To address the concern that existing environmental law does not adequately address pharmaceutical waste disposal, state and federal agencies are revisiting current policies and practices for the disposal of all harmful pharmaceutical wastes, including those which are not currently covered by RCRA. To that end, the EPA has proposed an amendment to the Universal Waste Rule which would add hazardous pharmaceutical wastes to the federal universal waste program. (See Federal Register, Dec. 2, 2008, Volume 73, Number 232.) The universal waste program is essentially a streamlined management program for certain hazardous wastes designed in part to ease the burden of managing wastes and promote collection and recycling of commonly generated wastes. Although the EPA had initially anticipated the amendment would be effective by April of 2011, concerns expressed in response to the proposal with respect to the lack of notification and tracking requirements for facilities handling and transporting universal pharmaceutical wastes have delayed its implementation. In order to properly address these concerns, the EPA has indicated that it is considering additional regulatory options regarding the tracking and notification requirements, along with other issues relevant to the proper management and disposal of hazardous wastes. It is anticipated the addition of pharmaceuticals to the universal waste category will provide definitive regulations which govern their disposal. However, states are permitted to enforce regulations that are more stringent than the universal waste regulations and there is no guarantee that New Jersey would accept the more lenient practice of including waste pharmaceuticals as universal waste will be accepted by the States.

continued on page 21

Understanding Emergency Department Capacity

Failure Mode Analysis: The Bi-Modal Key to ED Crowding

Todd Warden

Richard MacKenzie

by Todd Warden, MD and Richard S. MacKenzie, MD, FACEP
With Special Thanks to Dominic Ruocco, MD and Gladys M. Sillero, MSN, CCRN, CNS, APN for their contributions

Yes, it can be very frustrating. You are part of the hospital administration and want to help the ED become more successful at providing care to the patients they serve. You know that the clinical care is good and you have respect for the doctors and nurses that work there but you also know that by most available metrics that measure ED quality, the ED is not performing at a level that satisfies you, the ED leadership or the patients. The measures of performance that virtually every ED monitors are:

- Time to provider
- Left Without Being Seen (LWBS) or Left Without Treatment (LWOT) volume and percentile
- Time on diversion
- Patient satisfaction scores

Generally you feel that these indicators do not actually reflect the true quality of your ED team or their service in the department. Many of the old assumptions about the types of patients that are leaving the department without treatment have been debunked; they are not really that sick, they probably don't have insurance or they are not sick enough to be admitted. Now you are probably concerned about the direct loss of revenue and the indirect impact on the hospital's reputation when ED service suffers.

Over the last ten years ED leadership, in response in part to pressure from hospital administrators, has become intensely aware that ED services are the lifeblood of the institution and they have implemented virtually hundreds of changes to process in an attempt to improve the service they provide. In April of 2009, The Governmental Accounting Office (GAO), at the request of Max Baucus, the Chairman of the Senate Finance Committee, performed an exhaustive review of the state of our ED services. This was a follow up report to a similar study performed in 2003. It is entitled *HOSPITAL EMERGENCY DEPARTMENTS: Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames.* This was a very disappointing report on the community of Emergency Medicine's response to ED crowding. The GAO reviewed 197 articles in the EM literature that reported attempts to improve ED processes and improve performance.

> Further, we reported that hospitals and communities had conducted a wide range of activities to manage crowding in emergency departments, but that problems with crowding persisted in spite of these efforts. These activities included efforts to expand capacity and increase efficiency in hospitals, and community activities to implement systems and rules to manage diversion. These efforts were unable to reverse crowding trends at hospital emergency departments, and we found that studies assessing the effect of these efforts were limited. (GAO, April 2009)

The failure of these attempts to fix our EDs, both locally and nationally, has demoralized our ED leadership. This has lead to frustration, defensiveness and an excessive focus on the external causes of ED crowding. At times it may feel like the focus on external causes takes precedence over a more pragmatic approach that would allow providers to fix the things that they can control, the internal throughput issues of the ED. The focus on external causes of ED crowding, such as lab and X-ray turnaround, patient boarders and medical staff responsiveness, has become an obsession within the academic ED community. Patient boarding is now discussed to the point of virtual exclusion of all other causes of crowding that might be considered.

> Of the 77 articles we reviewed that discussed factors contributing to crowding, 45 articles reported a lack of access to inpatient beds as a factor contributing to emergency department crowding, with 13 of these articles reporting it was the main factor contributing to crowding. (GAO, April 2009)

Press Ganey's annual release, "*2010 Emergency Department Pulse Report: Patient Perspectives on American Healthcare",* states that based on evaluations of 1.5 million patients treated in 1,893 hospitals in 2009, the average time from the patient entering the ED until they are discharged is four hours and seven minutes. It is also noted that since 2002, even after intense

process improvement activities by the ED community and outside experts, including Press Ganey, the average time in the ED has decreased by only 31 minutes. They do acknowledge that better process management and throughput is preferable in order to mitigate these delays for patients, but now they promote better communication with patients on why they are waiting to improve patient satisfaction. They have come to the conclusion, it appears, that this route is easier to attain than real performance gains in ED performance.

This same tangential approach to ED process challenges is being played out with ED leadership as well. It has become easier to externalize and focus on the barriers that exist outside of the ED rather than continue to push internal failed initiatives. The psychological toll on the leadership has been evident since the late 90s and is manifesting itself in their behavior to the point one might feel it is contributing to the problem.

- Lack of flexibility with trying new ideas especially if the ideas were not developed internally
- Common responses to a new idea may include, "we tried that already and it did not work"
- Physicians in particular will use the academic literature citing the impact of patient boarding
- Chronic externalization of reasons for poor ED performance
- Erratic jumping from one potential solution to another without making one work (cause de jour)
- Constant focus on more ED beds to eliminate crowding
- Lack of understanding of patient capacity needs or bed turnover strategies

If there was ever a time that the ED needed a hand from the "numbers guys or gals" to help them take a deep breath, clear their heads and refocus, it is now. Providers need to step back and take another look at the math of running an Emergency Department and be willing to adjust the mental model of how an ED should work. Providers need to objectively examine internal productivity and capacity to see what is under their control in the effort to improve the ED's performance and to gain a better grasp of the "real" moving parts of the department. The ED leadership will need to move away from many of the gut responses that have evolved over the years. Yes, ancillary and support departments could be doing more to help decompress the ED, but it is much easier to fix outside ills when the internal inefficiencies and bottlenecks have been addressed within the ED itself.

Later in this article, the authors and collaborators will present a new conceptual framework for the management of ED patient throughput. It will challenge the traditional view of ED process for both the nursing and physician leaders and in particular the relationship of the patient and the stretcher. Generally this new way of looking at how stretchers are used will make sense to a financial person because he or she understands resource utilization and how to best manage a scarce resource. Clinical personnel have historically not had to be concerned with resource management and find it harder to make this leap. However, if you follow this argument through and persevere with the leadership the results will speak for themselves by generating a minimum of a 35% increase in the capacity of existing beds within the ED. If you are currently considering expanding your ED footprint this new concept on bed utilization could have a dramatic impact on the size of needed space and the capital required to meet your growth needs by moving the focus from the *number* of ED beds to the *capacity* of the ED beds and thereby mitigating the capital required to meet the needs of your patient population.

Assess Your Current Resources

The most valuable resource, other than your ED team, is your available ED space and its stretchers. As one CFO explained to us as we discussed how a new ED design would increase the number of patients able to obtain care in the ED, "I don't care about ED capacity. I care about the number of bills I can generate per bed per year". This one statement totally transformed how we view ED finance as it relates to process, and process as it relates to design.

Most EDs have a very traditional design. They have triage and registration up front in close proximity to the patient waiting room. The other two components of the typical ED are the Fast Track and the Main ED area. This design has been in place for at least the last 25 years and even today the latest designs have not developed much beyond this basic footprint except for the additional amenities. Maybe it is not so surprising that design innovations have not evolved very far in the last decade since the process successes that generally drive design are limited (form follows function/process). Also, it is of interest that the annual capacity assumptions for an ED bed have not changed from 2,000 patients per bed per year in the last 25 years. ACEP and major architectural firms that specialize in ED design are still using this multiplier. They also assume that Fast Track beds, since they treat less acute patients, should be able to treat and bill 3,000 patients per bed per year. One caveat to keep in mind is that Fast Track beds are usually open for approximately 12 hours a day so the true productivity of a Fast Track bed real estate is about 1,500 patients per bed per year. So a quick assessment of your ED capacity based on the traditional model would look like this for an ED that sees about 50,000 patients per year:

- 20 Main ED beds @ 2,000 patients per bed per year = 40,000 patients per year
- 6 Fast Track beds @ 3,000 patients per bed per year = 18,000 patients per year, adjusted for 12 hours/day operations, true capacity = 9,000 patients
- Total capacity based on traditional model of 26 beds is 49,000 patients per year

The depiction in Exhibit #1 shows the traditional model for an ED of this size.

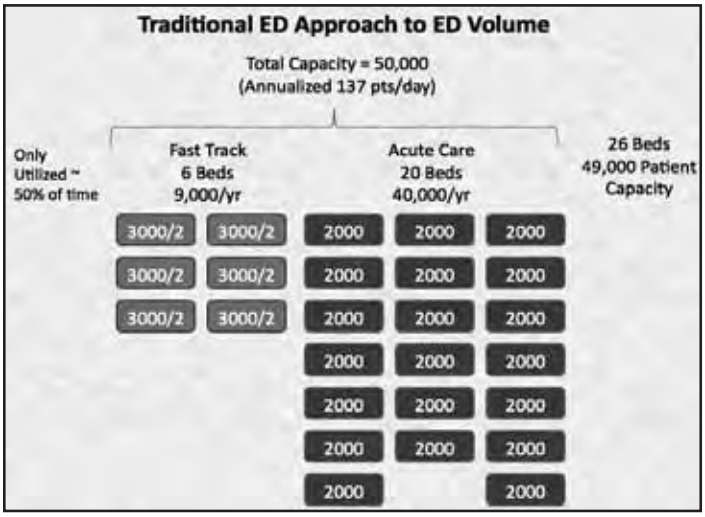
This is a classic configuration and one can observe it all across the nation. Unfortunately, it is a model that has been reproduced time and time again without a total understanding of the real volume and capacity challenges that face every ED every single day. We will make an argument that this model is

continued on page 14

continued from page 13

flawed and has led to virtually every ED nationwide having insufficient capacity to accommodate the patients that present to the ED. Worse yet is the fact that since these capacity assumptions are still in wide use, the vast majority of new construction is designed to repeat the failures of the past either because of an insufficient number of beds or lack of innovative processes to assure existing beds can accommodate the capacity. This explains why most new ED construction does not meet the intended expectations and rarely creates the level of performance as reflected in typical ED metrics.

Exhibit 1



Calculate the True Volume/Capacity Needs of Your ED

ED volume is usually discussed as a flat rate. If you have an ED that sees about 50,000 patients per year, then that translates to 137 patient per day and 5.7 patients per hour. As it turns out this is a very primitive approach. On some level this has been recognized by the ED leadership by staffing more robustly for both nurses and physicians during the busy hours of the day. However, other than the small contribution of the additional Fast Track beds that are opened for 12 hours per day, there is very little flex in the system to compensate for the distribution of patients by hour of day. This is magnified by the enormous variation in patient volume by day of year.

The graph in Exhibit #2 helps illustrate the fallacy of a flat-line approach to managing ED capacity. This ED with a 50,000 patient per year volume is built for 137 patients per day or 5.7 patients per hour but what happens on the 50% of days where the volume is greater than that, and what happens when the volume peaks at 187 patients per day?

This second perspective in Exhibit 3 shows that when it is really busy, this ED approaches an annualized volume of over 68,000 patients per year. In contrast there are days when the ED looks like a 33,000 patient per year ED. In fact there is a 105% swing in slowest to busiest days of the year. This limitation of the traditional flat-line approach is magnified dramatically when we look at the volume swing in an ED on a daily basis.

Exhibit 2

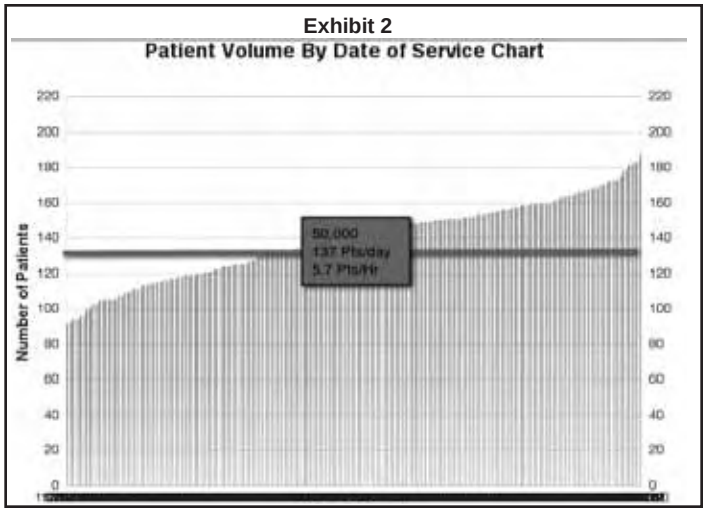


Exhibit 3

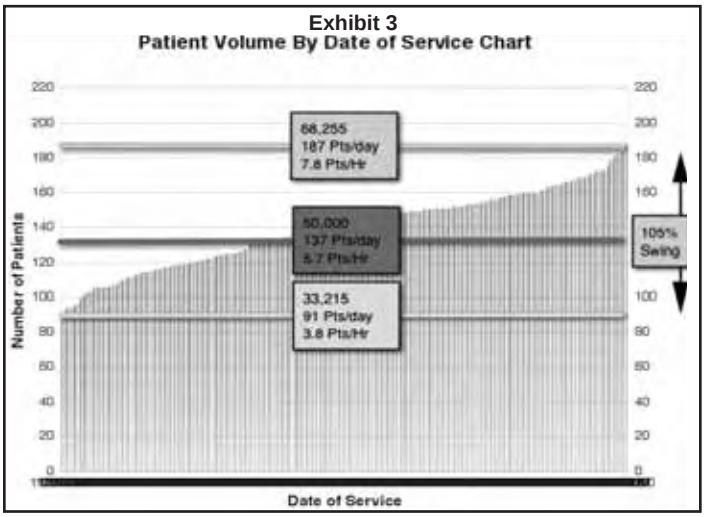
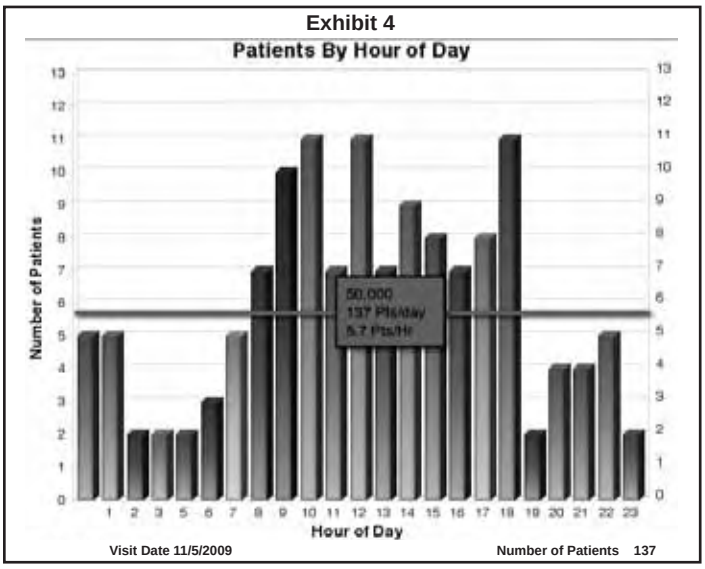


Exhibit 4 shows the traditional way that most experts view the ED and how they determine how to design/build an ED to address capacity needs. It depicts the number of patients presenting to the ED by hour of the day for a typical 50,000+ volume ED with 137 patients per day. The capacity of the ED we used as an example above should be able to accommodate 49,000 patients per year (20 Main ED beds and 6 Fast Track beds). Yet we know that an ED with this typical configuration would have patients lined up in the hallways, significant numbers of LWBS and challenges with regard to patient satisfaction. The ED leadership would be focused on patients being held in the ED, slow lab and x-ray turnaround times and problems with medical staff responsiveness.

Assuming the ED processes are efficient enough to manage 2,000 patients per bed this ED is statistically only ½ bed short of the volume challenges based on this assumption. Do we believe that a ½ bed shortage fully explains the awful results one sees in a typical ED on a day-in and day-out basis? Or maybe the ED performance failure is due to all of the external forces that are at work. Maybe the academicians are right; the number one cause of ED Crowding is patients held for admission.

If patients presented on a flat line and at a rate of 6 patients per hour your ED would work pretty well. So what else is at work and why is this is such a dogged problem nationally?

Exhibit 4



Challenge Old Assumptions

The truth of the matter is that patients do not arrive in a flat hourly rate during the day and, as pointed out previously, patient volume certainly varies significantly during the year. Exhibit 5 demonstrates the magnitude of this bi-modal daily volume variation for an ED with an estimated annual volume of 50,000 on an average day of 137 patients per day. During late evening and early morning the ED looks like a 38,000 volume ED and during late morning through to late evening it looks like an ED seeing almost 74,000 patients per year. That means that the ED needs to run at a capacity 48% higher than for which it is designed for 12 hours per day to be successful. If we continue to manage EDs as if patients present in a flat-line manner we will continue to demoralize our leadership and staff in the ED by providing insufficient resources to manage the actual patient volumes.

Exhibit 5

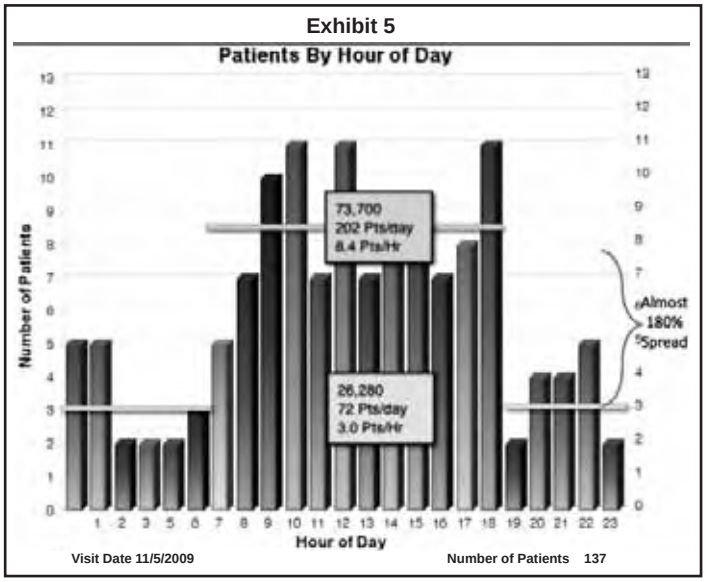
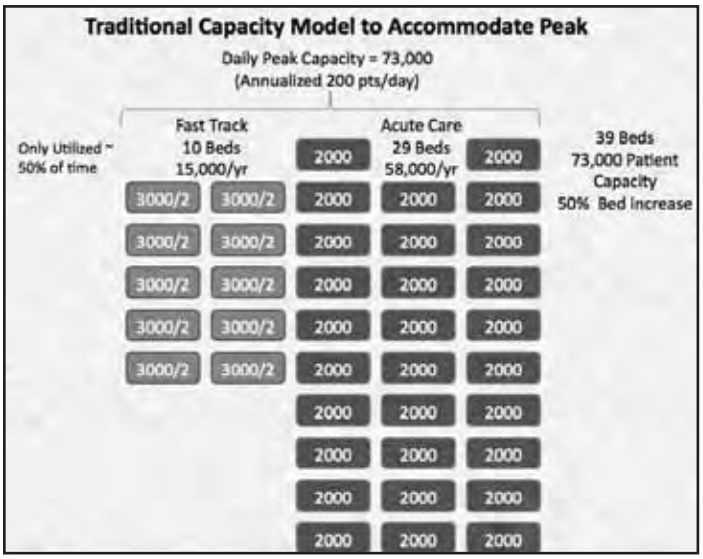


Exhibit 6 reveals the size the ED would have to be to eliminate bottlenecks due to limitation in the number of stretchers using the traditional assumptions relative to bed capacity.

Exhibit 6



In order to manage this ED so that resources would be available for patients using the traditional capacity model, the number of ED beds would have to be increased by 13 additional beds to meet the true capacity necessary for the bi-modal distribution of patients. This is a 50% increase in capacity just to accommodate the daily actual peak volume of an average day in the ED.

New construction estimates are that each additional ED bed built will cost $1 million (M). Increasing your bed capacity to accommodate this bimodal peak would require $13M in capital expenditure at a bare minimum. How can any hospital afford to add incremental beds if they can only bill for 2,000 patients per bed per year? The answer is that very few institutions can afford such an expensive solution in this environment. A more cost-effective way to increase capacity is to change the notion of stretcher productivity and begin managing the stretcher like the valuable resource that it really is. Implementing a Rapid Evaluation Unit (REU), either in existing space or in new construction, is a powerful way to intimately integrate function and process with design.

New Approach to ED Resource (Stretcher) Management

Over the years we have experimented with a number of different ways to eliminate the bottlenecks that occur in the ED. The first barrier we encounter in the ED is traditional Triage and Registration. Many experts have been proponents of "immediate bedding" and bedside registration and bedside triage/assessment. This is a fairly widely accepted practice at many progressive institutions across the country, *when beds are available*. The primary problem these institutions have faced is that nagging problem of what to do when the beds fill up.

continued on page 16

continued from page 15

In the final analysis what every ED is faced with are the laws of physics. If you relieve one barrier holding back the flow of a medium (in this case the patients) it will move along to the next bottleneck and begin to pool. Very few experts in the field have been able to understand that establishment of free flow requires the sequential removal of a series of barriers. If you remove a barrier and flow picks up only to bottleneck a little down stream, flow slows or stops until that barrier is eliminated. If you fix something downstream, such as patients being boarded in the ED, and do not address the upstream resistance then you will not get the desired effect of fixing the boarding. This illustrates the weakness of focusing externally on causes of ED overcrowding, because they will never be as successful as you hope they will be unless the internal factors are addressed.

We have already illustrated how the bi-modal distribution of patients presenting to the ED will create a volume issue every single day that cannot be overcome without addressing the fact that the ED is traditionally designed 50% too small for a peak that happens every single day. No matter what you do about test turnaround time or boarding, an unhindered flow of patients will still cause problems until more major internal barriers are addressed. The ED will continue to underperform and intensify leadership's defensiveness and frustration.

While working with an ED physician group in the early 2000s we identified the "stretcher" limitation in our practices. We began working with some clients to try to solve this issue and realized how difficult it was to change the staff's view of the patient's "right to own a bed." Our frustration was that a patient could come in for an ankle sprain and stay in the department and occupy an incredibly valuable resource for 2.5 hours. In actuality the patient really only required 5 minutes from the nurse for assessment, 5 minutes for registration and 5 minutes for the doctor to examine the patient. Although the patient only needed 15 minutes of total "stretcher time", he virtually owned the bed for 150 minutes. We soon realized that the majority of patients "owned" their bed longer than was necessary for appropriate evaluation and treatment and that by allowing that, we were wasting thousands of hours of stretcher time on patients that really did not need that resource.

It became clear that if we were able to limit a patient's time on a bed to only the time that was specifically needed for clinical assessment, drawing of labs and initiation of treatment that we could dramatically increase the turnover of beds in the department. We were fortunate to have a series of clients that were willing to test our strategy. In 2003 we introduced the concept to a community hospital in NJ that had experienced some significant safety concerns due to extremely long waits in the ED waiting room. It was of the utmost importance to reduce the length of time in the waiting room to eliminate any further untoward events. The hospital agreed to portion off a small piece of the waiting room to build a clinical waiting room. We called this area the "Discharge Area."

Any patient who was obviously going to be discharged, but needed to wait for the results of testing or response to treatment and clinically no longer needed a stretcher, was sent to this area to free up the bed. The impact was immediate and dramatic. This small step so significantly increased the bed turnover that the waiting room was emptied, left without being seen patients were radically reduced and patient satisfaction tripled in the first month of implementation. We did not understand it at the time, but by increasing the bed turnover in the ED we were able to increase capacity enough to overcome the bi-modal volume peak for that department. Since that time this program has been implemented in a number of different formats but always focused on increasing the number of patients per bed, per year for some portion of the beds in the ED.

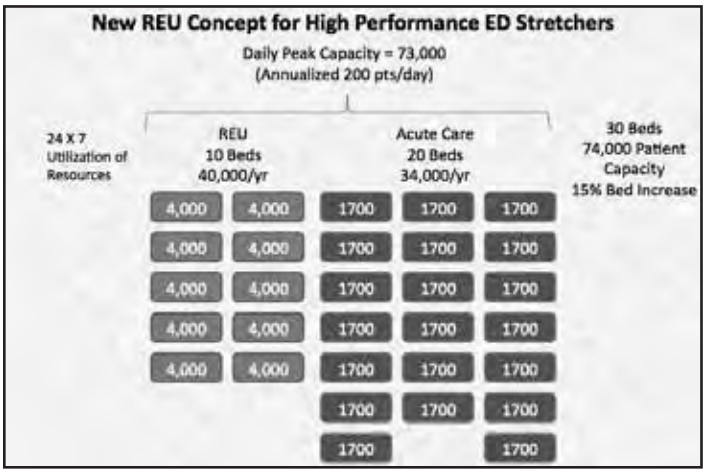
A few years later Dr. Warden was asked by a hospital turnaround company to evaluate the processes of a Florida Emergency Department that had the worst walk-out rate and general performance that we have encountered in 30 years of practice. They had a 24% LWOT rate, employed physicians, unionized staff and a resident training program. They were losing $2.5M alone on patients that were leaving as LWOTs. In addition they were experiencing losses of admissions that were leaving the department and diversions that were bypassing the institution. As part of the process solution we implemented "immediate bedding" along with bedside triage and registration processes. We also designed an Internal Disposition Area (IDA) and assigned a nurse to this area to supervise the patients. In addition we worked aggressively with the physicians to mentor them in the new process to move patients into the IDA. In the first day of operations we were able to empty the waiting room and eliminate all of the LWOTs and diversions. After 6 months the CFO announced that the changes in the ED allowed them to project an increase in the annual revenue by $2.5M without any attendant construction cost or additional ED staffing.

The Rapid Evaluation Unit (REU) Model

The understanding that we could identify a group of patients who were low acuity, had a very high likelihood of being discharged and did not need a stretcher for their entire stay in the ED was key to the development of the REU model. This model has challenged the traditional productivity model by creating capacity in the ED by providing a clinical area comprised of chairs and recliners for patients and attended by a nurse specialist (the Discharge or Disposition Nurse). This formal change in a fundamental precept of Emergency Medicine, that a patient "owns their bed" has allowed us to create a group of "super performing beds" within the ED that can see 4,000 patients per bed per year. This has only been feasible when process considerations are tightly integrated with design changes that support and complement the aggressive process enhancements. However, the results or the REU program are dramatic and the understanding of the complexities offered to EDs with their annual and daily bi-modal volume changes allows the leadership to embark on a journey to more effective solutions within the ED. Exhibit #7 below shows efficiency

of this new model. Rather than the 50% increase in ED beds necessary to address the daily peak volume, this model shows that an addition of only 4 beds (a 15% increase in beds) creates a total of a 10-bed super-performing 24x7 unit and an area in the ED that can accommodate 40,000 patients per year if the processes are managed to the new standard of 4,000 patients per bed per year. In addition, it should be noted that because the patients that do eventually make it into the main ED have been filtered by the REU and their acuity is higher. Therefore we have made an adjustment of a 15% decrease in capacity to 1,700 patients per bed per year (34,000) for patients accommodated in the Main ED.

Exhibit 7



Implications

A deep understanding of the volume implications for the ED, both the annual variation and the magnitude of the bimodal volume swing in the daily presentation of patients to the ED is essential to understanding how management needs to approach solutions to ED throughput. Until it is understood that every ED is actually two EDs, the daytime ED (from 10 AM to 10 PM) and the evening and early morning ED (from 10 PM to 10 AM) the allocation of resources and management activity will be squandered. One way to look at this is that if one is going to expend time and energy to improve throughput, does one want to do this if one has not addressed a fundamental issue that would create failure for the staff if it went un-addressed. This is what is happening with our EDs nationally. We are spending an enormous amount of time and capital on fixing problems in the ED, but we are ignoring the most basic element, that if we want to eliminate the patient's wait, we need to have ample capacity to accommodate the patients that are presenting to the ED. Previously this was an extremely expensive proposition, in that, if we were going to expand capacity in the traditional means using the multiplier of 2,000 patients per bed per year enough to accommodate the enormous variation in patient volumes will be extraordinarily expensive and even more difficult to manage. History shows us that adding beds of lower capacity by massively expanding the ED footprint adds unintended consequences associated with distances, loss of visual management cues. In addition, though technology has many powerful advantages, it also adds significant negative consequences, which can slow the patient flow.

The REU is an extremely flexible model. It can be applied very cost-effectively to a traditional ED by converting an existing Fast Track area and conversion of other areas of real estate that are not necessary in the new model such as registration and triage areas. The underpinnings are clinical process based and complemented by modest structural reconfiguration, but scalable to a modest ED re-design process that has enormous capacity increase potential for any institution considering new ED construction. We have participated in the de novo design of a 3,000 square foot addition to one major system's ED. The capacity increase of 11 beds to a traditional ED provided an increase of 44,000 patient capacity for 1/4th the cost of a full redesign. This represents 40% more capacity for 75% less capital investment than the initial traditional proposal by a major ED architectural firm. We are currently exploring how this aggressive and progressive design can be integrated into a model for new ED design nationally to increase ED productivity, quality, and safety while eliminating the current chaotic nature of most ED practices.

About the authors

Todd Warden, MD is the founder and president of Emergenuity Inc. He is a Residency Trained Emergency Physician with 25 years of experience in ED management, physician leadership development and ED process management. More recently Todd has been focusing on the implementation of high performance units within the ED to minimize capital expenditures and maximize the utilization of existing ED space by tightly integrating innovative processes with complimentary design concepts. Todd can be reached at twarden@emergenuity.com.

Richard S. MacKenzie, MD, FACEP is an innovative physician manager experienced in turnaround and management of Emergency and Ambulatory Medicine with multiple sites in university and community settings. As Chairman for the Department of Emergency Medicine of Lehigh Valley Health Network, Dr. MacKenzie has direct and indirect oversight responsibility for 65 physicians, 30 mid-level providers, and 150+ other staff. In addition, Dr. MacKenzie is Clinical Associate Professor of Emergency Medicine for Penn State College of Medicine. Dr. MacKenzie can be reached at Richard.Mackenzie@lvhn.org.

Dominic Ruocco M.D. is Chairman, Department of Emergency Medicine at Palisades Medical Center. He is a member of the Harvard Emergency Medicine Leadership Council and the Columbia Presbyterian Health System ED Forum. He was a physician champion in the implementation of the REU at PMC. The implementation of the REU has resulted in an across the board improvement in our ED metrics. This came with no increase in staffing nor any capital expenditures.

Gladys M. Sillero, MSN, CCRN, CNS, APN is Clinical Coordinator/CNS at Palisades Medical Center. She actively participated with Dr. Ruocco, Medical Director, in the creation/evaluation of the REU (Rapid Evaluation Unit) process, and selected outcome data at Palisades Medical Center, which helped to streamline and expedite PMC's ED through-put. Evidence in the improvement was noted in the outcome data within first 1-2 months.

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The Growing Charity Challenge – Form 990 and Health Reform

Steve Levin

by Steve Levin

Providers have made great progress in expanding and developing financial counseling processes over the past several years. Unfortunately, a large number of patients are continuing to fall through the cracks. Many patients meriting financial assistance fail to participate in financial counseling and are instead declared to be bad-debt and sent to collections.

This situation, while disappointing, is taking on new concern with Form 990 filing obligations, in which hospital executives are required to declare the amount of charity they believe they missed by current processes and which ended up as bad-debt. This admission of process breakdown is in addition to documenting the various types of financial assistance delivered and scale of community benefit spending.

It is likely that community groups and consumer advocates will closely study the new information disclosed on the Form 990. They will use this information to form opinions with respect to how well not-for-profit hospitals are delivering on their community responsibilities.

Recently passed health reform legislation is also picking up on this issue, setting expectations for comprehensive financial assistance effort prior to any extraordinary collection activity. How this component of the legislation ultimately is converted into guidelines and operating standards remains to be seen; however, it is hard to imagine that the results will lessen the current anxieties. Similarly, it remains unclear what limits or restrictions the new Consumer Financial Protection Agency will impose.

Size of the Opportunity

Based on research done by Connance and PARO, it is common to find that 20-30% of a provider's bad-debt is from guarantors that would qualify for charity, but slipped through the cracks in the process. This is a meaningful percentage and is sure to attract attention when reported on Form 990.

Of course, the amount of missed charity for any individual hospital varies based on the local market, their specific financial assistance policies, and the financial counseling process in place. Poverty is a local phenomenon.

Root Causes of Missed Charity

Simply working harder under today's standard patient access and financial counseling processes is unlikely to overcome the missed charity issue. Structural challenges stand between many poor people participating in counseling and properly documenting their eligibility.

Consumers living in poverty have less education and higher illiteracy than the average household. While statistics on illiteracy and poverty are limited, the U.S. Department of Education estimates that, *on average*, 1 in 5 Americans are functionally illiterate. With this national average, a sizable share of the poor are very likely unable to fill in a basic charity application or even read a charity sign in the emergency room.

People living in poverty often lack stable addresses, are immigrants, or are embarrassed by their situation and prefer to not participate in application processes and announce their plight.

The Federal Reserve estimated that as many as 25% of those living in poverty lack access to traditional "banking" resources such as a savings or checking account. This means they are unable to provide financial documentation and databases of such information will not have their information.

Poverty and Credit Scores

The relationship between poverty and credit scores is an interesting one.

It stands to reason that if people living in poverty lack traditional banking relationships, they will also lack a credit score. However, the corollary is not true – just because one lacks a credit score does not mean they are poor. There are many reasons other than income that will cause an individual to lack a credit score. Consider the situations of students who are just entering the workforce, someone who is newly widowed or divorced, or recent immigrants.

Next, consider that credit scores are really not an income measure but a delinquency measure. They answer the question "is this person likely to repay a new credit obligation?" Poverty is not a question of being overextended or spending more than you make. It is simply a question of income and household structure.

A common example of the difference between credit scores and poverty is an elderly patient living on a fixed income without any property. This patient will often have a bank

continued on page 20

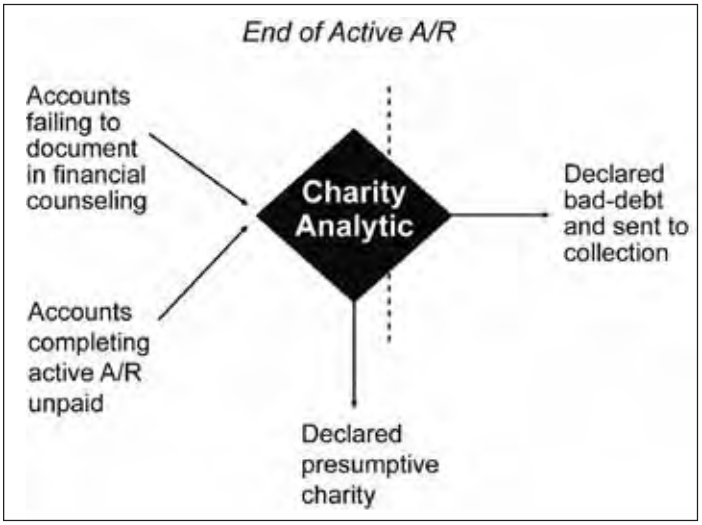
continued from page 19

account and a credit card, which they use sparingly or under tight control so as to never run up a bill they cannot afford. This patient will likely have a solid credit score, but also be eligible for poverty classification based on income. One can contrast this with a middle income consumer who has racked up large bills buying the latest electronics or being overextended on their mortgage. They probably have poor credit scores, but would not meet the charity test for low income.

Presumptive Charity Analytics Leading Solution

Presumptive charity analytics are the leading approach to addressing both day-to-day operational issues of missed charity and Form 990 disclosures. They are a type of predictive model built specifically for identifying accounts eligible for poverty classification. Presumptive charity analytics use publicly available information to predict whether or not that guarantor would have been approved for financial assistance had they participated in the process.

Providers are using predictive analytics to evaluate accounts that fail to document through standard financial counseling processes. Accounts are scored just prior to bad-debt assignment. Those qualifying for presumptive charity are reclassified as such and removed from the bad-debt placement file. Those failing to qualify are declared bad-debt and handled as such.



Using a presumptive charity analytic in this fashion complements the existing financial counseling and patient access processes by addressing recognized breakdowns and barriers. Every account, including those that were missed by or failed to participate in financial counseling, are reviewed using a proactive, consistent and repeatable process.

This approach also provides a clear pathway for Form 990 submissions. Hospitals are able to reclassify significant bad-debts as presumptive charity, demonstrating a truer view of their community benefit. The estimate of missed charity ending up in bad- debt is reduced to the error rate of the model applied against bad-debt placements. In total, the institution is communicating a comprehensive and proactive effort to identify and aid needy patients, even those unable to speak up. This is clearly on point with newly passed federal health reform legislation.

In order to implement this approach, charity policies need to explicitly note that presumptive charity can be conferred based on a third-party analytic. Similarly, auditors should be apprised of the decision to implement a presumptive analytic. Their input should be incorporated into the process and policies.

Picking a Presumptive Charity Analytic

There are a range of presumptive charity analytics available to identify missed charity eligible accounts. In picking a model, consider the following elements:

- **Local calibration.** Poverty is heavily weighted to local economic circumstances and socio-economic attributes. Better predictive models will be calibrated during implementation to the hospital's specific community.
- **How the model handles households without bank accounts and credit files.** Credit based models may have challenges with this population. Socio-demographic models are often better able to handle households living in the cash economy.
- **Information required.** Some models require a current address and guarantor social security number for scoring. Understanding differences in data requirements is important as it can have significant impact on Patient Access activities.
- **Portion of accounts a model cannot evaluate.** Better models will have broader coverage, e.g. fewer accounts that are not able to be predicted or assessed. Some models cannot evaluate as many as 30% of self-pay accounts, while others will have issues with as few as 1-2%.
- **Sliding Scale Calibration.** Models differ in the extent to which they can be tuned to a hospital's sliding-scale discount, e.g. the discount offered at different income thresholds.
- **Acceptance by IRS, Regulators and Other Organizations.** With many different vendors offering models, understand the extent to which the model in question has been used in previous filings or been recommended as an effective solution.

Few Simple Steps Solve Growing Issue

Analytics are commonly accessed through simple web-based applications and can be connected to a patient account system through secure file transfer. The system generates a file for scoring and sends it to the scoring website, much the same way patient accounting systems generate bad-debt placement files today. The web-based scoring system picks up

the file, scores each account and sends back a response file. Your patient account system grabs the file and automatically reclassifies accounts based on the score.

Within just a few weeks of selecting a charity analytic an organization can be automatically reviewing accounts as they age out to bad-debt. In some instances it is also possible to review, at initiation, existing bad-debt inventory and execute a one-time financial adjustment for those identified as presumptive charity eligible.

Adopting a presumptive charity analytic is a straight-forward, cost effective solution to a problem of significant public concern. It is additive to a great financial counseling and patient access program, closing the loop on patients missed in current routines, incapable of participating, or reluctant to make themselves visible. Your patients win and so does your organization.

About the Author
Steve Levin is CEO and co-founder of Connance. Contact him at slevin@connance.com or visit www.connance.com.

This article relies on material published in "a Form 990 Schedule H conundrum" by Shari Bailey, David Franklin and Keith Hearle, hfm magazine, April 2010. Shari Bailey is VP, Verité Healthcare Consulting, LLC; David Franklin is Chief Development Officer, Connance, Inc.; and Keith Hearle is President, Verité Healthcare Consulting, LLC.

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continued from page 11

The EPA is also conducting a study and developing 'best practices' for managing unused pharmaceuticals at health care facilities, which it anticipates will be published by late 2010. The study is aimed at understanding the factors which contribute to pharmaceuticals entering the water and has included a focused look at medical facilities which are believed to dispose of the largest quantities of unused pharmaceuticals into water. Generally, healthcare facilities discharge their wastewater to publicly owned treatment works. However, traditional wastewater treatment is not designed to remove pharmaceuticals. Additionally, while some of the upgraded facilities have more advanced treatment technologies, even these facilities are not specifically designed to remove pharmaceuticals. As a result, significant amounts of pharmaceutical waste passes through without being filtered which results in the waste ultimately passing through into our waterways. Based on these findings, the EPA has issued an interim report indicating its preliminary observations regarding existing disposal practices. This EPA report is available at http://www.epa.gov/guide/304m/ 2008/ hsi-PRELIM-study-200808.pdf

Take Back Programs

On October 12, 2010 the Secure and Responsible Drug Disposal Act of 2010, which amends the CSA and provides for the take-back disposal of controlled substances by legitimate users, i.e., patients, was signed into law by the President. Under the Secure Disposal Act, patients in possession of controlled substances would be authorized to transfer such drugs to a non-DEA registered person, including long-term-care facilities, who is authorized to dispose of them in accordance with regulations issued by the U.S. Attorney General, so as to prevent drug diversion.

The proposed legislation would also allow long-term care facilities to dispose of controlled substances in accordance with regulations to be promulgated by the Justice Department. The proposed legislation seeks to address existing problems with current laws that prevent patients and long-term care facilities, who are not DEA registrants, from effectively utilizing reverse distributors and drug return policies.

New Jersey has also undertaken strong initiatives to impose more stringent disposal requirements for pharmaceuticals. Studies conducted in New Jersey by the DEP, in collaboration with the U.S. Geological Survey, Rutgers University, UMDNJ and the federal Centers for Disease Control, have revealed that the State's ground and surface waters, as well as drinking water, contain low levels of various chemical compounds, including pharmaceuticals. In order to address this issue, the DEP is considering regulating organic contaminants as a class of contaminants as opposed to individual chemicals. The change would require the development of "treatment techniques" for the removal of contaminants from drinking water. The State has actively commenced the hiring of consultants to conduct comprehensive reviews on available treatment processes in furtherance of these options.

Legislative changes have also been proposed in New Jersey which would prohibit healthcare institutions, their employees and/or staff from flushing or pouring any unused medication into a sewer system or septic system. Additionally, the State's legislature has proposed that a New Jersey Water Supply and Pharmaceutical Product Study Commission (the "Commission") be established which would investigate, quantify and evaluate the risks of pharmaceutical products in the water supply of New Jersey. If approved, the Commission would be charged with developing recommendations for proper disposal methods and potential filtering techniques which would adequately remove pharmaceutical products from New Jersey's waste streams.

Conclusion

The issue of proper disposal of pharmaceuticals is complex and has become an increasing cause of concern among the healthcare and environmental communities alike. It is likely that significant changes to existing disposal policies and regulations will be made at both the federal and state level. In the

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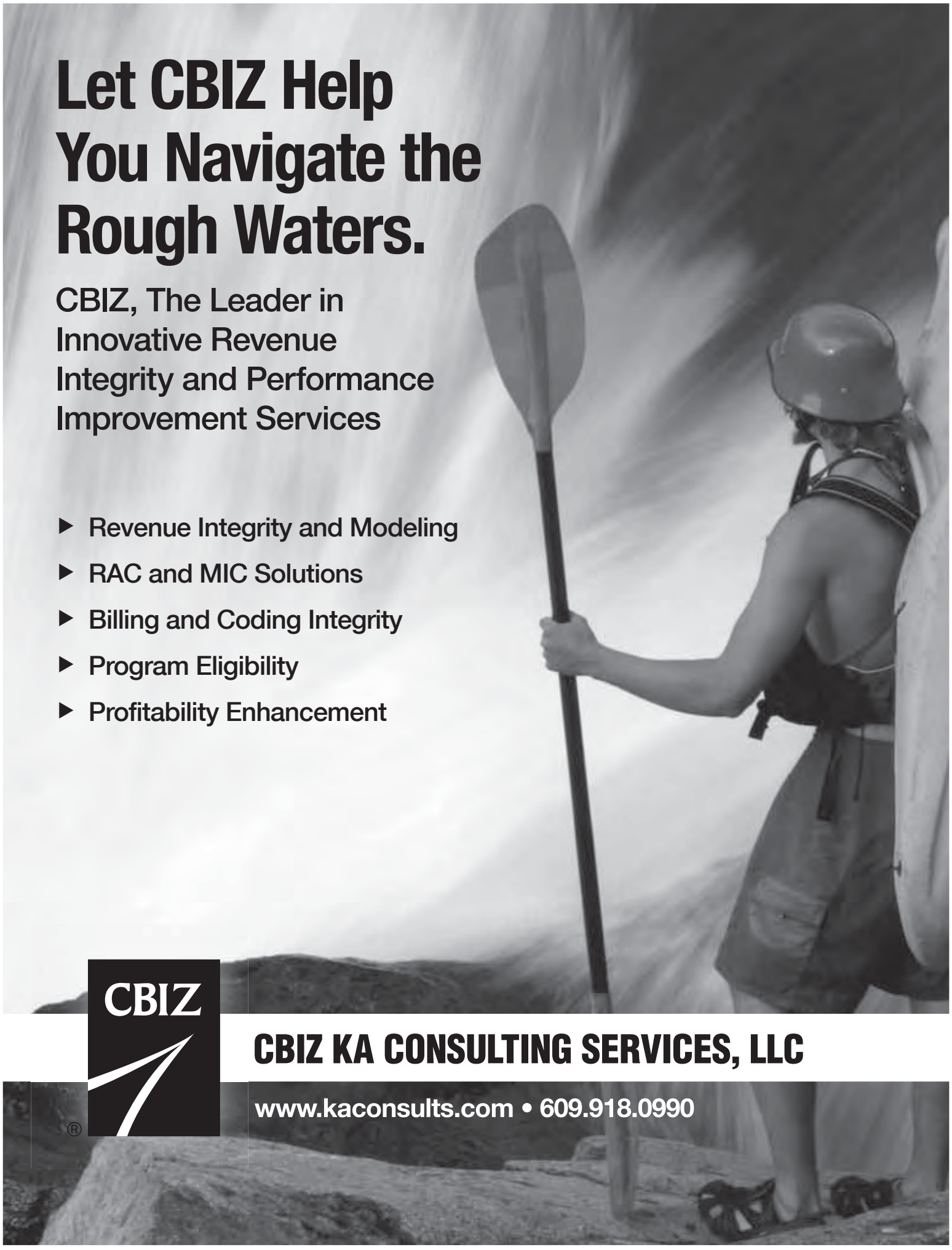
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Addressing Health Care Issues in a time of Reform:

Horizon BCBSNJ creates a new company, Horizon Healthcare Innovations, to collaborate with providers and change the health care system

Richard Popiel

by Richard G. Popiel, MD, MBA

Over the last year, New Jersey residents and the country at large have held a national debate over what kind of health care system we want and can afford. We all want access to high-quality and affordable care. Yet, by any measure, those three main components of our health care system - quality, access and cost - have been moving in the wrong direction. Residents in New Jersey feel this pain more so than those in many other states because we have among the highest cost of any state in the country when it comes to health care services, yet our health results lag behind those in many other states. In 2009, the Commonwealth Fund ranked New Jersey 30th in the nation for quality of care based on measures such as prevention, treatment and avoidable hospital use and costs. Despite efforts on the federal and State level to address these negative trends, the fundamental problems embedded in the health care system persist. Any sober assessment of the statistics and heart rendering stories of those who try to work within the existing system lead to one inescapable conclusion: the status quo is unsustainable.

Through 2009, Horizon Blue Cross Blue Shield of New Jersey closely followed the health reform discussions that took place at the federal level. As a large player in the health care industry, we have a stake in this process and wanted to intelligently consider the merits of the various positions offered for debate. After digesting a great deal of information and after being able to see the final form of the federal law, we believe there is still a great deal of work to be done. Indeed, despite efforts by our federal officials to tackle these deeply rooted problems, they remain largely unaddressed.

Horizon BCBSNJ is stepping into the void that currently exists and seizing what we believe is a unique opportunity to collaborate with physicians, hospitals, and other care providers to implement quality improvements in our health care system. We launched a subsidiary, Horizon Healthcare Innovations, LLC, whose focus is to improve the quality, accessibility and affordability of health care. Horizon Healthcare Innovations will work collaboratively with stakeholders, including employers, patients, doctors, hospitals and others, to implement research-based initiatives, retain respected third parties to measure initiative results in a transparent fashion and publicize those findings for others to analyze and use. We will implement the best in class initiatives that have been proven to improve outcomes, lower costs or reduce barriers to access to care. Through our focused efforts, unparalleled cooperation with stakeholders, commitment to transparency and accountability, and our longstanding track record of success in New Jersey, we know that our transformative approach will yield excellent results. Our goal is simple yet has been elusive for many years - to dramatically improve the quality, access to and cost of health care in New Jersey.

As the President and Chief Operating Officer of Horizon Healthcare Innovations, I am excited to begin the truly important work that lies ahead for me and my entire team. We have already begun to explore innovative ways to improve the quality and value of health care for our members. Here is a glimpse of what we will be doing.

In general, Horizon Healthcare Innovations will focus on pilots that:

- Align treatment incentives for physicians, hospitals, employers, and patients;
- Provide greater focus on primary care and care coordination through various means, including the more widespread use of electronic health records (EHRs);
- Institute programs to promote quality, evidence-based medical approaches; and

continued on page 24

continued from page 23

- Test and demonstrate preventive health care treatment plans for chronic conditions.

As we implement our pilots, we will follow a few basic principles. First, the results of any pilot that we plan to implement more broadly must be evaluated by independent experts. Second, before we implement a pilot, we must have objective evidence showing that the pilot is able to improve quality, cost and/or accessibility to health care. Third, when we implement a pilot, we will continue to track its record of achievement and only continue to implement those pilots that demonstrate a track record of success.

To provide a sense of the type of initiatives that Horizon Healthcare Innovations will be working on, here are a few examples of ideas that are in our pipeline. To better handle the problem of monitoring chronic conditions, we are working with a company on an easy to use smart phone application that provides two-way communication between a patient and his or her doctor. This will enable the patient to receive reminders to follow a proscribed therapy plan or medication schedule and allow the medical staff to monitor the patient's adherence to the plan or schedule. Through this simple use of existing technology, we can eliminate lapses in medication, failure to follow therapy schedules, unnecessary follow-up visits or countless other wrong turns in the health care delivery system. We are convinced that small but thoughtful changes like this can lead to better management and big savings for consumers.

Another example is our primary care medical home model. In this model, patients' dedicated physicians, along with their care team, will seek to actively engage their patients in a personal care plan that strives to maximize the patients' health. Physicians can coordinate care to help ensure procedures are appropriate, necessary and effective and make appropriate recommendations for specialists and other health care services. This may prevent complications by providing access and treatment in early stages of conditions. It is believed — and numerous pilot programs around the country have shown — that care provided in PCMHs can improve quality and patient experience. PCMHs help reduce unnecessary services and waste that currently impact affordability.

We know that our current health care system is unsustainable. Horizon Blue Cross Blue Shield of New Jersey, through its new subsidiary, Horizon Healthcare Innovations, LLC wants to be a leader in working to fix the problems that plague our health care system. In the coming months we will be reaching out to other stakeholders to see if they will work with us on the difficult challenges that lie ahead. We believe that through innovation and cooperation we can forge a new path that will lead to measurable improvement in the entire health care system.

For additional information on Horizon Healthcare Innovations and our models of care, please visit <www.HorizonHealthcareInnovations.com>.

About the author

Dr. Richard Popiel is President and Chief Operating Officer of Horizon Healthcare Innovations. He continues to serve as a member of the Board of Directors of Horizon Healthcare of New Jersey. He is also a member of the Board of the New Jersey Sharing Network (local Organ Procurement Organization), the local chapter of the American Cancer Society and the George Washington University Alumni Association. Formerly, Dr. Popiel held the position of Vice President and Chief Medical Officer at Horizon Blue Cross Blue Shield of New Jersey.

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continued from page 21

interim, healthcare entities should focus on reviewing their existing disposal practices and engage legal and consulting professionals to evaluate their current practices which might subject them to exposure or penalties for violations of existing regulations under either state or federal laws. To the extent a safer viable alternative is available for disposal which is in compliance with federal and state regulations, all efforts should be made to implement alternatives, particularly where flushing is the existing method of disposal. As is evident by the actions of federal and state regulatory agencies, previously accepted methods of disposal will no longer be tolerated. Accordingly, hospitals and healthcare facilities must be proactive with their disposal policies and enact safer alternatives before the need arises.

About the authors

Suzanne M. Avena is Partner and Chair of the Environmental Practice Group at Garfunkel Wild, P.C. She counsels in all matters of regulatory compliance and enforcement, corporate and real estate ventures and environmental litigation. She has particular expertise in structuring contaminated (Brownfield) transactions. She can be reached at savena@garfunkelwild.com.

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Jeffrey S. Brown is a Partner/Director of Garfunkel Wild, P.C. who is responsible for the firm's New Jersey office. He represents various hospitals, long-term care facilities, physicians' practices and other health care related clients. Mr. Brown a frequent lecturer on health care issues, was selected as Leadership Fellow for the State of New Jersey in which he analyzed health care issues in terms of statewide significance. He has also been honored by inclusion in Strathmore's Who's Who and has been chosen as a New Jersy Super Lawyer and was recently cited for excellence in "Healthcare" by Chambers USA. Mr. Brown can be reached at jbrown@gwtlaw.com.

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Independent Auditors' Report

Board of Directors
Healthcare Financial Management Association
New Jersey Chapter

We have audited the accompanying statements of financial position of the Healthcare Financial Management Association - New Jersey Chapter as of May 31, 2010 and 2009 and the related statements of activities and changes in unrestricted net assets and statements of cash flows for the years then ended. These financial statements are the responsibility of the Chapter's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of the Chapter's internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Chapter's internal control over financial reporting. Accordingly, we express no such opinion. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Healthcare Financial Management Association - New Jersey Chapter as of May 31, 2010 and 2009 and the results of its activities and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

July 30, 2010

Healthcare Financial Management Association
New Jersey Chapter
Statements of Financial Position
As of May 31, 2010 and 2009

	2010	2009
Assets		
Current assets		
Cash and cash equivalents	$ 262,716	$ 129,007
Receivables for program and other activities, net	9,075	14,377
Prepaid expenses	16,529	31,399
Total current assets	288,320	174,783
Equipment and other assets, net	7,200	7,500
Total assets	$ 295,520	$ 182,283
Liabilities and Unrestricted Net Assets		
Liabilities		
Accounts payable and accrued liabilities	$ 90,036	$ 26,764
Accrued payroll and payroll taxes	4,325	3,937
Deferred revenue	17,950	---
Total liabilities	112,311	30,701
Unrestricted net assets	183,209	151,582
Total liabilities and unrestricted net assets	$ 295,520	$ 182,283

The Notes to the Financial Statements are an integral part of these statements.

Healthcare Financial Management Association
New Jersey Chapter
Statements of Activities and Changes in Unrestricted Net Assets
Years Ended May 31, 2010 and 2009

	2010	2009
Revenue and gains		
Meetings and continuing education programs	$ 114,542	$ 116,080
Annual Institute	366,275	373,450
Social outings and events	72,110	80,339
National rebate	25,753	25,387
Advertising	51,200	57,157
Interest income	959	2,491
Other income	455	1,342
Total revenue and gains	631,294	656,246
Expenses		
Program services and scholarships	467,926	503,074
Membership services	45,325	43,801
Management and general	86,416	87,267
Total expenses	599,667	634,142
Change in unrestricted net assets	31,627	22,104
Net assets, beginning of year	151,582	129,478
Net assets, end of year	$ 183,209	$ 151,582

The Notes to the Financial Statements are an integral part of these statements.

Healthcare Financial Management Association
New Jersey Chapter
Statements of Cash Flows
Years Ended May 31, 2010 and 2009

	2010	2009
Cash flows from operating activities		
Change in unrestricted net assets	$ 31,627	$ 22,104
Adjustments to reconcile changes in net assets to net cash flows provided (used) by operating activities		
Depreciation	3,540	1,690
Provision for bad debts	5,000	---
(Increase) decrease in operating assets		
Receivables for program and other activities	302	(8,505)
Prepaid expenses	14,870	(20,021)
Increase (decrease) in operating liabilities		
Accounts payable and accrued liabilities	63,272	(49,442)
Accrued payroll and payroll taxes	388	206
Deferred revenue	17,950	(48,600)
Net cash flows provided (used) by operating activities	136,949	(102,568)
Cash flows from investing activities		
Purchase of equipment and other assets	(3,240)	(9,000)
Net increase (decrease) in cash and cash equivalents	133,709	(111,568)
Cash and cash equivalents, beginning of year	129,007	240,575
Cash and cash equivalents, end of year	$ 262,716	$ 129,007

The Notes to the Financial Statements are an integral part of these statements.

Healthcare Financial Management Association
New Jersey Chapter
Notes to Financial Statements
Years Ended May 31, 2010 and 2009

1. Organization and Summary of Significant Accounting Policies

Organization
The Healthcare Financial Management Association - New Jersey Chapter (the "Chapter") is an association of individuals organized to improve financial management of healthcare institutions and related healthcare organizations.

Basis of Presentation
The accompanying financial statements are prepared on the accrual basis of accounting which reflects income when earned and expenses when incurred. The classification of the Chapter's net assets and its revenue, gains and expenses is based on the existence or absence of donor or other imposed restrictions. The Chapter is required to report information regarding its financial position and activities according to three classes of net assets: unrestricted net assets, temporarily restricted net assets, and permanently restricted net assets. At May 31, 2010 and 2009, the Chapter had no temporarily restricted or permanently restricted net assets.

Cash and Cash Equivalents
Cash and cash equivalents include highly liquid short-term investments with original maturities of one year or less.

Receivables for Program and Other Activities
Receivables for program and other activities are recorded at the estimated net realizable amount and do not bear interest. The allowance for uncollectible accounts is the Chapter's best estimate of the amount of credit losses in the Chapter's existing receivables. The Chapter determines the allowance based on historical write-off experience. The Chapter reviews its allowance for uncollectible accounts periodically. Past due balances are reviewed individually for collectibility. Account balances are written off after all means of collection have been exhausted and the potential for recovery is considered remote.

Equipment and Other Assets
Equipment and other assets are stated at cost. Depreciation expense is computed using the straight-line method over the estimated useful lives of the assets. When assets are retired or otherwise disposed of, the cost and related accumulated depreciation are removed from the accounts and any gain or loss is recognized in income for the period. The cost of maintenance and repairs is charged to expense as incurred.

Chapter Revenue
The Chapter provides various educational and professional programs primarily for its Members. The revenue generated from these programs is recorded on the accrual basis of accounting in the period in which the programs are provided.

Use of Estimates
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Operating Indicator
The Chapter's change in net assets reflected on accompanying statements of activities and changes in unrestricted net assets includes all revenue, gains and expenses for the reporting period.

Impairment of Long-Lived Assets
Long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to the future net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amounts of the assets exceed the fair value of the assets. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell. There were no impairment charges recorded during the years ended May 31, 2010 and 2009.

New Accounting Pronouncements
In March 2008, the Financial Accounting Standards Board (FASB) issued Statement No. 161, "Disclosures about Derivative Instruments and Hedging Activities" which is now included in Accounting Standards Codification (ASC) Topic 815 "Derivatives and Hedging". The new pronouncement is intended to improve financial reporting about derivative instruments and hedging activities by requiring enhanced disclosures to enable users of the financial statements to better understand the effects of derivatives and hedging on an entity's financial position, financial performance and cash flows. This pronouncement has had no effect on the Chapter's financial statements as the Chapter currently does not have any derivative instruments or engage in any hedging activities.

In May 2009, the FASB issued Statement No. 165, "Subsequent Events" which is now included as part of ASC Topic 855 "Subsequent Events". This section of the ASC requires the Chapter to disclose the date through which it evaluated subsequent events and whether that date corresponds with the issuance of the financial statements and is effective for financial statements with fiscal years ending after June 15, 2009. Based on this evaluation, the Chapter has determined that no subsequent events have occurred which require disclosure through July 30, 2010, which is the date that these financial statements are available for release.

Tax Status
The Chapter's financial activities are combined with the National Healthcare Financial Management Association for the purpose of filing Federal Form 990. The National Association is a tax-exempt entity as defined by Section 501(c)(6) of the Internal Revenue Code. Accordingly, no provision for Federal or State income taxes has been provided for in the accompanying financial statements.

The Chapter's accounting policy is to evaluate uncertain tax positions in accordance with ASC Topic 740 "Income Taxes". Pursuant to the guidance in this accounting pronouncement, the Chapter has determined that no unrecognized tax benefits exist as of May 31, 2010 and 2009 and does not expect this determination to change significantly over the next 12 months.

Reclassifications
Certain reclassifications have been made to the 2009 financial statements in order to conform with the 2010 presentation.

2. Equipment and Other Assets

Equipment and other assets at May 31, 2010 and 2009 consists of the following:

	Estimated Useful Lives	2010	2009
Video equipment	5 years	$ 4,160	$ 4,160
Computer equipment	3 years	3,347	3,347
Website development	3 years	12,240	9,000
		19,747	16,507
Less: Accumulated Depreciation		(12,547)	(9,007)
		$ 7,200	$ 7,500

3. National Rebate

The National Healthcare Financial Management Association administers the annual membership dues renewal and collection process. Each local Chapter is rebated a percentage of the membership dues relating to its Chapter. Such rebate amounts were $25,753 and $25,387 for the years ended May 31, 2010 and 2009, respectively, and are reflected as part of Revenue and Gains on the accompanying Statements of Activities and Changes in Unrestricted Net Assets.

4. Donated Services

The Chapter receives, at no cost, volunteer services to operate and administer Chapter programs and activities. The value of this contributed time is not reflected in the accompanying financial statements since such services are not susceptible to objective measurement or valuation.

5. Concentration of Credit Risk

Financial instruments that potentially subject the Chapter to concentrations of credit risk consist primarily of cash and cash equivalent balances. The Chapter maintains its cash and cash equivalents in bank deposit accounts, the balances of which, at times, may exceed federally insured limits. With respect to these cash and cash equivalent balances, the Chapter has not experienced any losses in such accounts. The Chapter believes it is not exposed to any significant credit risk on these balances.

6. Classification of Expenses

Operating expenses incurred by the Chapter in connection with its operations for the years ended May 31, 2010 and 2009 are summarized as follows:

2010	Program Services & Scholarships	Membership Services	Management & General	Total
Meetings and continuing education programs	$ 143,816	$ ---	$ ---	$ 143,816
Annual Institute	246,713	---	---	246,713
Social outings and events	62,397	---	---	62,397
Scholarships	15,000	---	---	15,000
Directories and publications	---	45,325	---	45,325
Payroll	---	---	39,487	39,487
Payroll taxes	---	---	4,092	4,092
Professional fees	---	---	9,025	9,025
Website	---	---	5,787	5,787
Insurance	---	---	2,934	2,934
Telephone	---	---	1,124	1,124
Postage	---	---	3,595	3,595
Member recognition	---	---	3,107	3,107
Depreciation	---	---	3,540	3,540
Provision for bad debts	---	---	5,000	5,000
Other	---	---	8,725	8,725
Total operating expenses	$ 467,926	$ 45,325	$ 86,416	$ 599,667

Healthcare Financial Management Association
New Jersey Chapter
Notes to Financial Statements
Years Ended May 31, 2010 and 2009

2009	Program Services & Scholarships	Membership Services	Management & General	Total
Meetings and continuing education programs	$ 136,919	$ ---	$ ---	$ 136,919
Annual institute	286,366	---	---	286,366
Social outings and events	67,789	---	---	67,789
Scholarships	12,000	---	---	12,000
Directories and publications	---	43,801	---	43,801
Payroll	---	---	37,741	37,741
Payroll taxes	---	---	4,121	4,121
Professional fees	---	---	9,025	9,025
Website	---	---	6,686	6,686
Insurance	---	---	2,929	2,929
Telephone	---	---	4,895	4,895
Postage	---	---	5,774	5,774
Member recognition	---	---	4,023	4,023
Depreciation	---	---	1,690	1,690
Other	---	---	10,383	10,383
Total operating expenses	$ 503,074	$ 43,801	$ 87,267	$ 634,142

7. Subsequent Events

The Chapter has evaluated subsequent events occurring after the statement of financial position date of May 31, 2010 through the date of July 30, 2010 which is the date the financial statements were available to be issued. Based on this evaluation, the Chapter has determined that no subsequent events have occurred, which require disclosure in the financial statements.

Meet A New Member

	Angela Craparotta
Who is your employer, and what is your position?	I am the Manager of Inpatient Utilization Management for Princeton House Behavioral Health.
What was your first job as a teen?	Score keeper - Trenton CYO Basketball League.
What do you like best about your work responsibilities?	Ever changing - always new and exciting.
My favorite place is...	With my family.
I will not eat...	Anything dairy.
If I'm not at work, you will find me...	At the gym.

•Certification Corner•

Certification:
Change Comes Bearing Gifts - Changes to the HFMA Certification Program – January 1, 2011

Why the Program is Changing

HFMA's certification program is changing January 1, 2011. You ask why? Our membership told us that the certification program was difficult to access; the study guides were cumbersome and expensive. They wanted easy, flexible access to the educational materials to meet their continuing education requirements within their busy schedules. Our health care finance executives said they needed finance managers with a broad, cross-functional knowledge for successful business operations. In addition, our membership wanted easier access to testing sites.

It was clear that improvements to the certification process were needed to better serve our membership while maintaining the high standards that makes HFMA certification so attractive to employers. Under the guidance of the HFMA Board of Examiners, the Certified Healthcare Financial Professional Certification Program has been restructured and changes will go into effect starting January 1, 2011.

These changes affect the CHFP designation; the current FHFMA requirements will stay the same.

New Program Features

- A single, comprehensive four-hour certification examination will replace the two exams (core and specialty).
- New members can become certified right away; the two-year HFMA membership requirement is being eliminated.
- New online study materials (available after January 1) will replace the printed hard copy study guides.
- Members will become certified immediately upon passing the online exam; the paper CHFP application will be eliminated.

Changes to the Certification Program Content

Today's healthcare financial managers regularly work in cross-functional teams. They need to possess a common body of knowledge that is technically deep, cross-functional, and integrated.

HFMA has identified six knowledge areas as essential to healthcare financial management: revenue cycle, budgeting & forecasting, financial reporting, internal controls, disbursements, and contracting. All of these areas are already tested in the old certification exams but will be better integrated with each other in the new exam.

New Jersey Chapter's Commitment to Our Members

Since many of you are considering becoming certified or are actively preparing for the exams, we want to let you know that our NJ Chapter will continue to support your professional development goals through our coaching courses and reimbursement policies.

The NJ Chapter is encouraging members to become Certified Healthcare Financial Professional (CHFP), and ultimately Fellows in HFMA, by reducing the financial burden associated with achieving these designations for 2010. The NJ-HFMA Board of Directors will reimburse NJ chapter members for applicable certification related fees. Reimbursable fees include the testing fees for the Core Exam and one Specialty Exam, CHFP application fee, and local technical fees. NJHFMA sponsored certification exam study courses will be eligible for reimbursement too. For those that are interested, the NJ Chapter will further reimburse the examination and application fees related to successfully obtaining certification in additional specialties beyond the CHFP or FHFMA designation. Reimbursement will be made to the member, or to the member's employer, based upon the source of the original payment.

We offered a proctored exam on Saturday, November 13th at two locations: ARMDS, Burlington, NJ office and ARMDS, Bloomfield, NJ office. If you think you are still interested in taking the exam, you may schedule an alternative date with a proctor that is convenient to both of you before December 31, 2010. The date of the exam, location and proctor need to be determined prior to registering to take the proctored exam. Please look on the website http://www.hfmanj.org/Events.calendar for more details.

Next Steps

1. **If you have not taken or passed a certification exam but were planning to do so this fall:**
   Complete your self-study for both exams this year. You must attempt both the core and specialty exams this year. If you don't pass, you have until April 1, 2011 to retake them (one retake). Alternatively, wait until January 1, 2011, and use the new online self-study materials to prepare for the new exam.
2. **If you have taken one certification exam in the last two years and passed it:**
   You must attempt the second exam before December 31,

continued on page 32

Ask the Ethics Guy®!

Principle No. 2: Make Things Better

Ethics asks us to use our knowledge and skills to positively affect others. But, we also must be judicious in how we use our resources to do so.

Bruce Weinstein

by Bruce Weinstein, Ph.D.

"Fredo, you're nothing to me now. You're not a brother, you're not a friend. I don't want to know you or what you do. I don't want to see you at the hotels. I don't want you near my house. When you see our mother, I want to know a day in advance, so I won't be there. You understand?"

—Michael Corleone, in The Godfather: Part II, after learning that his brother Fredo played a role in an attempt on his life.

Last issue I introduced this miniseries covering the five fundamental or "life" principles by providing an overview of the principles and saying a little bit about the first one (see my column in the September/October issue of FOCUS, "Five Easy Principles?"). To recap, the five Life Principles are:

- Do No Harm
- Make Things Better
- Respect Others
- Be Fair
- Be Compassionate

This issue we'll look at Life Principle No. 2: Make Things Better. This is where ethics splits off from the law. After all, there are legal as well as ethical implications of intentionally harming others. However, no law requires that we help others or make the world a better place. If, at the end of our lives, we look back and see that we devoted ourselves primarily or exclusively to satisfying our own needs and desires, and we haven't done anything illegal, that's fine. But is a life devoted strictly to "me" a fully rich and satisfying life? Is it an ethical one? Is it the best life we can live?

Of course not. If you're reading this column, though, chances are you already buy into the "make things better" principle. In fact, I suspect that the reason you went into the line of work you did is because you recognize that this is one way, perhaps the best way, for you to use your knowledge and talents to make a positive difference in the lives of others. There are lots of ways—some of them much easier—for you to simply make a buck.

But you took this job because—dare I use such flowery language?—you saw this occupation as a calling. I feel comfortable making this statement, because if you took this job simply to acquire wealth, with no immediate or long-range concern for helping others, you probably aren't interested in reading a column about ethics.

Don't Rank the Life Principles

Now don't get me wrong. I'm not knocking the acquisition of wealth. As we'll see later when we look at Life Principle No. 5, ethics does not require us to be completely self-sacrificing. The question is, though, does focusing simply on gratifying one's own desires lead to happiness? Does this bring out the best in us?

You might say that Life Principle No. 2, Make Things Better, is not as vital as Life Principle No. 1, Do No Harm. That is, it is more important to avoid harming people than it is to help them. Although it is easier to apply Life Principle No. 1 than No. 2, since Do No Harm requires either avoiding action or taking only minimal action, it is a mistake to rank these principles. Both are part of a checklist we should consider when deciding how to act.

One of the main differences, though, between Life Principle Nos. 1 and 2 is that Do No Harm applies to everyone who could be affected by our actions, while No. 2 has to, of necessity, be applied selectively. Even Mother Teresa could not possibly have benefited everyone in the world, though she went much further than most of us.

Whom Should We Benefit?

There is only so much of ourselves we can give without becoming emotionally and financially bankrupt. How should we decide who has a rightful claim on the goods or actions we can bestow upon them?

continued on page 32

continued from page 30

2010 and, if you don't pass, retake it by April 1, 2011.

3. **If you are interested in certification but haven't begun preparing for it:**
   If you haven't begun to prepare for the exam, it would probably be better to wait until January 1, 2011 and use the new online self-study materials to prepare for the new exam.

Test Your Knowledge:

Assigning or allocating costs to individual managers who are primarily responsible for making decisions about those costs is_____.

a. Variance evaluation
b. Cost accounting
c. Shared responsibility
d. Responsibility accounting

For the answer and more information about the HFMA certification program go to http://www.hfmanj.org/Certification3.page or contact one of the members below:

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Maria Facciponti, FHFMA – Committee Co-Chair
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Michael Alwell, FHFMA
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Email: malwell@smmcnj.org

Lisa R. Hartman, M.P.H - Education Committee Chair
Work: (609) 430-7789
Email: lhartman@princetonhcs.org

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continued from page 31

All things being equal, the closer someone is to us, the stronger our duties are toward him or her. Imagine a series of nine concentric circles, with "A" being the innermost circle, radiating outward:

A) Self
B) Spouse or partner
C) Immediate family (mother, father, children)
D) Distant family (grandparents, aunts and uncles, nephews and nieces, cousins)
E) Oldest and best friends
F) Boss, co-workers, assistants
G) Members of the immediate community
H) Fellow citizens
I) Everyone else

It's unfortunate to miss a friend's birthday, but it is unconscionable to forget our spouse's. It's kind to listen compassionately to a co-worker's complaints about her deadbeat husband over lunch, but it is obligatory to alleviate our children's anxiety about going to school for the first time.

In and Out of Circles

This imaginary diagram is only a guideline for ranking who in our lives deserves our help. It doesn't always hold. Think about how Michael Corleone ultimately responded to being betrayed by his brother: He authorized Fredo's murder. (Of course, Fredo had not exactly ordered his circles appropriately.) While Michael's response was extreme and revealed how much he had deteriorated morally, it also shows how through their actions, people—even blood relatives—can move closer or further away from us.

Ethics asks—even requires—that we use our knowledge and skills to benefit others. In so doing, we enrich our own lives. As we'll see later, however, getting something back isn't the reason to take ethics seriously; it's just a nice consequence of doing so.

Next issue we'll look at Life Principle No. 3, Respect Others, and three ways we can apply this principle in everyday life.

About the author

Dr. Bruce Weinstein is the public speaker and corporate consultant known as The Ethics Guy. His new book, Is It Still Cheating If I Don't Get Caught?, (Macmillan/Roaring Brook Press) shows teens how to solve the ethical dilemmas they face. Follow Weinstein on Twitter at TheEthicsGuy. For more information, visit TheEthicsGuy.com.

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•Focus on Finance•

Answers to your Accounting and Tax Questions

A Hospital CFOs Top 10 New Year's Resolutions for 2011

Q. As a hospital CFO, what are the things I should be thinking about and doing, going into 2011?

A. I had the pleasure of listening to a well-known New Jersey economist who described today's economy as that of a "reverse square root"… it was holding steady, took a big dip, came back up but not to previous levels, and is leveling out again. He was hopeful that we will not witness a double-dip recession. But this is hallow solace to those dependent on charity care, whose numbers have risen at hospitals across the nation with no real increase in reimbursement from state or federal sources. Closer to home, the situation reflects similarly. There is a great degree of uncertainty in the industry, fueled by concerns over heathcare reform, increased enforcement actions by OIG and RAC auditors, new Medicaid Integrity contractors coming online, bond covenant defaults, lack of capital for projects and erosion of the bottom line. As a hospital CFO, what are the things you should be thinking about and doing, going into 2011? The following is a list of Top 10 New Year's Resolutions every hospital CFO should be making in order to move forward on a positive note in 2011:

1. Also seen in last year's Top 10 list, this point bears repeating: Make all decisions in concert with an eye on the bottom line, remembering the axiom "With no money, there is no mission!" Don't contract if it does not make sense and do make sure you get paid for everything the hospital is legitimately entitled to. If a line of business does not have a positive contribution margin, you should consider eliminating it. Also, don't forget to bundle hospital based physician costs (hospitalists, NPPs, social workers and employed physicians) into your rates if you have not done that already. Under healthcare reform, more people than ever will start to show up at your facility but not with the best insurance coverage; efficiency and cost controls will drive you toward profitability since most of these new patients will be eligible for Medicaid expanded benefits, it will be a strain on hospitals. Procedure demand will be up on an outpatient basis since pent up demand from 2010 will finally materialize; don't forget to price your procedures to be competitive with free standing facilities, if possible.
2. Be proactive in understanding change and adapt to it before others use it as a strategic advantage over my hospital. Medi-cal homes are going to be a key driver of man-aging healthcare costs under reform, do your homework on how to adapt your institution to be a leader of embracing change and to profit from it! Physician alignment with hospitals will become increasingly the norm, embrace it and prepare for it.
3. Invest in activities that will make a difference in quality at your hospital. Payment reform is rewarding facilities that can do the right things and measure them. Healthcare associated infections and patient centered outcomes are front in center of the healthcare reform law's initiatives; anyone who fails to address these changes will lose reimbursement. Don't forget to document and demonstrate meaningful use through your HIS!
4. Also, still on the list but no less important this year than last; don't try to do everything yourself. Most CEOs and CFOs are Type As who are reluctant to ask for help or share their burdens. You would be surprised how much the rank and file will support you if they are engaged as part of the solution. Also, don't be afraid to ask a trusted advisor (your CPA or go to consultant) for assistance in tasks or projects that you could not reasonably complete with internal resources. Now more than ever, sweeping must-do tasks under a rug will not yield the desired results: if you have not completed internal audit

Lewis Bivona, Jr.

Make all decisions in concert with an eye on the bottom line, remembering the axiom "With no money, there is no mission!"

priorities, RAC prep, enhanced 990 reporting or any other number of compliance projects, the results of this neglect will catch up with you quickly and harshly.

5. Do invest in compliance activities and make them a strategic initiative and ingrain them in your organizational culture. With the increased scrutiny that hospitals will be receiving by all governmental payors, you cannot afford to side step good business and governance practices. Compliance and internal controls will be a key ally in saving your hospital from embarrassing press articles and, even worse, monetary recoupments and fines. More than last year, both the Federal and State governments are investing in more resources to bear on regulatory audits from the OIG, DSH, RAC and the IRS.
6. Prepare for the Version 5010 electronic filing standards and ICD-10 now. CMS pushed back the implementation dates of both by one year, but that is it. Those that are not ready will suffer financially. 5010 filing will be required by 10/1/2012, with ICD-10 coding kicking in a year later; neither of these initiatives can be put off any longer since system testing and educating billers, coders, staff and physicians will be required.
7. Just like last year, keep your friends close and your bankers closer. Letters of credit and financing for new projects that will have long term yields to the organization cannot be accomplished without a source of funds. Managing capital projects will be more of a priority under healthcare reform than ever. Lenders have money available and are under pressure to make good loans; bankers and other capital sources will also be looking for you to demonstrate that you are taking positive steps towards improving performance as a condition of borrowing and will be judiciously reviewing your operating assumptions and financial statements.
8. Pension funds still need to be dealt with. Significant underfunding exists and will have to be addressed; both unions and regulators are looking at them. If you are a union shop, you can expect this funding issue to be one of your biggest thorns in your side. Operational efficiencies (like lowering fees) and possible restructuring of plans can yield huge results. Also, don't forget to include these financing requirements in your budget so they don't get lost when negotiating with payors.
9. Consider the possibility of a merger with another hospital. M&A activity is expected to peak in the next couple of years, as single hospitals will find that it is harder to achieve economies of scale that will be required under healthcare reform. Review of data supports that hospital systems typically perform 3-4% points higher than unaffiliated hospitals.
10. Be a catalyst for change and get involved in initiatives that can move your hospital forward… nothing at a hospital happens without support from finance. Be involved in the projects that can drive positive margins (GPO evaluations, benchmarking, patient experience feedback, customer care training, ACO development, patient safety, insurer/hospital incentive alignments, and clinical protocols) and create loyalty amongst all key stakeholders.

Remember that success rarely comes to those who wait… it comes to those that do!

Remember that success rarely comes to those who wait… it comes to those that do! Use these tips wisely to propel your organization forward in 2011!

About the author

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Mayors Wellness Campaign Update

Emily Littman

by Emily Littman

As summer was heating up all across the Garden State, so were the programs and activities of the Mayors Wellness Campaign (MWC). A collaboration between the New Jersey Health Care Quality Institute (NJHCQI) and the New Jersey State League of Municipalities (NJSLOM), the MWC reached its fifth anniversary this fall and already counts nearly 300 of the state's mayors as active participants.

The MWC supports mayors as champions of community health. The goal is to increase opportunities for New Jersey residents to participate in daily physical activity with a long-term goal of reducing health care costs secondary to obesity. Through public-private partnerships, the MWC provides structure and resources for healthy community initiatives. By encouraging mayors to play a leadership role in supporting local opportunities for active, healthy lifestyles, the intent of the MWC is to improve health and make New Jersey a national leader in community-based health interventions.

In 2010, two more towns (Nutley and Hillsborough) received the coveted MWC "New Jersey Healthy Town" designation, bringing the number of towns honored to eight. The others are Bridgewater, Clifton, Hamilton Township (Mercer County), Madison, Parsippany, and Woodbridge. In order to be designated:

- *A community must be a Mayors Wellness Campaign participant for one year or more;*
- *A community must demonstrate sustainable programs in each of the Mayors Wellness Campaign categories: Youth in Motion, Seniors in Motion, Employers in Motion and Community in Motion; and*
- *A community must be willing to share its program information with other communities.*

15 mayors participated in first MWC Cook-Off held in Parsippany, NJ in 2007

The MWC staff is currently reviewing applications from several additional towns seeking the designation.

Recent activities and initiatives include:

- Nutley, the newest Healthy Town, launched a Mayor's Weight Loss Challenge this summer. The program lasted for 16 weeks and included a running club and 5K training.
- A second "Toxic Waistlines" competition was launched on June 1st in Bernards Township and 140 of the town's residents signed up to compete. A grant to fund the initiative was provided by the National Business Coalition on Health. The participants competed for prizes to see who could lose the most weight and "toxic waistline" inches over the summer.
- The Mayors Wellness Campaign effort in Boonton recently announced a new and innovative way to get residents fit with a "Walk to Market" initiative designed to get people to walk to the popular farmers market in town. On the first day of the market, the first 100 people who walked there received a free market bag.
- The Mayor of Chatham announced he is considering an outdoor smoking ban in park and recreational areas. In making the announcement, Chatham Mayor V. Nelson Vaughan III said, "Certainly it's part of my mayor's wellness campaign." Mayor Vaughan also introduced a program this July called "Know Your Numbers" which challenged citizens to be aware of their heart rate, BMI, cholesterol, and blood pressure to encourage healthy living.
- The city of Perth Amboy held a "Put Your Community in Motion" health fair as part of its Mayors Wellness

MWC Director Emily Littman presents Healthy Town Flag to Nutley Mayor Joanne Cocchiola

Campaign. MWC Director Emily Littman participated in the event with Mayor Wilda Diaz and representatives of Wegmans supermarket.

- Mayors Wellness Campaign Director Emily Littman joined Mayor Jonathan Hornik in Marlboro's annual Mayor's Bike and Stroll on June 5th.
- Another "Mayors Healthy Cook-off" is underway for late summer and will feature a "barbeque" theme.
- Two communities reached out to children to emphasize healthy eating earlier this year. Plainfield held a "Kids Iron Chef" event on March 20th, and Morris Township hosted a Kids Healthy Chef Day on May 14th.
- Shore community North Wildwood again held a big summer Mayors Wellness Campaign push through the city's recreation department. Activities included a state-of-the-art free, fitness/exercise room, adult basketball and flag football leagues, aerobics, yoga, and Zumba classes, runs, walks, and marathons like "Sandblast Beach Run" and "Tri/Du" in the Wildwoods.
- The Borough of Bay Head has given their Mayors Wellness Campaign the slogan "GO Bay Head!" and had numerous activities throughout the summer.

Bernards Twp. Mayor Scott Spitzer with Karen Ellis, RN during the official weigh-in for the Toxic Waistlines competition

- Belmar took a unique approach to its Mayors Wellness Campaign by sponsoring a skateboarding safety event. The skate park safety clinic, which was free to the public, provided healthy snacks and water for those skateboarding, as well as the chance to win helmets for skateboarding and bicycling through raffles.
- Mayor Maura De Nicola of Franklin Lakes teamed up with the Mayors Wellness Campaign to sponsor a Teen Kula for Karma family yoga & fitness day in April. The community also held a Bike-a-thon and Community bike ride to benefit Camp No Limits in June. Over 100 bicyclists participated, and a total of $3,800 was raised for Camp No Limits.
- Piscataway held a "Biggest Loser Piscataway" contest for people who live or work in the town. Beginning in July, the program finished on October 4th, when the final weigh-in took place and prizes were awarded.
- The mayors of Madison (Morris County) and Ramsey (Bergen County) know how to get their communities in motion. Both towns have walking clubs that meet daily to tour the community and get exercise at the same time. The Rose City Steppers have been active in Madison for many years, and Ramsey started a new program of "Ramsey Walks" for its citizens.

These are just a handful of the scores of MWC activities taking place across New Jersey. Is your town participating?

About the author

Emily Littman is the Director of the Mayors Wellness Campaign and the Director of Research and Programs at The New Jersey Health Care Quality Institute. Emily can be reached at elittman@njhcqi.org.

Members of the Rose City Steppers participate in a walk through the Drew University forest and campus.

CFO Spotlight:

John J. McSorley, Executive Vice President and Chief Financial Officer, QualCare Alliance Networks, Inc.

John McSorley

FOCUS: CFO backgrounds are diverse, please tell us about yours. How did you get started? What is your education and professional background?

JOHN: Originally I was going to be in aviation and attended Embry Riddle Aeronautical University my first year of school. While taking business courses, I decided my true interest was to follow in my father's footsteps and concentrate on accounting and business. I transferred to the University of Scranton where I obtained by bachelors degree in accounting and finance. I joined the Deloitte and Touche New York Audit practice where I developed to National Senior Manager for HealthCare Practice in New York. From there, I followed my insurance experience to become President and CEO of Group Council Mutual Insurance Company, a mutual property and casualty insurer specializing in malpractice and business casualty lines. In 1997, I joined QualCare as its Chief Financial Officer and Chief Information Officer. Since 1997, QualCare has grown from $8 million to $55 million in revenue.

FOCUS: Did you ever think, all those years ago, that you would be here, doing this today?

JOHN: Growing up in New Jersey and observing my father, who was a partner at KPMG Peat Marwick and one of the top insurance tax partners in the country, I was able to see first hand how rewarding a professional career could be. While public accounting served me well as the "best" training ground one could ever ask for, private industry always interested me. QualCare has provided me with a challenging career in an ever changing environment which has allowed me to develop as a professional. Success is hard to come by if you are not in a growth environment.

FOCUS: What new skills do you think are needed for rising CFOs?

JOHN: With the convergence of U.S. GAAP with International Financial Reporting Standards, the game is changing every year for CFOs. The stability of old methods is changing and the ability to see ahead of the change is the challenge CFOs must meet every day. These challenges are further complicated by the effects of regulatory changes from National Health Care Reform and other Governmental and Industry requirements. Keeping current on changing regulations and requirements and remaining flexible to deal with their impacts will be a key to success in the future.

FOCUS: Tell us a little about QualCare. What is the company's history? What products and services does QualCare offer?

JOHN: QualCare was started in 1993 by Annette Catino in response to New Jersey deregulation and the proposed Clinton health plan. QualCare is a provider sponsored managed care organization offering health plan claims administration, utilization and disease management and workers compensation claims administration services. QualCare also offers health and workers compensation network access through its state-wide proprietary network of hospital, physician and ancillary provider contracts. This network services PPO, HMO Network, POS Network and Workers Compensation product lines through out New Jersey. QualCare also provides services to providers for risk contract and charity care administration. Through its contract with Affiliated Physicians Multiple Employer Welfare Association Trust, QualCare administrates and manages the operations of the Trust's health products designed specifically for the physician community and their staff.

FOCUS: What's in store for QualCare in the future?

JOHN: QualCare continues to support the provider community and is working with its provider sponsors to develop initiatives for Accountable Care Organizations. QualCare is uniquely positioned to support the implementation of such plans by virtue of its provider sponsorship. As the requirements and regulations related to Health Care Reform are rolled out, QualCare will be at the forefront with its clients with assistance in keeping plan costs under control in the new regulatory environment.

FOCUS: What are your spare time activities?

JOHN: Golfing and Boating are favorite pastimes, although sometimes mutually exclusive.

FOCUS: What are your professional memberships?

JOHN: AICPA, NJSCPA, NYSCPA, AHIP, AAPPO (Board Member), Monmouth Ocean Health Insurance Exchange (Board Member), Affiliated Physicians MEWA Trust (Board Member).

FOCUS: You are just told you have 30 minutes to pack - you are going to a sparsely populated island. What would you bring, besides food, clothes, hygiene products, etc?

JOHN: Golf clubs, I don't go anywhere without my golf clubs.

Member Spotlight:
Adam Bavifard

Adam Bavifard

FOCUS: Please provide us with a short bio of yourself.

ADAM: I'm originally from Buffalo, NY (but I'm not a Buffalo Bills fan) and went to the University at Buffalo for both my Bachelor's and Master's. My undergraduate degree is in Biology, and before graduate school, I was focused more on healthcare from an "in the lab" standpoint. While getting an MBA, I worked with Buffalo's local healthcare community on consulting projects and became more focused on the business side of things. In 2008, I moved to the NYC Metro market to pursue a career in commercial banking with M&T Bank. I currently live in Hoboken.

FOCUS: Please talk about your employer and your duties there.

ADAM: M&T Bank is headquartered in Buffalo, our footprint extends from New York State down through the Mid-Atlantic region and into Northern Virginia. M&T is over 150 years old; but most of our growth has occurred since 1983. We operate much like a community bank, with credit decisions being finalized by individuals with local market knowledge, but we are a full-service large bank and can leverage our capabilities to service business of all sizes. In January, I will have been with M&T Bank for three years. I'm a commercial lender that generalizes in middle market companies and specializes in healthcare (which we define as businesses that are reimbursed by Medicare or Medicaid). My responsibilities include managing a portfolio of healthcare and middle market loans, as well as finding new opportunities to grow M&T's presence in New Jersey. I think something that M&T does well is being responsive to customer needs.

FOCUS: Please name a few of the special challenges you face in your position.

ADAM: Like all of you reading this, we are challenged by the high degree of uncertainty facing healthcare both in New Jersey and nationally. In addition to uncertainty, the recession has led to operational hardships for both customers and prospective customers. It's an exciting challenge to find credit structures that effectively mitigate risk of loss and enable our customers to put their best foot forward.

FOCUS: What advice can you give other professionals that are interested in entering your line of work?

ADAM: Accept that you will continually learn new ways to address challenges. I think that if you're willing to learn and build on your knowledge base you will enable yourself to be creative throughout your career.

FOCUS: What are your hobbies and outside interests?

ADAM: I enjoy the outdoors, playing soccer, fishing, and playing guitar. I'm also actively involved with the United Way of Bergen County's Young Leaders group and fundraising for the Juvenile Diabetes Research Foundation.

•Focus on...New Jobs in New Jersey•

JOB BANK SUMMARY LISTING

HFMA-NJ's Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to HFMA-NJ's **Job Bank Online** *at* **www.hfmanj.org.**

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Job Position and Organization

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Northern New Jersey

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Provider of managed healthcare services
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December 14, 2010
Webinar
Free Webinar: Vendor Management - A Case Study of What it is and How It Creates Value 12pm-1pm

January 11, 2011
The Woodbridge Hilton
January Quarterly Meeting all day

January 18, 2011
Holiday Inn of East Windsor
Use IT or Lose IT: Complying with HIPAA/HITECH and Electronic Health Record Requirements to achieve Healthcare Reform 8am-3:30pm

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•Who's Who in NJ Chapter Committees•

2010-2011 Chapter Committees and Scheduled Meeting Dates

**NOTE: Committees have use of the NJ HFMA Conference Call line.*
The call in number is (888) 269-3831 for all but *the PFS and Institute Committees.*
The call in number for PFS and Insitute Committees is (888) 290-0578.
If the committee uses the conference call line, their respective attendee codes are listed with the meeting date information below.

PLEASE NOTE THAT THIS IS A PRELIMINARY LIST - CONFIRM MEETINGS WTH COMMITTEE CHAIRS BEFORE ATTENDING.

COMMITTEE	CHAIRMAN/EMAIL/ PHONE	CO-CHAIR/EMAIL/ PHONE	SCHEDULED MEETING DATES/TIMES	LOCATION	BOARD LIAISON
CARE (Compliance, Audit, Risk, & Ethics)	Darlene Mitchell mitchell.darlene@hunterdonhealthcare.org 908-237-7059	Michael McKeever mckeeverm@deborah.org 609-893-1200 ext 5201	First Thursday of the Month 9:00 AM Attendee Code: 5952498	Meeting in person at Deloitte & Touche, Princeton, NJ for Oct., Jan., April and July Balance are calls. Please call to confirm	Heather Weber heather.weber@parentebeard.com 732-388-5210 ext 12769
Communications	Elizabeth Litten ELitten@foxrothschild.com 609-896-3600	Al Rottkamp ajcr123@aol.com 609-584-6508	First Thursday of each month 9:15 AM Attendee Code: 7844155	Fox Rothschild offices 997 Lenox Dr Bldg 3 Lawrenceville, NJ	Tony Consoli anthony.f.consoli@marsh.com 973-401-5223
Education & Certification	Lisa Hartman lhartman@princetonhcs.org 609-430-7789	Matt Glass Matthew_Glass@ml.com 732-632-5854	First Friday of each month 8:30 AM Attendee Code: 7363742	Conference Calls with in-person quarterly meetings. Call for info.	Tracy Davison-DiCanto tdavison-dicanto@princetonhcs.org 609-620-8471
FACT (Finance, Accounting, Capital & Taxes)	John Doll JohnnyDoll@verizon.net 732-915-5430	Adam Bavifard arbavifard@mtb.com 201-368-4522	First Wednesday of each Month 8:30 AM Attendee Code: 8730600	To alternate between in person and conf. calls; locations TBD	Tom Shanahan Tshanahan@rbmc.org 732-324-5401
Institute 2010	Deborah Shapiro dshapiro@wfs-services.com 201-617-7100	Howard Krain hkrain@microsoft.com 908-377-5020	First Tuesday of each Month 8:00 AM Attendee Code: 8788393	WFS offices Secaucus, NJ	Mary Taylor MTaylor@SOCH.com 609-978-3373
Managed Care	Elizabeth Jennings Ejennings@magnacare.com 516-282-8233	Joe Privatera privitera@mail.holyname.org 201-833-7010	6/17, 7/20, 9/16, 10/13, 12/16 – 9-11:00 AM No conference calling	New Jersey Hospital Association Board Room	Dan Willis dkwillis6@gmail.com 908-301-5458
Membership Services/ Networking	John Manzi jmanzi@panaceahealthsolutions.com 732-575-2520	Erica Waller Ewaller@princetonhcs.org 609-620-8335	Call for meeting arrangements Attendee Code: 5495569	Locations alternate by month – please contact the chairs	Caitlin Zulla czulla@medassets.com 201-786-6020
Patient Access Services	William Hunt whunt@humed.com 201-996-2897	Diana Sessions dsession@rwjuhh.edu 609-584-6465	Second Thursday of each Month 9:30 AM Attendee Code: 8942192	CBIZ KA Consulting offices in East Windsor, NJ	Laurie Grey lgrey@princetonhcs.org 609-620-8383
Patient Financial Services	Marilyn Koczan mkoczan@meridianhealth.com 732-897-7126	Josette Melillo jmelill@valleyhealth.com 201- 291-6017	Second Friday of each Month 10:00 AM Attendee Code: 6748634	New Jersey Hospital Association Board Room	Mary Cronin Mcronin@beslerconsulting.com 732-839-1217
Regulatory & Reimbursement	Mike Sabo MJSabo@meridianhealth.com 732-751-3389	Scott Besler Sbesler@beslerconsulting.com 732-839-1219	Third Tuesday of each Month 9:00 AM Attendee Code: 9169098	Locations alternate by month - please contact the chairs	Joanne Vaul Jvaul@CBIZ.com 609-967-4562

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Elizabeth A. Litten

Date: 10/5/10 Corrected

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continued from page 8

ticket dispensers **Mary Cronin, JaneAnn Shee-han,** and **Deborah Shapiro**, everyone is served and no one has to worry about being raided by Eliot Ness and the Feds!

Thursday – October 21, 2010 AM: It's all healthcare reform all the time today! We assemble in the Event Center for a hearty breakfast and our first keynote speaker. **Mike Alwell** kicks off the event by introducing Debora Kuchka-Craig, the honorary chairperson of HFMA National for this year. And she is inspiring! "Step Up" is her theme and she has us stepping lively throughout her presentation. **Mary Taylor** then takes over to introduce the next general session speaker, **Betsy Ryan**, the President & CEO of the New Jersey Hospital Association, who gives us an update on the state of the State. And, between the slide presentations provided by our speakers, the Vendor Slideshow, featuring ads and logos of our sponsors, is running on the two Jumbotrons. Advertising never looked so good! The attendees then stream out for the morning breakout sessions returning at noon for lunch in the Event Center.

After lunch, **Brian Sherin**, the NJ Chapter immediate Past President, hosts the Awards Ceremony whereby the chapter awards are handed out. All of the award winners come up to accept their plaques or statues and to have their pictures taken for posterity. In addition to the general accolades and awards, nights at the Borgata and/or free conference registrations are also provided as part of Chapter Member Recognition. You have to be in it to win it!

Thursday – October 21, 2010 PM: We kickoff the afternoon education with Dr. Dlugacz speaking on the "Changing Role of Healthcare Financial Leadership". Having literally written the book on Value-Based Healthcare (which sells briskly immediately after his talk), he lays out the challenges ahead for all of us working in healthcare. After a brief break, everyone dives into the afternoon sessions for the final breakout education classes of the conference. At 5:00 PM, a clean sweep of all the rooms to pick up the CPE sign in sheets and evaluations is done and education is finished for the day. The attendees disperse to rest up for the last big social events of the evening – the President's Reception and the Dessert Reception/Karaoke Party.

Thursday – October 21, 2010 even later: Although the elegant Water

continued on page 44

continued from page 43

Club is not available to us for the President's Reception, we are privileged to hold the event in the Signature Room. At 6:00 PM sharp, we are greeted with a large, airy space, a keyboardist playing on the side, two fully stocked bars, and tables groaning with the largest shrimp we've ever seen! Between **Tracy Davison-DiCanto, Deborah Shapiro** and **JaneAnn Sheehan,** thousands of drink tickets are disbursed. Appetites are running high and we have to order more food. But, we made sure that the shrimp never ran out and that baby lamb chops were passed throughout the event. The room starts to clear around 8 PM as everyone leaves to go to dinner at the restaurant of their choice and the action moves to MIXX for the open bar and the Phillies game on upstairs. As the game heats up, several people run out to get their Phillies jerseys and hats to help their team along.

Thursday – October 21, 2010 even later than that! At 10 PM, the dessert reception and karaoke party starts off slightly mellow with music playing in the background and everyone bellying up to the bar. The Phillies game is still going and we can hear the cheers. But the party gets started with our first karaoke song and we don't stop until we drop. The DJ is hard pressed to keep up with the requests, everyone is dancing and we keep the party going until 1 AM. [In fact, we have so many people at MIXX that we exceed the room occupancy safety limit!] The group

renditions were the most spirited – with a large chorus gathered for New Jersey's anthem, "Living on a Prayer" - and we end the evening with "Sweet Home Alabama" and about 30 of us on the dance floor. Once again, the karaoke was the liveliest event of the conference and everyone leaves singing and dancing to try to get some rest before the next day's wrap up.

Friday – October 21, 2010 AM: Based on the recommendations from the previous year, we awake to a very hearty breakfast of bacon, eggs, oatmeal, and so on – something to fortify us as we come into the general sessions. The Borgata staff has been busy erecting a wall between the general session area and the vendor booths so that the vendors will have an opportunity to break down their booths at their leisure. However, there is still an opening between the two sections so that vendors can participate in the general sessions and the attendees can still circulate among the booths. Tables have also been removed in the General Ses-

continued on page 46

continued from page 45

sion area so we have a slightly more intimate feel to the room as we get started. **Mike Alwell** kicks off the morning with house-keeping items and introduces our first speaker, **Dr. Brad Nieder, aka Dr. Phunny**, who keeps us in stitches! His very humorous presentation on "Laughter is the Best Medicine" is so funny it's "sick"! And, his endpiece tribute to Dr. Seuss has people lining up after his presentation to purchase his books and tapes that are on sale in the pre-Event Center lobby. The good doctor is followed by Doctor Good, **Dr. Bruce Weinstein**, "the Ethics Guy", who is introduced by **Howard Krain,** Institute co-chair. Dr. Weinstein challenges us to consider how ethical behavior can assist us in making better decisions and in being better people managers. It also gives us something to think about next time we post pictures on Facebook! And, Dr. Weinstein does a brisk business as well selling books and DVD's in the pre-Event Center lobby and soliciting testimonials for his great presentation.

To round out the morning sessions, we have the ever-popular CFO panel. Moderating it this year is **Brian Sherin**, with three powerhouse CFO's – **Stella Visaggio**, of Hackettstown Regional Medical Center, **Kevin Brennan**, of Geisinger Health System (and a true Phillies fan!), and **Neil Lubarsky**, of Thomas Jefferson University Hospital. [Unfortunately, our fourth CFO was unavoidably detained.] Brian and panel discuss the difficult issues facing hospitals today in light of healthcare reform legislation and offer insight into how they and their institutions are meeting the challenges. Being able to share information and processes openly among facilities is one way that we all will benefit in the future.

The morning, as well as the Institute, ends with the Booth Bingo drawing. **Mary Taylor** thanks everyone involved in the Institute, especially our business partners and sponsors without whom this excellent event could not happen. The booth bingo prizes are gthen handed out to the lucky winners.

Fourth prize of a night's stay at the Woodbridge Hilton is won by **Howard Tepper** who also participated in the Institute as a speaker. Third prize of two Rangers tickets is won by **Mary Grant** who scores big by also winning the iPad giveaway hosted by J.H.Cohn. Second prize, a Blu-Ray DVD player, is won by **Russell Hicswa**, and, finally, the Grand Prize of free registration for the 2011 Institute and 2 nights stay at the Borgata is won by **Pamela Mohr.** The Insitute Committee gets together for one last round of goodbyes and makes sure that everyone is available for the next meeting to have a debrief. We want to ensure that we do all the things that everyone loved again and improve on those events and items that didn't work to perfection.

CAN'T WAIT UNTIL NEXT YEAR! SAVE THE DATE FOR THE 35TH ANNUAL INSTITUTE ON OCTOBER 12-14, 2011 AT THE BORGATA!

About the author

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