The Virginia AAHAM Insider

A Newsletter by and for the members of the Virginia Chapter of AAHAM

Spring 2016 Volume 38 Issue 1

The President's Message

Greetings Virginia AAHAM Members and Friends!

I'm so happy that we are well on our way to enjoying Spring weather here in our beautiful State of Virginia. After the winter that dragged out the way it did, we certainly deserve warmer and sunnier days!

As always there is a lot going on at Virginia AAHAM and I'm happy to see all the activity. The Education Committee has put together a wonderful conference, our Spring Regional Meeting, for us again this year in Charlottesville that will be held on Friday, April 7th at the Holiday Inn. Many folks have already registered to attend this event, and I encourage all of you to attend. For more information, you can visit our Calendar of Events page on our website www.vaaaham.com.

We're on Facebook! Yes, that's right we are getting better and better at staying in touch with all our members and friends at Virginia AAHAM. The Communications Committee recently launched our site and will be putting chapter updates out there for folks to see. So, please visit our site at https://www.facebook.com/vaaaham and like our page, and visit it often for chapter happenings and updates. On a similar topic, the committee is also looking at revamping our website and enhancing the information we have available. Stay tuned for exciting changes in this area as well!

Have you renewed your membership for 2016? If not, there's no better time than the present. If you haven't renewed, you most likely will be receiving a call or an email from Linda Patry or one of the members of the Membership Committee. Keeping your AAHAM membership current and up to date insures you that you will continue to receive all the benefits AAHAM and Virginia AAHAM have to offer. If you have questions regarding AAHAM membership, you may contact Linda directly. Her contact information is located on the Executive Board page at our website www.vaaaham.com.

Once again, for our second year in a row, the Virginia Chapter of AAHAM and the Certification Committee will be sponsoring scholarships to members who want assistance in paying for one of our certification exams and don't receive assistance from their employer. Be on the lookout for information on this year's program that should be coming out soon!

I wish to congratulate Deanna Almond and Darrah Seawell for winning the two registrations we had available for this year's Legislative Day Lottery that the chapter held. Each year AAHAM hosts a day on Capitol Hill for members from across the country to come together and meet with each other, and with our legislators in Congress to express our ideas on items of interest at AAHAM. It's always an inspiring and enlightening time that I hope they enjoy as much as I do. If you'd like to attend this year, there's still time to register by visiting the AAHAM website at www.aaham.org.

I'm, looking forward to seeing you at one of our upcoming meetings, enjoy this beautiful weather!

David

David Nicholas, CRCE-I

President, Virginia Chapter of AAHAM

The Virginia AAHAM Insider

1st Place Winner for Excellence in Journalism

2014-2015 National Journal Award!

Inside this issue:

The Virginia Chapter of AAHAM

American Association of Healthcare Administrative Management

Does Cash Equal Performance? - The Year of Measurements

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Well, we are in 2016…Happy New Year! So we ask: what will the New Year bring? What New Year resolutions have I made? Are they still "in-play?" Have we made resolutions at home, personal, at work or all three? Are they realistic? Have I set up monitoring mechanisms for each of them? Well, as Revenue Cycle managers, let's dig into this further. We have conducted measurements in many distinct areas for our clients and have discovered a number of different considerations. We would like to share some of these with you.

Changes have occurred in our industry that can greatly affect the cash outcome for our facility. One area that seems to be changing on an annual basis is reimbursement from all third party payers including government payers. Since the institution of DRGs (diagnostic related groups) in 1983; APGs (ambulatory patient groups) in 1990; RBRVS (resource based relative value system) in 1992; and APCs (ambulatory payment classification) in 2001, a patient's diagnosis has become more and more important regarding reimbursement. Today, diagnosis and quality outcome results are being addressed through new reimbursement methodologies which move the risk to providers and focus from volume to value. So it becomes extremely important to us to not only monitor our reimbursement (cash) payments but also monitor our third party contract reimbursement methodologies.

We recognize that some facilities may have different methodologies among the various contracts but a reimbursement comparison (of payers with similar volumes for similar services) can indicate a potential benefit to changing low paying reimbursement arrangements.

Fiscal Year Data

XYZ Hospital	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Allowed	71.8%	64.0%	51.4%	62.6%	60.3%	62.9%	59.3%	96.4%	95.8%	42.0%
Collected	60.5%	53.0%	39.8%	48.4%	46.4%	46.4%	40.6%	39.9%	52.2%	11.8%

The above chart indicates a third party comparison (color names) for a period of time (fiscal year). However, this can be conducted for any time period and frequent reviews will assist agile organizations in better forecasting and mitigating future losses. What it shows is the percent of both allowed and collected against charges. This chart presents a high-level overview that can indicate the desire to do some further measurements, especially when looking at "poor performers" payers yellow, white and black. So, let us dig further.

Does Cash Equal Performance? - The Year of Measurements

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INPATIENT										
Fiscal Year Data										
XYZ Hospital	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
I/P Allow	57.0%	61.9%	38.7%	51.3%	39.6%	86.0%	30.3%	100.0%	100.0%	6.8%
I/P Coll	55.2%	59.4%	33.8%	45.8%	35.2%	78.6%	22.4%	59.0%	83.2%	5.2%
OUTPATIENT										
Fiscal Year Data										
XYZ Hospital	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
O/P Allow	75.1%	64.5%	53.9%	65.5%	65.2%	55.8%	69.8%	95.7%	94.9%	46.6%
O/P Coll	61.7%	51.2%	41.0%	49.1%	49.0%	36.6%	47.3%	36.0%	45.7%	12.7%

The above chart has broken down the full facility experience into inpatient and outpatient. As most contracts utilize unique payment methods for each of these, understanding performance by service type is paramount to determining favorable rates or methods. The above inpatient chart demonstrates the differences between the allowable and collected percentages have decisive distinctions. These numbers indicate a few methods are in use as two payers have 100% allowable (most likely percent of charge) and the others vary enough to indicate DRGs for base rates and/or per diem. Additionally, the variance can be caused by case rates or 'carve -outs' that can greatly impact collections, especially when your service mix changes and high-dollar procedures may become less favorable than previous years. The collected amount may be representative of the patient's deductible but it is certainly worth performing the calculation to validate this factor and conduct further research when presented with large variances or major shifts over-time.

Similarly, the outpatient services may have different reimbursement methodologies that could give cause to further analyze which is most beneficial to your organization (APC's, case rates, or percent of charge). Developing a strong understanding or payer performance and having full knowledge of the intricacies of contracts is necessary to have better negotiations in the future and maximize collections.

With the increasing factor of diagnosis into the reimbursement models, organizations should be monitoring medical specialties revenue and collection trends. Reviewing allowed and collected amounts by procedure type, service type, and specialty will enable you to review reimbursement methodologies that are more/less favorable to your organization. Be sure to regularly break data down to *average* reimbursement by DRG/CPT/HCPCs to negate volume shifts that may impact total dollar results. Understanding service area or specialty may be extremely helpful if a facility has, or is thinking about, a "center of excellence". Many facilities are designing and developing centers of excellence to increase market share, refine costs to profits, and provide high quality of care to the community. The charts below provide examples of medical specialty data.

Does Cash Equal Performance? - The Year of Measurements

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Allowed by Area	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	71.8%	64.0%	51.4%	62.6%	60.3%	62.9%	59.3%	96.4%	95.8%	42.0%
Gen Med	55.6%	62.2%	46.5%	44.8%	45.2%	86.4%	15.6%	100.0%	100.0%	6.8%
Surgery	55.5%	60.9%	29.1%	59.4%	26.9%	97.4%	58.2%	100.0%	100.0%	n/a
Psychiatric	61.4%	68.6%	89.2%	n/a	93.2%	100.0%	33.4%	n/a	100.0%	n/a
Rehab	65.4%	63.2%	40.8%	n/a	37.8%	n/a	44.3%	n/a	n/a	n/a
OB/Gyn	69.2%	45.9%	n/a	40.0%	n/a	5.4%	n/a	n/a	n/a	n/a
Other	39.0%	62.7%	23.8%	34.9%	32.0%	n/a	50.1%	n/a	n/a	n/a

Collected by area	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	60.5%	53.0%	39.8%	48.4%	46.4%	46.4%	40.6%	39.9%	52.2%	11.8%
Gen Med	53.0%	60.1%	42.3%	40.5%	42.2%	79.3%	9.8%	58.1%	85.8%	5.2%
Surgery	54.3%	58.0%	24.0%	52.1%	22.9%	89.6%	45.9%	60.9%	76.6%	n/a
Psychiatric	59.3%	66.1%	79.0%	n/a	50.3%	65.0%	25.6%	n/a	78.9%	n/a
Rehab	62.2%	60.0%	38.1%	n/a	30.1%	n/a	35.4%	n/a	n/a	n/a
OB/Gyn	69.2%	45.7%	n/a	32.3%	n/a	5.4%	n/a	n/a	n/a	n/a
Other	39.0%	53.5%	18.0%	32.2%	17.4%	n/a	43.7%	n/a	n/a	n/a

From this type of analysis, one can measure the reimbursement strengths and weaknesses involving inpatient services. For instance, insurance pink and black pay very well in general medicine and surgery compared to others. Also, insurance blue, green, orange and pink pay very well in psychiatric services. This data also tells us that there will probably not be a "center of excellence" for OB/Gyn.

Aside from medical specialties, one may want to measure your financial reimbursement data by the type of health plan you are currently under. We recognize that within each type of plan one can also have 'specialty clauses' or "carve-outs" that can be negotiated separately. However, the examination of the overall plan, especially as it relates to other payers, is a good start for further discussions. The following charts show the allowed by plan and the collected by plan as the basis for analysis.

Does Cash Equal Performance? - The Year of Measurements

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Allowed by Plan Type	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	71.8%	64.0%	51.4%	62.6%	60.3%	62.9%	59.3%	96.4%	95.8%	42.0%
PPO	72.0%	64.3%	51.0%	65.4%	60.4%	63.8%	58.2%	96.6%	95.8%	n/a
HMO	76.1%	66.4%	52.4%	56.5%	59.9%	n/a	n/a	98.8%	n/a	n/a
Comp	74.1%	56.9%	53.5%	71.9%	67.1%	51.5%	88.3%	n/a	95.0%	n/a
ACO	63.6%	50.7%	31.1%	59.5%	69.5%	38.7%	61.7%	n/a	n/a	n/a
Secondary	67.3%	62.2%	62.4%	61.5%	33.9%	n/a	97.3%	n/a	n/a	n/a
Value	69.9%	65.9%	50.3%	74.6%	59.1%	n/a	67.2%	n/a	n/a	n/a

Collect by Plan Type	RED	BLUE	GREEN	BROWN	ORANGE	PINK	YELLOW	WHITE	BLACK	Workers' Comp
Total	60.5%	53.0%	39.8%	48.4%	46.4%	46.4%	40.6%	39.9%	52.2%	11.8%
PPO	60.7%	53.3%	38.4%	50.3%	47.8%	47.2%	40.6%	39.8%	53.4%	n/a
HMO	47.2%	37.2%	42.6%	44.6%	45.2%	n/a	n/a	46.4%	n/a	n/a
Comp	41.5%	45.9%	39.7%	51.2%	47.0%	41.1%	41.0%	n/a	34.1%	n/a
ACO	56.6%	33.0%	15.5%	42.6%	22.7%	27.2%	48.0%	n/a	n/a	n/a
Secondary	47.2%	53.7%	42.4%	41.0%	26.9%	n/a	97.3%	n/a	n/a	n/a
Value	33.8%	56.3%	35.5%	42.6%	38.9%	n/a	58.8%	n/a	n/a	n/a

Of these ten plans, negotiations have been accomplished for six of the ten to have both a PPO (Preferred Provider Organization) and an HMO (Health Maintenance Organization). This can be very valuable information since we are seeing a trend by payors to just have ONE plan for its clients and not have a series of complicated calculations that tend to confuse most companies and individuals. Having this basic information, one can conduct contract negotiations in an enhanced manner. For instance, insurance red shows a higher percentage of allowed for the HMO as for the PPO but it has a lower collectability rate.

This overall information from your own reimbursement experience can truly help to use past and current payer performance with service mix and patient volumes to focus on what areas need further measurement or identified for potential changes. This knowledge can have multiple benefits as it can assist with the negotiations associated with managed care contracts but it can also provide data driven decisions in examining costs as compared to actual reimbursement. If an organization can reduce cost in certain higher reimbursement areas then they can improve the overall bottom line. As stated earlier, this data can also assist in the design and development of a 'center of excellence' or possibly negotiate an increased reimbursement in those medical specialties where cost can be reduced.

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Does Cash Equal Performance? - The Year of Measurements

What to do next? Using these measurements and having this type of data is very useful for investigating other areas of the Revenue Cycle. For instance, shifts in payer performance and allowed/collection ratios may be an indicator of increased denials, an area that we all have to deal with on a regular basis. With the implementation of the new coding system, ICD-10 (International Classification of Diseases – 10th edition), there has been greater emphasis on specificity. All of the medical necessity diagnostic codes were changed under ICD-10 and now there must be a greater awareness of these requirements. In preparation for ICD-10, many people stated that there would be a tremendous increase in claim denials. If you have seen an increase in denials or large changes in collections, then you may want to do a 'data-dive' to address any concerns. In some cases we have seen where one payor is paying for a service and another payor is denying payment for that service even though there is the same diagnosis.

Analysis through denial reports can help to start any investigation and challenge. Some suggestions for denial reports are:

- Denials by reason
- Denials by plan
- Denials by reason and plan
- Denials by denial code by medical source
- Denials by CPT (current procedural terminology)
- Denials by revenue code and
- Denials by month to indicate any trends

Data rarely, if ever, provides a complete story and will never provide a singular solution for the complex healthcare systems we manage. Beginning a deeper dive into your own reimbursement experience and utilizing trends and comparative analysis to focus investigations into correlative reports and performance elements will increase the final results of your efforts. Data can point to many positive things in our daily operations and we should utilize this information to enhance the full revenue cycle operational flow. If you have any questions, please let us know.

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Collections of patients' outstanding bills, those charges not covered by health insurance plans, are set to challenge medical practices across the country, if they haven't already. Consequently, physicians will need to migrate toward other methods to collect patient payments, including offering online payment portals and accessibility for patients to make a single or series of electronic funds transfer (EFT) payments via ACH.

The Affordable Care Act has compelled many companies to change the healthcare plans they offer to employees in order to reduce their rising costs associated with plan implementation. Consequently, many employers have shifted to high deductible healthcare plans being offered by health insurance companies. But these plans require employees to satisfy a significantly higher level of medical costs up front, before any insurance will kick in. Today, many healthcare plans sport annual individual employee deductibles of $5,000 or even more – a high hurdle for many insured individuals.

Patient Pain by the Numbers

According to the 2015 healthcare report from the Kaiser Family Foundation, the average plan deductible is now $1,318 -- up from $917 in 2010. Adding to that financial burden for employees, premiums for single healthcare coverage have risen 27% during the past five years to more than $6,200 per year (and to more than $17,500 in annual premiums for family coverage). Notably, wages have only increased an average of 10% over that same period (2010 to 2015)

Doctors Feeling the Strain

While high deductible plans can make business sense for insurance companies seeking to reign in costs, these can pose challenges for well-intentioned medical doctors running their own businesses.

2010 data from the Medical Group Management Association (MGMA), a trade association of medical practice administrators and executives representing 385,000 physicians, shows that 30% of patients walk out of their doctor's office without paying. Medical practices were responsible for collecting $1 out of every $4 directly from patients. In July 2015, an MGMA survey found that collecting patient due balances is among the top 10 pain points for nearly 96% of doctors. Those numbers are expected to jump in tandem with patients having to pay for medical services against higher deductibles and higher out-of-pocket premiums.

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It's no longer just a matter of doctors' offices collecting traditional co-payments from patients. Although not specific to collections of medical payments from patients, data from the Commercial Collection Agency Section Commercial Law League of America shows that the probability of collecting a debt generally drops to 73% after three months, and to 50% after six months. Debt that is one year past due only has a 25% chance of *ever* being collected.

Finding Solutions: Developing an Online Payment Portal

Providers should look to expand payment option capabilities to provide more solutions for their patients. While collecting payments at the time of service is the ideal, offering broader payment options can increase payment collection. Data from MGMA in 2010 indicates doctors collect a fractional $15.77 for every $100 in unpaid patient bills once a patient's outstanding debt is turned over for collection. Physicians will need to not only retrain staff as to what to do in light of the changing landscape, but doctors will also need to consider other solutions.

Best practices for doctors can include having candid and detailed up front discussions with patients as to what any service or procedure will cost and what the out-of-pocket expenses will be for the patient. The faster a patient can get an estimated bill, the more likely he/she will be inclined to pay. Physicians who are already, or are open to, accepting the healthcare EFT standard can speed up the collections of funds from health plan providers, thereby enabling doctors to deliver an accurate bill to patients faster.

Doctors must also look at the problem more holistically and consider giving patients expanded options for paying their bills beyond using paper checks, whose usage has waned in the electronic age. This can include developing online payment portals.

For example, are credit cards currently accepted by the practice, and can patients log onto the practice's website and pay by credit card right then and there, 24/7/365? Does the online payment portal allow for a single electronic funds transfer (via an easy and quick ACH payment) from a patient's bank account? Patients have become quite accustomed to receiving ACH payments because that's how many receive their pay – through Direct Deposit via ACH. In fact, more than 80% of U.S. workers receive their pay using Direct Deposit.. Can patients who cannot pay the entire bill now set up to have a series of EFT via ACH payments periodically made to the doctor until the entire cost is paid? This option could be appealing and much less expensive to patients who may favor a direct payment series over credit card finance charges.

Moreover, ACH payments are much more cost-effective for doctors; costing an average of 31 cents per transaction as charged by financial institutions versus 3% fee for each credit card transaction. Credit card processing costs can quickly add up for medical practices, as can fees that must be paid to collections agencies to recoup unpaid money from patients. In addition, ACH payments can be just as easily executed for a one-person rural medical practice as for large multiple-doctor, multiple-office practices, making it practical for all.

Physicians who want to ensure collection of their patient revenue will want to consider alternative payment options that make sense for most patients and can cure their own collection headaches.

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The Costs of Clinical Risk

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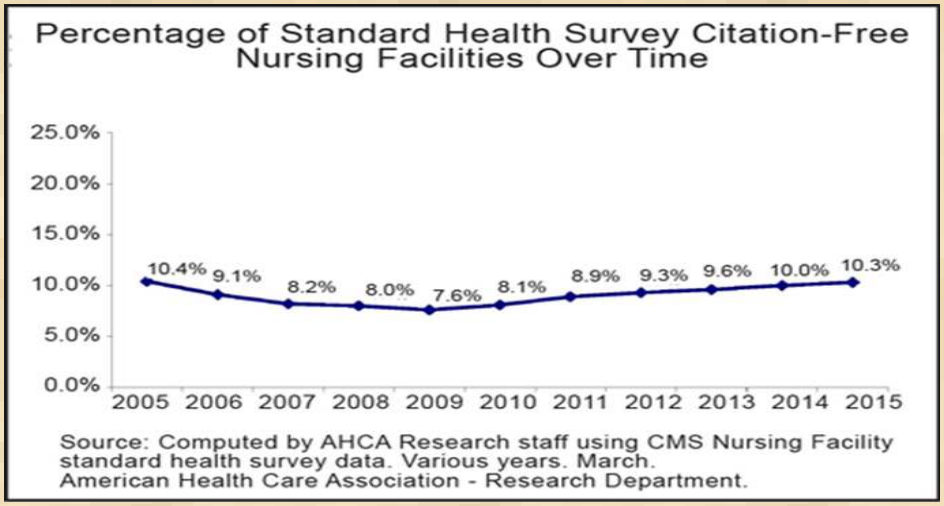
The nursing home industry has often been described as one of the most regulated industries in the country. This is not surprising, as nursing homes care for the most fragile individuals within the health care spectrum and are predominately reimbursed through government programs. The financial instability that can arise as a result of clinical and operational risk can affect refinancing efforts in various ways, which explains why risk management is a major area of focus for nursing home providers.

The high cost of risk is easily demonstrated by a quick glance at recent legal actions brought against nursing homes around the world:

- A nursing home in Tennessee was fined $1.2 million following 35 deficiencies for medication errors, dirty bathrooms and neglect of residents.
- Thirty-six nursing homes in Pennsylvania were sued by the state's attorney general's office for alleged understaffing and depriving residents of their basic needs.
- Two of the largest nursing home chains were accused of routinely billing for therapy services that were either unnecessary or not medically reasonable.

As seen in the chart below, only 10.3% of nursing facilities were citation-free in 2015. Although that number has steadily been improving since 2009, there clearly remains ample room for improvement when it comes to risk management at nursing homes nationwide.



The Costs of Clinical Risk

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The financial cost of risk not only involves expenditures related to risk remediation, as seen in the last two examples, but can require increased facility staffing or reduced service delivery which can directly decrease a facility's cash flow and ability to borrow. These are just a few examples of actual unforeseen expenses that can devastate the game plan of predictable results and financial stability for an operator.

When lawsuits against nursing homes occur, even if a civil judgment is found in favor of the nursing home, the fines associated with Centers for Medicare and Medicaid Services (CMS) citations and disputing the allegations can be detrimental to a facility's financial stability. Costs of risk include the sum total of self-insured losses, civil monetary penalties (CMPs), denials of payment on new admissions (DPNAs), lost admissions, additional staffing and legal/consulting fees as well as reputational risk through media or word-of-mouth. A proactive approach to minimizing risk should include establishing achievable goals measured by industry ratings such as the Nursing Home Compare 5-Star system, onsite reviews and third party databases. In doing so, operators should recognize, measure and monitor the areas of greatest exposure. Steps to success include:

- **Check information in the public domain**. Validate that publicly reported information for the facility is accurate
- **Be prepared**. Identify trends and conditions that lead to costly compliance and regulatory risk as well as potential litigation
- **Understand the risk and revenue spiral**. Anticipate a facility's reputational risk and the sponsor's ability to attract the most desirable patient mix including Accountable Care Organization (ACO) referrals
- **Link risk to financing long-term care (LTC) assets**. The total cost of risk is an ongoing predictive aspect and includes determining how it affects cost availability of debt.

The Costs of Clinical Risk

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Check Information in the Public Domain

By using public data sources such as Medicare.gov; investors, sponsors and principals can identify patients with high-risk conditions (such as a high likelihood to fall or develop pressure ulcers) so that appropriate care planning can take place and provide insight to assist in managing family expectations. The source document to capture this patient health information for government reimbursement purposes and acuity statistics is the Minimum Data Set (MDS) record. This is also factored into the 5-Star rating and determines the acuity and staffing ratings for their state. Despite the various critics of the 5-Star system, it is still considered the industry benchmark and providers as well as lenders would do well to understand how the scores are calculated in order to place the numbers in context. After all, these data sources are used by consumers, insurers, plaintiff attorneys and regulatory agencies for the purpose of sizing up nursing home providers.

In health care organizations, reputation is directly and positively correlated with financial success. Health care reform has increased the amount of information available to the public and requirements for transparency will provide more insight into an organization's capital structure. As ACOs are launched, reputation and results will drive referrals and facilities that don't perform will lose revenue opportunities. Not surprisingly, prospective patients and their family members are reluctant to select a health care provider with below average performance or a high number of complaints, making it critical to manage risk and mitigate non-compliance. Furthermore, referral sources, such as physicians and hospital discharge planners, have access to public information (along with word-of-mouth) for the purpose of making good placement choices for their rehabilitation patients.

Be Prepared

The time and cost of preparing for the CMS-directed State Department of Health Inspection process (approximately every 12 months) can be extensive for most facilities. The initial cost is in management and staff time, but if the survey does not go well, added costs will come from responding to citations, revising care processes, and covering consulting or legal expenses. Surely the greatest cost, although more difficult to quantify, is the business lost or reputation damaged by deficiencies.

The Costs of Clinical Risk

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Bad health inspections can strain relationships with the referring hospital, resulting in physicians that no longer feel comfortable referring new patients to a particular nursing home.

Tools are available today that enable a facility to benchmark its performance against others in its survey district or state and anticipate the next likely citation. The most popular is the Nursing Home Compare 5-Star report. It is important to dig below the surface, however, to understand what is driving the scores in the areas of health inspections, staffing and quality measures in order to put the report in context and to understand if the facility is improving or declining. Realistically, many events can be anticipated and avoided with a deliberate Quality Assurance Performance Improvement (QAPI) program to manage risk.

By utilizing public and private databases, information such as occupancy, payer mix, staffing, survey citations and quality measures can be combined with loss history to provide a quantitative model for measuring risk. Once benchmarks are established for the potentially modifiable risk factors, risk management prescriptions are developed to focus on those areas that can have significant adverse impact on the overall risk of the facility. Should an adverse event occur, remediation efforts to correct non-compliance issues can impact cash flow, causing the facility to forgo other important expenditures and ultimately perpetuating more risk.

Understand the Risk and Revenue Spiral

When risk-related adverse events occur and they are communicated to referral sources, a disruption in referral flow with a reduction in revenue can occur. The direct effect of any severe citations can be devastating to an operator’s revenue stream, not to mention a public relations nightmare. Therefore, a damaged reputation from survey deficiencies, resident complaints and poor-quality measures, whether valid or not, can have a negative impact on the cost of risk and trigger a downward spiral that can be difficult to stop. Lost revenue equates to lower investment in quality improvement programs, less money available for staff improvement, and a reduction in cash flow and the capitalization rate required to meet a lender’s conditions.

The Costs of Clinical Risk

Since staffing is the largest line item in a LTC facility's budget, this is where the axe most often falls. Some facility administrators respond to diminishing revenues by adjusting the staffing matrix from registered nurses (RNs) to less expensive licensed practical nurses (LPNs) or reducing certified nursing assistants (CNAs). Over the long term, however, these shifts will not deliver the expected savings. When facilities fail to properly staff to meet patients' needs, risk increases. It takes one claim or one citation to cancel out any expected savings from using a lower-cost staffing matrix. Inappropriate staffing also leads to turnover, which results in utilization of contract workers and discontinuity of resident care. Each of these impacts quality of care and can result in more unanticipated costs and increased risk.

Quality of Care

With nearly two million licensed beds in the U.S. and an increased national focus on the quality of long-term care, nursing homes must be diligent in assessing and improving their facilities by closely monitoring their areas of risk and greatest exposure. The total cost of risk is ongoing and includes determining how predictable trends affect future profitability. When adverse events occur, they result in fines, expenditures to regain compliance, defense costs (internal and external) and harm to the nursing home's reputation. Ultimately, when a facility gets a reputation as a provider of poor patient care, it is difficult to regain the trust of the community and maintain a consistent referral flow.

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How To Motivate Your Employees from a motivational speaker's perspective

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Stop telling me what to do.

That's data. It has not impact. It's not emotional. It has a pushing action. And I don't like to be pushed. You're selling, and I don't want to be sold. But I'm still willing to buy. If you…

Tell me why it matters.
Why does what I do here matter on a bigger scale? Give me something to believe in that's more than my job description and more than the fact that you want to make money. Tell me why it matters. Or even better….SHOW ME.

Through Story.
Instead of telling me what to do. Instead of pushing. Instead of using facts and figures and statistics, pull me in. Compel and attract my attention. Let me walk into and experience the story of how what we do matters to the world and why. For it's in the story where this data becomes emotional. It's in the story where I get to come to my own conclusion. It's in the story where I see it from all sides – where I walk into your story and my story at the same time.

Find out my story.
You have a story. And so does our customer. But so do I. I need to know that you care about my story too. That you're not just thinking about what you need or what the customer needs, but that you're also thinking about what I need – what motivates me. Give me the same attention and respect you give the customers. Show me that you value me just as much. Make

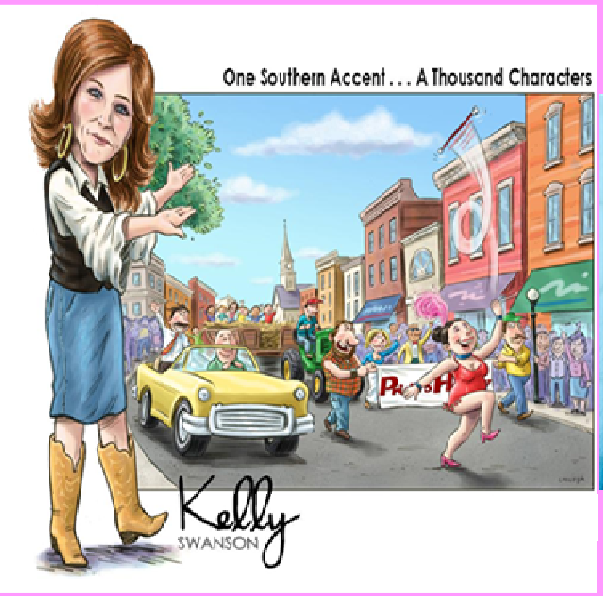
How To Motivate Your Employees from a motivational speaker's perspective

If you want to get the best out of your people – find the best in your people.

Make sure everybody is part of the story – believes in the story – embodies the story – of who you are and what you do – but even more, why you do it.

When we can make our brand story part of our customer's story and part of our employee's story – we truly have a winning combination. That is how the power of story can change the culture of your organization and truly motivate your people.

If you're still wondering how to make your people happy, you're setting yourself up for failure. Instead, focus on making them feel valued. And you do this by connecting your story to theirs.



Credit Control Corporation

Financial Receivables Specialists

Cutting Edge Technology

Results

Customer Service

SERVICES

- Bad debt collections with credit reporting options
- Medicare bad debt collections with activity documentation
- Pre-collection programs supporting patient retention
- Budget account management
- 3rd party claims filing capabilities
- Full spectrum reporting
- Secure electronic data exchange
- Multiple skip tracing resources
- Convenient IVR/Web-based payment options available 24/7
- Premier customer and client service

HISTORY

- Extensive collection & accounts receivable management services since 1953
- Experienced collection and support staff
- Flexible programs designed to meet specific client goals
- Long-term client "partnering" relationships
- Engaged management teams

For more information, please contact
Terry Fuller or Rika Gripp at 1.800.723.5463

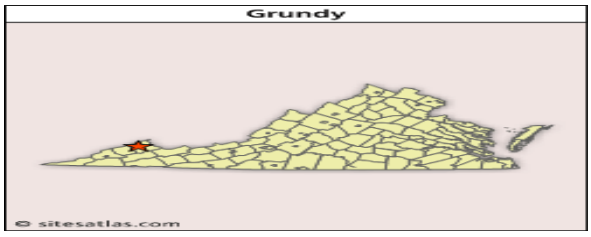
Hospital Spotlight.... Buchanan General Hospital

Buchanan General Hospital History

Since its establishment in Grundy, Virginia, in 1979, Buchanan General Hospital has provided high-quality medical care to the people of Buchanan County and the surrounding counties in Virginia, Kentucky and West Virginia. The 134-bed hospital is staffed with skilled physicians of various specialties, and employs over 300 dedicated support staff. Services include: Acute Care; Emergency Care; Cardiac Care; Cancer Care; Intensive Care; Outpatient Services; Ear, Nose & Throat Services; Physical Therapy; Respiratory Therapy; Diagnostic and Interventional Diagnostic Imaging; Nuclear Medicine; General Surgical Services.

Serving the Needs of Buchanan County and the Surrounding Area

Through the sacrifices of many, Buchanan General Hospital has provided a tradition of caring for over thirty two years; providing the best of care, close to home to the residents of this mountainous region. Being part of the community has been an important goal since our beginning in October 1979. With your help and loyalty we can continue to grow and provide even better health services on which you can depend far into the future.



Meet one of your Board Members. . . . . .

HELLO!...MY NAME IS MS LINDA

Linda Conner

VA AAHAM Treasurer

Manager, Patient Financial Services

Sentara Halifax Regional Hospital

- I grew up in . . . . . **South Boston, Virginia**
- My hobbies include. . . . . **walking and riding motorcycles**
- My favorite sports teams are . . . . . **I don't follow sports too much any longer but always cheer for Virginia teams.**
- What's an interesting fact about yourself . . . . . **I love being outside.**
- Give 2 truths and 1 lie. . . . . **I have two beautiful granddaughters. God is great, life is good and people are crazy.**

Friday is the worst day of the week.

Certification… why bother?

You may wonder why you should bother with obtaining your certification. After all, it's a lot of work—Let us enlighten you! Certification is an investment in your personal growth and your professional future.

Benefits of obtaining AAHAM certification:

- Professional development
- Individual enrichment
- Employer awareness
- Recognition by industry and build a network of connections in the elite group that shares your designation
- Personal challenge and satisfaction
- National recognition
- Recognition and access to the positions and promotions you seek and deserve

—AND—

An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

Expertise—you possess the knowledge to meet the industry's highest standards and the capacity to pass a rigorous certification examination.

Professionalism—your pursuit of excellence supports the quality of service in your career and in the healthcare industry.

CRCE-I & CRCE-P exams are considered to be the best indication of knowledge in our field. Set a goal yourself to pass the exam. It will be gratifying to prove to yourself that you can pass this difficult exam, and that your years of experience and hard work will be evident to all by the

Study guides are loaned out to members. You do not have to purchase your own study guide.

If you are interested in testing your knowledge and gaining the recognition that comes with certification, contact Leanna Marshall for additional information.

Leanna Marshall, CRCE-I

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

Virginia AAHAM offers a certification payment reward for passing the professional exam. AAHAM will reimburse the member for the cost of the exam.

Newly Certified…

First Name	Last Name	Certification	Facility
Ashleigh	Burnette	CRCS-I	Augusta Health
Soronya	Fleming	CRCS-I	Centra Health
Venus	Senior	CRCS-I	Inova Health Systems
William	Hearn	CRCS-I	Centra Health
Anthony	Montgomery	CRCS-I	UVA Medical Center
Catherine	Green	CRCS-I	Mary Washington Hospital
Judith	Robertson	CRCS-I	Mary Washington Healthcare
Lenoira	Cooper	CRCS-I	Mary Washington Healthcare
Michael	Garde	CRCS-I	Mary Washington Healthcare
Nancy	Kamenski	CRCS-I	Mary Washinton Healthcare
Nezenine	Munoz	CRCS-I	Mary Washington Healthcare
Patricia	Smith	CRCS-I	Medicorp
Phindi	Johnson	CRCS-I	Mary Washington Healthcare
Scarlett	George	CRCS-I	Mary Washington Healthcare
Heather	Haywood	CRCS-P	Wythe County Community

Congratulations!

We are proud of you!!

Certification

2016 Certification Schedule

March 14-25, 2016
March 2016 Exam Period

April 15, 2016
Registration deadline for July 2016 Exam Period

July 11-22, 2016
July 2016 Exam Period

August 15, 2016
Registration deadline for November 2016 Exam Period

November 7-18, 2016
November 2016 Exam Period

The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management

2016 Membership Application

Please enter your data below, and then send this form, along with the $30.00 annual dues to the address below to join or renew your membership with the Virginia Chapter of AAHAM.

Take advantage of these important benefits…

- Problem solving and solution sharing with your associates
- Membership directory
- Reduced fees for chapter education events
- Educational seminars & workshops
- Chapter newsletter
- Interaction & networking with peers
- Access and preparation assistance for certification tests that demonstrate your professional skills

Please enter your information below.

First Name:	Last Name:
Certification:	Employer Name:
Job Title:	Mailing Address:
Day Phone #:	City:
Fax #:	State & Zip Code:
E-Mail:	

MEMBERSHIP RECOMMENDED BY: _____

For additional information contact Linda Patry @ 540-741-1591 or via email at: Linda.Patry@mwhc.com

Please mail the completed form with our dues payment of $30.00 to the following address:

Treasurer, Virginia AAHAM
Linda Conner
2204 Wilborn Ave.
South Boston, VA 24592

-OR-

Take advantage of our online membership application and payment options. Visit our website at http://www.vaaaham.com/Membership_Application.html

Virginia AAHAM Tax ID: 54-1351774

Penn Credit

HEALTHCARE PROGRAMS

Penn Credit provides debt collection services for:

- Hospitals
- Specialty Groups
- Physician Groups
- EMS Organizations
- Long Term Care
- Home Health Agencies

Our Extended Business Office (EBO) programs include:

- Self-Pay Recovery
- Worker's Compensation Follow-Up
- Auto Insurance Follow-Up
- Commercial Insurance Follow-Up
- Managed Care Follow-Up
- Settlement of Account Balances
- Pre-Collection & A/R Clean-Up
- Charity Care Qualifications
- System Conversion Support

Dale Brumbach
VP of Client Relations
800-720-7293
dale.brumbach@penncredit.com

The Virginia Chapter of AAHAM Executive Board 2014-2015

Chairman of the Board

(Chapter of Excellence Committee)

Linda McLaughlin, CRCE-I

Director, Director Finance and Governmental Services

VCU Health System

PO Box 980227, Richmond, VA 23298-027

Office—(804)828-6315 Email– linda.b.mclaughlin@gmail.com

President

(Committee Chairperson: Nominating Committee; Accounts Receivable/Third Party Payer Committee)

David Nicholas, CRCE-I

President, Mercury Accounts Receivables Services

Office - (703) 825-8762

Email— David@Mercury.ARS.com

First Vice President

(Committee Chairperson: Membership & Chapter Development:Chapter Awareness)

Linda Patry, CRCE-I

Director, Patient Financial Services

Mary Washington Hospital

2300 Fall Hill Ave. Suite 311 Fredericksburg, VA. 22401

Office—(540)741-1591 Email– Linda.Patry@mwhc.com

Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Dushantha Chelliah

2212 Greenbrier Dr.

Charlottesville, VA, 22901

Office - (434)924-9266

Email- DC5P@hscmail.mcc.virginia.edu

Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Amy Beech, CRCE-I

Patient Accounting Supervisor

Augusta Health

PO Box 1000, Fishersville, VA 22939

Office—(540)245-7216 Email—abeech@augustahealth.com

The Virginia Chapter of AAHAM Executive Board 2014-2015

Treasurer

(Committee Chairperson: Vendor Awards Committee)

Linda Connor, CRCE-I

Manager of Patient Financial Services

Sentara Halifax Regional Hospital

Office: (434) 517-3433

Email: linda.conner@halifaxregional.com

Appointed Board Member

(Committee Chairperson: Finance Committee; Constitution & By-Laws Committee; Historical Committee)

Brenda Chambers, CRCE-I,P

Revenue Integrity

HCA - RSSC Capital Division

7300 Beaufont Springs Drive; Boulders VIII – 2nd Floor;

Richmond, VA 23225 Office—(804)267-5790 Email—Brenda.Chambers@hcahealthcare.com

Appointed Board Member

(Committee Chairperson: Certification Committee)

Leanna Marshall, CRCE-I

UVA Health System (Retired)

814 Montrose Avenue, Charlottesville, VA 22902

Phone—(434)293-8891 Fax—(434)977-8748

Email—ayden1@embarqmail.com

Honorary Board Member

Michael Worley, CRCE-I

Revenue Cycle Consultant

1807 Mount Vernon Street, Waynesboro, VA 22980

Office—(540)470-0020 Email—mworley@ntelos.net

Appointed Board Member

(Committee Chairperson: Communications Chair)

Katie Creef, CRCE-I

Director of Patient Accounting

Augusta Health

P.O. Box 1000 Fishersville, VA. 22939

Office- (540)332-5159 Email-kcreef@augustahealth.com

On the Lighter Side...by Sara Quick

There's no better time than spring to get outside, take in the sights and sounds of the great outdoors, and enjoy our beautiful state. Virginia is certainly famous for some of its beautiful countryside.

On A Lighter Note – Let's Have a Little Easter Fun...By Sara Quick

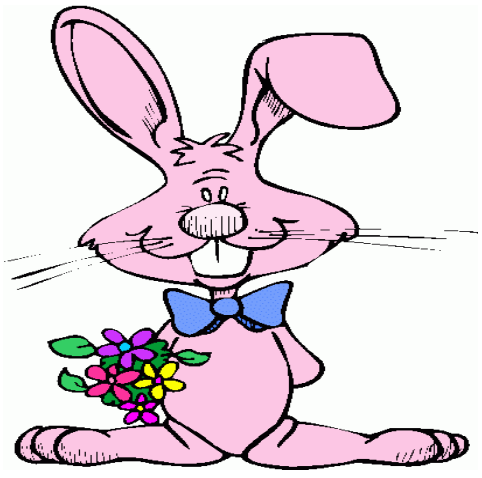
Basket
Bonnet
Bunny
Chocolates
Daffodils

Easter
Eggs
Flowers
Gumdrop
Hopping

```
      A T B H
    E B E N N U
  R F B G C G P N
N E L O G H N A G T
  A T O N S O I R N I
Y E S W N L C P A I B S
N B A E E I O P D R B F
N Y E R T D L O E P A E
U L L S N O A H K S R A
B L I P H F T U L I P S
A E L D F F E N O H P B
R J Y I B A S K E T S F
  H P O R D M U G J B
    S Y A D N U S R
      E B S T
```

Hunt
Jellybean
Lily
Parade

Rabbit
Spring
Sunday
Tulips



National News— www.aaham.org

AAHAM announced a new mid-level certification at the 2014 Annual National Institute (ANI) in San Diego, CA, the Certified Revenue Integrity Professional (CRIP). This certification is intended for individuals in the revenue cycle to help ensure that facilities effectively manage their facilities charge master, and bill and document appropriately for all services rendered to a patient. This certification requires an in-depth, working knowledge of various revenue cycle areas and proper skill sets needed to increase revenue and reimbursement for facilities. It also ensures that proper charging takes place to maintain compliance within the insurance payer programs. With the addition of this new certification, AAHAM now offers a complete career ladder, beginning with the CRCS and culminating with the CRCE.

Visit the website for more information http://www.aaham.org

Calendar of Events:

12th Annual Legislative Day

Hyatt Regency on Capital Hill, Washington DC.

April 25-26, 2016

2016 Annual National Institute Caesar's Palace, Las Vegas, Nevada

October 5-7, 2016

Stay up-to-date on Administrative Simplification and other healthcare Legislative issues of interest by visiting the National AAHAM web site:

https://www.capwiz.com/aaham/home/

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Sponsorship

—Dale Brumbach, Vendor Sponsorship / Corporate Partners Chair

Dale.brumbach@penncredit.com

Platinum Sponsorship - $1,500

- **Exhibit space available at both the May & December Conference**
- **Full-page ad in ALL newsletters**
- **Full-page ad distributed at ALL meetings**
- **Free Registration at BOTH the May & December educational conference for four (4) sponsor employees**
- **Plus much more…**

Gold Sponsorship - $1,200

- **Exhibit space available at both the May & December Conference**
- **Full-page ad in ALL newsletters**
- **Full-page ad distributed at ALL meetings**
- **Plus much more…**

Silver Sponsorship - $1,000

- **Exhibit space available at EITHER the May OR December Conference**
- **Half-page ad in ALL newsletters**
- **Half-page ad distributed at BOTH meetings**
- **Plus much more…**

The Virginia Chapter of the American Association of Healthcare Management (VA AAHAM) exists to provide or facilitate professional education, promote professional excellence, provide opportunities for sharing management strategies and tactics through professional networking. You and your organization are important to this mission. Virginia AAHAM benefits by drawing on the experience and education that you and your organization can bring to the activities and efforts of our association. Virginia AAHAM's mission also benefits from the financial support that many organizations provide. I hope that you will consider supporting Virginia AAHAM this year.

Mark your calendars!

Upcoming VA AAHAM events:

April 8, 2016– Spring Regional Conference

Charlottesville, VA.

September 23, 2016– Fall Regional Conference

Warrenton, VA.

Annual Meeting & Conference

Williamsburg, VA

December 7—9, 2016

Go to our web site for more information and registration:

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

www.vaaaham.com

Contest for Newsletter Articles!

Writers Wanted!

The Virginia Chapter of AAHAM will award **$100** to the author of the best article submitted to the Publications Committee during 2016. Submit articles to Amy Beech abeech@augustahealth.com. Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent.

This publication is brought to you through the collective efforts of the **Publications Committee**

Amy Beech, CRCE-I

abeech@augustahealth.com

Sara Quick, CRCS-I,P

squick@augustahealth.com

What is AAHAM?

AAHAM is a premier professional organization for healthcare administrative management. Our goal is to provide quality member services and leadership in the areas of education, communication, representation, professional standards and certification. Virginia AAHAM was founded in 1982 as the American Guild of Patient Account Management. Initially formed to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a based constituency of healthcare professionals.