Summer 2018 Volume 47 Issue 1

# The Virginia AAHAM Insider

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

## The President's Message

Dear Virginia AAHAM Members and Friends:

As I sit down to write this message, it's a beautiful, sunny, summer day, however not too long ago, Virginia was hit with major rain storms and record-breaking flooding. Whenever a natural disaster occurs, we hear countless stories of neighbors helping neighbors. I just love those stories, as they warm my heart and make me so hopeful for our future.

We encounter the same great stories within our AAHAM chapter. We see members networking with other members and sharing their struggles, tips and tricks to navigate through the countless regulations, systems and processes. This is what makes AAHAM great and the Virginia Chapter excels at helping others. I am so proud to be working alongside each of you!

Dushantha Chelliah and his committee have once again assembled a superb agenda that will help us tame our troubled waters...together! Please consider attending the Fall Regional Conference on Friday, September 21st, at Mary Washington Healthcare in Fredericksburg. There will be a wide array of topics presented such as: communication, bundled payments, automating claim status, contract language, as well as hearing from some of our major third-party payer representatives. This is a great opportunity to not only benefit from educational topics that are near and dear to you all, but to also connect with your peers to exchange ideas, solutions and build relationships.

The national AAHAM organization follows suit by offering the Annual National Institute (ANI) from October 17th through the 19th, in beautiful Bonita Springs, Florida. You may find the agenda at www.AAAHAM.org/AnnualNationalInstitue.aspx.
And while you are booking your calendar, please be sure to reserve December 5th through the 7th to attend the Annual Virginia Chapter of AAHAM Conference. We will be traveling to Kingsmill Resort in Williamsburg again this year! Your Board of Directors is excited to host another meeting in this fabulous location and we know the agenda will not disappoint.

I would like to close my message by offering this quote from Misha "Networking is not collecting contacts! Networking is about planting relations." Wishing you a wonderful summer and looking forward to 'planting' alongside of you soon!

Yours in AAHAM,

Lin

Linda M. Patry, CRCE-I
President, Virginia Chapter of AAHAM

Inside this issue:



The Virginia Chapter of AAHAM

American Association of Healthcare Administrative Management

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## The Heart of the Revenue Cycle

Rob Borchert, CRCE-I

Years ago, at a Maine Chapter Institute, John Currier gave a short presentation/ discussion regarding the activities of National AAHAM (American Association of Healthcare Administrative Management). During this discussion, I made the statement that HFMA (Healthcare Financial Management Association) may be the "brains" of the Revenue Cycle but AAHAM is the "HEART" of the Revenue Cycle. This is true in so many ways that I can also say that AAHAM is the heart and soul of the Revenue Cycle.

With AAHAM celebrating 50 years, it is a milestone that speaks extremely well of not only our organization but also of its many achievements. I have been a member of AGPAM/ AAHAM (American Guild of Patient Account Management) since 1981 (Wow – 37 years!) and can certainly speak to both the growth and accomplishments of this organization.

It was in 1981 that I was hired by Coopers & Lybrand (now PriceWaterhouseCoopers or PWC). I was hired in July (fourth person hired), I was assigned to implement a new computer system in a small hospital in Kirksville, MO. – Grimm-Smith Osteopathic Hospital. At that point, I knew basically "nothing" about healthcare. As a CPA and Consulting Firm, they sent me to join HFMA which I did and learned more about financial data concepts. I found out about AGPAM and joined it. At my "first" meeting, I recognized and realized that this is where I will learn the most about the "revenue cycle". I am not even sure that we used the term "revenue cycle" back then!

Well, you can imagine, I was trying to implement a patient accounting system (J.S. Data – [john sacco]) in this 75 bed for-profit hospital. Challenge "Yes" – with help "No". I met wonderful people in AGPAM and asked many, many questions. This was my "Center of Excellence" for learning the Revenue Cycle. I learned of the historical battle between registration and the business office; I learned about the historical battle between medical records and the business office; I learned about the historical battle between physicians and the business office; I learned and learned some more. Believe me, back then, the more knowledge I gained, the more I could strive to improve the processes. Actually, being from outside industry, I could see where processes were broken, where communication was lacking, and where history was more of a BLOCK than a "Stepping Stone". It was a wonderful experience.

Let me share with you some of the "experiences" and you "older folk", like me, as well as you "younger folk" can get a laugh. In those days, we did not have 'order entry' at the department level but rather key punching the charges into the patient's account. Well, since we collected charges from various departments, we decided to use color-coded charge sheets. First thing I did was to form a "Revenue Cycle Committee" for advice/ advise and consent. We all agreed that we needed a lot of communication and cooperation to complete this project on time. This was fun as we allowed (decided by historical volume) each department to pick out their own color...thus we had red for surgery (inpatient); blue for laboratory; purple for radiology; orange for outpatient surgery; black for pharmacy; shades of grey for therapies; "stickers" for medical supplies to be placed on the patient's "card" at the nurses' station and others. Each charge sheet (form) was three parts with both check off boxes and space for write-ins. First (top) copy was for patient's chart; second part (with just chargemaster codes) was for data processing; and the third part was for patient account filing. Thus, we had a process (oh, each charge form/ticket has a number on it for inventory and accountability purposes.) Each department was sorted and considered a batch. Batches were processed, and the system posted charges to each patient account. Form numbers were also entered to keep track of inventory...this became extremely important regarding medical supplies and pharmacy. Audits were conducted quarterly. In fact, in the beginning [after implementation] I stood at the entrance to the cafeteria and sent every nurse back to his/her station if they showed up with "stickers" on their uniforms.

## The Heart of the Revenue Cycle Rob Borchert, CRCE-I

They had to go back and place them on the patient's charge card. All in all this was hard work but very rewarding I tried to make it as much fun as possible. I actually was assigned this hospital project the end of July 1981 and the task was to fully implement the system by December 31, 1981. Well, we were about one week late, but we did it. In fact, my revenue cycle team gave me a belated Christmas present...a real bull whip and said that they had never worked so hard in their life (I still have the whip).

From that wonderful beginning, I was fortunate enough to go to an IBM conference in Atlanta, GA and actually meet John Sacco, the founder/writer of J.S. Data. We became friends and he recommended me to his clients, both new and old. We shared some wonderful experiences. Along with this, I kept going to the AGPAM meetings and learning and sharing. I began speaking about my experiences and in time became a Board Member and eventually President of the Missouri Hawthorn Chapter. It was a privilege and an honor to work with fellow AGPAM members and to attend the National Board meeting. Many of the awards given today are named after fellow National Board members who gave so much of themselves to this organization as well as to the healthcare facilities they served. I continued to learn more and more about the revenue cycle and during this time, the term 'revenue cycle' became the best expression of what a patient account manager really needs to do, namely, manage the full revenue cycle from the beginning (including communications with physicians' offices) and the final resolution of an account. It is also around this time we changed the name to AAHAM indicating the recognition that we do more than just handle a patient's account. Great change...more meaning; just like changing CPAM (Certified Patient Account Manager) to CRCE (Certified Revenue Cycle Executive) and other certifications achieved through AAHAM.

Now, back to a little history. After the full implementation of the new patient accounting system and one year later...this 75 bed for-profit (owned by physicians) achieved an additional (and continual) cash flow of $2 million dollars. This a result of collecting ALL of the charges from the new processes put into place. Needless to say, the physicians were very happy and wanted me to stay on-site. To this end, I assisted (with the help of both the Revenue Cycle team members and other PWC staff) to fine-tune the patient accounting system processes, enhance the Chargemaster, build a medical record system; build a physicians' office scheduling/registration and patient accounting system and other smaller projects.
With the federal government implementing the new inpatient DRG (Diagnosis Related Group) reimbursement system, I was able to actually use the CCR (Cost to Charge Ratio) process (from the accounting side of the house) and generate inpatient bills that indicated the departmental costs to their specific charges. This helped to identify both departments and physicians in their service offerings to patients and indicated both higher and lower CCRs to the actual DRG payment. This was accomplished before the actual date of October 1983 implementation of the new inpatient reimbursement system so that the hospital could address any overage areas to reduce any potential loss. Funny story which may have happened to some of our older readers. After the implementation of DRGs, the

## The Heart of the Revenue Cycle Rob Borchert, CRCE-I

patient would still receive an itemized bill of services rendered. The Medicare patients also received an EOB (Eligibility of Benefits) document indicated the amount of billed charges from the hospital and the reimbursement from the government to the hospital. Well, one day an elderly lady came in with both her itemized bill from the hospital and the EOB from Medicare. It seemed that the itemized billed charges showed a total dollar about of $8,550 and the EOB showed a reimbursement of $10,000. The elderly lady came into the business office to get her "refund". I was present at the time and the wonderful person in the office who met with her called ME to fully explain why she would not be getting her refund. In the beginning of the DRG reimbursement system, there were a lot of questions regarding underpayments and overpayments especially in the full accounting process, never-mind Medicare patients.

During 1983 and 1985, I had a number of different assignments with PWC including the 'take-down' of the McAuto system at Buffalo General Hospital in Buffalo, NY. This was/is a 1200 bed hospital with large associated physician practices and a monthly cash flow of about $10 million (at the time). Well, I had a wonderful team of people both client staff and PWC staff and managed this take-down very well. In fact, one month we collected almost $14 million dollars and I (PWC) threw a party for all registration, medical records and patient accounting staff at the Hilton with a great Disc Jockey, food and drinks. Both the Chief Financial Officer and the Chief Executive Officer showed up and congratulated everyone for a great job and to keep up the great work. What a night! What a memory! When people work together and processes flow correctly, it is fun every day to go to work.

After 37 years, I can still say the same thing. In fact, my wife says that my work in the revenue cycle is the 'mistress' that she can not compete with. However, I am now so old that I don't know what I would do with a mistress. Truly, I have been blessed by working in the revenue cycle in all healthcare facilities that bill third party carriers. I have worked in large multi-hospital systems, university based systems, community hospitals, critical access hospitals, all types of physician groups, skilled nursing facilities, military treatment centers for the Department of Defense, veteran affairs hospitals for the Department of Veteran Affairs, and various support companies like transplant medication companies, medical supply companies and you name it. Not retired as yet, I still serve at "my client's request" so if you would like to be my client, just call me. I have also been privileged to be a writer for the national magazine, The Journal, and for local chapters when they ask. I have given many presentations at many Annual National Institutes as well as local chapters across the country. I respond when you call!!!!!

Thank you AAHAM for many wonderful years and experiences. Thank you for all of the wonderful and talented people that I have met and whether you are retired or still working, keep up the great work that you all do in the "REVENUE CYCLE".

Sincerely,
Rob Borchert

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# Legislative Day Update

Brenda Chambers, Jack Pustilnik and Mary Prendergast represented the VA AAHAM Chapter in March in Washington, DC for AAHAM's annual Legislative Day.

They met with Senator Warner and Senator Kaine's office as well as a few other congressman and senators in VA. They were lobbying for 340B, which affects 22 hospitals in Virginia.

We are hoping their effort and the efforts of national will help to keep this going in VA Senator Kaine is on the HELP subcommittee which had that hearing 2 weeks ago about 340B. Kaine's team is well versed in 340B and the OPPS final rule. They will not introduce a bill on the Senate side, but they are 100% in favor of protecting 340B and will use upcoming hearings to voice his support. That being said, if we have some helpful intel from the senate side regarding others who may be supportive of legislation we can forward that to our contact. He also said to forward him any helpful information to further educate on the finer points of 340B.

Senator Warner is also very much in the know of 340B and the OPPS rule. They don't want to push legislation because of the fight over legislative authority over regulatory authority, feeling that HRSA already has power to affect the OPPS.

Both Kaine and Warner want to see greater transparency.

# Using Advanced Analytics to Get More from your Follow Up Staff

By Peter Angerhofer and Jeff Means, Colburn Hill Group

Most PFS directors are familiar with productivity benchmarks, which generally suggest something between 40 and 60 follow up touches per day for follow up staff. While these benchmarks can highlight when staff are falling below those standards, they fail to help improve outcomes in three fundamental ways:

1. They don't give staff (or managers) any insight on how to reach the benchmark
2. They don't speak to the likelihood of collection on the accounts that staff are working
3. They don't measure the quality of the actions performed by the staff when they do touch an account.

By deploying some analytical horsepower to their AR before accounts get assigned, hospital revenue cycle managers can improve productivity, present the right claims to their follow up staff, and maximize follow up quality to realize the highest return on the labor cost related to follow up. The result is lower absolute levels of AR, "cleaner" AR where the true value is easier to evaluate, and ultimately more cash collections.

## Pulling the Right Levers

To understand the levers that can improve follow up performance, it is first valuable to think about the goals of follow up and some of the building blocks that make up a successful PFS operation.

The goal of any PFS operation is simple enough -- maximize collections, while minimizing cost to collect. But too often, managers assume that those outcomes and costs are nearly fixed – that improvements will not fundamentally change results. As a result, they seek incremental, marginal changes in the thought process. But breaking down the components of follow up brings radical, step function process improvements into focus.

Our research indicates that roughly 40% of total AR volume at an average provider has no cash value. It is made up of inappropriately posted contractuals, claims that have passed filing or appeal limits, or denials like bundling which will not be paid. While the posting process is intended to adjust many of these balances to zero, complexities with payer remits, takebacks, and inconsistent use of denials codes leave these balances open. Improvement in the posting process can reduce the frequency of these issues but is unlikely to remove them altogether.

A large segment of claims in most provider AR -- roughly 25% -- has a collection opportunity but requires only a very simple action. For example, posting issues or partial denials can mean that claims stay in the primary financial class even after payment is complete; the simple step of moving the balance to the next payer or to the patient can start the payment process. Another common problem comes when a claim bills out of the patient accounting system, but never reaches the payer, failing in the bill editor, the clearinghouse, or even within the payer adjudication system. Resolving the failure or even simply rebilling the claim is usually enough to get the claim on the path to payment.

Commonly, a claim in either of these categories will require staff time to resolve. Each time one of these claims shows up on a worklist, staff need to spend time researching the claim – understanding the billing and follow up history, determining why it hasn't paid, and evaluating potential next steps. Only when that process is complete can staff *actually start working* the claim, creating value by either collecting on or adjusting the balance. Given a generally accepted average of approximately 10 minutes to work a claim, staff are likely to use 6-8 minutes of that time in the research phase and only 2-4 taking the actual steps that create value. That means at least 60% of the time, staff activity is not directly adding value.

## Where Staff Create Value

Whether the claim has a collection opportunity or not, and whether staff spend 10 minutes or 2 minutes creating value, that effort counts towards productivity. If 60% of staff time is research and not action, and if at least 40% of claims have no value and action and another 25% have minimal value, it means only 14% of the actions taken by follow up staff provide substantial value.

**See Exhibit 1**

To improve outcomes and generate more cash at lower costs, PFS shops should seek approaches which focus staff time on the High Value category and deemphasize the No and Low Value categories. In fact, most managers and more workflow tools have adopted this approach already. Organizing work queues by balance and age is an effort to achieve this goal, but it only provides the most basic benefits.

An advanced, more robust version of that effort would shift staff time away from the non- collectable and simple claims to put more focus on those with real collection opportunities.

**See Exhibit 2**

The goal of those analytics should be to 1) route the right claims to staff to be worked, and; 2) help staff work them in the most efficient and efficacious manner possible.

Using analytics, we have seen clients segment their AR into four distinct categories:

1. Non-Collectable
2. Simple Claims
3. Analytics Suggestions
4. Complex Claims

First, the analytics identify claims with no collection opportunity. Using automation, these claims are adjusted off to the appropriate writeoff or contractual codes. The use of automation eliminates almost all staff time previously devoted to this simple administrative task.

Similarly, where analytics indicate a simple task (like rebilling or changing a financial class) is the appropriate next step in the collection process, automation can take those actions. In Non- Collectable and Simple Claims, automation can eliminate 65% of the effort required of follow up staff.

The third and fourth categories are subsets of the complex claim categories. Advanced analytics can be used to determine the appropriate next steps and offer analytically driven suggestions. Our experience with clients demonstrates this correlates to roughly 25% of claims. By providing analytic insight into the reasons for non-payment, this process allows staff to minimize the time they spend researching a claim and move rapidly to the action phase. Our experience indicates that the use of advanced analytics can focus up to 80% of staff time on actions as opposed to research. These analytics can also improve staff productivity by grouping accounts with similar next steps and thereby allowing staff to move quickly through claims with similar problems and solutions.

Unfortunately, in 10% of cases, the analytics cannot provide any additional insight and staff are forced to work those Complex Claims in the same manual process as before, devoting most of their time to research.

## 400% Improvement in Follow Up

By eliminating staff time spent on claims that can be automated and minimizing the research component on the remaining claims,use of analytics can shift the time allocation of staff from only 14% high value time to nearly 70% high value time, more than quadrupling their efforts!

By eliminating the low value touches and providing an intelligent work queueing process, advanced analytics can provide a roadmap for managers and staff attempting to reach benchmark productivity standards. Analytics can also make those touches more valuable by making sure that staff time is focused on claims with real collection opportunities. And whether through automation or analytical suggestions, managers who deploy advanced analytics can provide improve the quality of staff time by ensuring consistency and standardization of outcomes. And each of those improvements will contribute to more cash and lower AR days, allowing providers to meet or even exceed their own operational benchmarks.

*Colburn Hill Group provides consulting and tech-enabled solutions to hospitals and large physician organization, addressing pain-points across the revenue cycle.*

Exhibit 1

| Type of Account | Time Allocation | Action | Research |
|---|---|---|---|
| | | 40% | 60% |
| Non-Collectable | 40% | 16.00% | 24.00% |
| Simple Claims | 25% | 10.00% | 15.00% |
| Complex Claims | 35% | 14.00% | 21.00% |
| | | | |
| | | No Value | 76.00% |
| | | Low Value | 10.00% |
| | | High Value | 14.00% |

Exhibit 2

| Type of Action | Type of Account | Volume | Time Allocation | Action | Research |
|---|---|---|---|---|---|
| | | | | 0% | 0% |
| Automated | Non-Collectable | 40% | | 0.00% | 0.00% |
| Automated | Simple Claims | 25% | | 0.00% | 0.00% |
| | | | | | |
| | | | | 80.00% | 20.00% |
| Manual | Analytic Suggestions | 25% | 71% | 57.10% | 14.30% |
| | | | | 40.00% | 60.00% |
| Manual | Complex Claims | 10% | 29% | 11.40% | 17.10% |
| | | | | | |
| | No Value | 31.40% | | | |
| | High Value | 68.60% | | | |

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Contact: Matthew Hundley -
Certification Director
703-281-4043 x 3
matthew@aaham.org

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American Association of Healthcare Administrative Management
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1968 - 2018

For Immediate Release:
June 3, 2018

Steven Ellinger Earns AAHAM Certified Revenue Cycle Executive - Institutional Designation

Washington, DC - The American Association of Healthcare Administrative Management (AAHAM) has awarded **Steven Ellinger**, the prestigious designation of **Certified Revenue Cycle Executive - Institutional (CRCE-I)**. The CRCE-I certification signifies that Steven Ellinger has completed a rigorous professional competency examination addressing the complex areas of Patient Access, Billing, Credit & Collections, and Revenue Cycle Management.

By achieving the CRCE-I designation, individuals demonstrate that they possess not only the knowledge base required to pass the 8-hour examination but also a dedication to excellence and the advancement of their profession. This level of knowledge and commitment is highly valued by healthcare executives and certification is frequently a pre-requisite for patient account management positions.

Successful management of the revenue cycle operation is critical for the financial well-being of a healthcare institution, clinic or physician's office. A mark of excellence for more than 30 years, the CRCE-I (Certified Revenue Cycle Executive - Institutional) certification process measures the technical and functional knowledge necessary to achieve this success.

To maintain AAHAM Executive certification, Steven Ellinger will be required to earn 40 continuing education units every two years in activities such as attending educational seminars, authoring articles and giving presentations, and coaching others for certification exams.

AAHAM is a national association of more than 2500 healthcare administrative management professionals with 31 chapters across the U.S and in India. A resource center for information, education and advocacy, AAHAM is the premier professional organization in healthcare administrative management, providing education, communication, professional standards and certification.

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# Woodrow Samuel Scholarship

## Woodrow Samuel Annual Scholarship Application

### Purpose:

The Virginia State AAHAM Scholarship Award was established with the primary purpose of educating its membership in the management of health care receivables. As the chapter increased in membership and cash equity, the concept of a scholarship program was initiated by the Executive Board of Directors and was first offered in the fall of 1987. The Executive Board of Virginia AAHAM has continued to make the scholarship program available as it is believed educational funds are a benefit to individual members, the Chapter, and dependents of our members. In 2007, the name of the scholarship was changed to the Woodrow Samuel Scholarship Award to recognize a lifetime member of the VA State AAHAM organization. A maximum of $1,000 scholarship award will be given.

### Eligibility:

Eligible nominees must:

- ☐ Be a Virginia AAHAM member or a child of a Virginia AAHAM member as of January 1 of the current year.
- ☐ Eligible nominees can apply for the scholarship award on an annual basis.
- ☐ Members must be employed full time in a healthcare related field and dependents must be enrolled in an accredited college or school.
- ☐ Chapter dues of the member must be paid prior to the acceptance of requested scholarship applications.
- ☐ Classes taken must be taken during the current school year.

### Nomination Procedure:

Nominees must:

- ☐ Complete the application form
- ☐ Include at least one letter of reference.
- ☐ Include or attach any documentation you would like to have considered.
- ☐ Include an essay on why winning the scholarship is important.

### Submission:

The form will be completed and returned to the address listed at the end of the application. This application will be postmarked no later than January 30th of the year the application is submitted to the Virginia State AAHAM Scholarship Chairman. All application materials and supporting documentation will be reviewed by the Virginia State Scholarship Committee. After all applications are reviewed, the applicant will be notified if they have been selected as a Scholarship recipient by the Chair of the Scholarship Committee.

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# 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 or make a promise to 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 CRCE-I/CRCE-P designation after your name.

The webinars that were held on credit & collection; Patient access and Billing are out on the web site.. Also a practice test is out there and the power points from the three webinars are on the web site. You have to be a Va AAHAM member to access this information. If anyone needs help with studying to contact me by e-mail ayden1@embarqmail.com or 434-293-8891 or 434-962-8508

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

Charlottesville, VA 22902

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

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# Certification

## 2018 Certification Schedule

**March 12-23, 2018**
March 2018 Exam Period

**April 18, 2018**
Registration deadline for July 2018 Exam Period

**July 9-20, 2018**
July 2018 Exam Period

**August 15, 2018**
Registration deadline for November 2018 Exam Period

**November 5-16, 2018**
November 2017 Exam Period

**December 19, 2018**
Registration deadline for March 2019 Exam Period

The Virginia Chapter of
AAHAM
American Association of Healthcare Administrative Management

## 2018 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
- Access and preparation assistance for certification tests that demonstrate your professional skills
- Educational seminars & workshops
- Chapter newsletter
- Interaction & networking with peers

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

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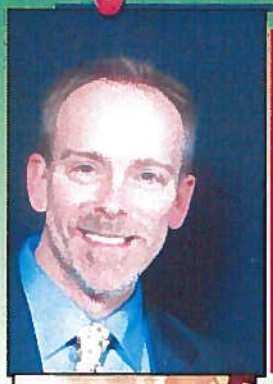
# Virginia AAHAM Executive Board 2018-2019



## Chairman of the Board

(Chapter of Excellence Committee)

President, Mercury Accounts Receivables Services

Office - (703) 825-8762

Email– David@Mercury.ARS.com

## President

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

Linda Patry, CRCE-I

Director, Patient Financial Services

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## First Vice President

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

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(Committee Chairperson: Education Committee; Government Relations Committee)

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## Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Pam Cornell, CRCE-I

Manager, Patient Accouns Billing and Follow Up

Mary Washington Healthcare

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# Virginia AAHAM Executive Board 2018-2019

## Treasurer

(Committee Chairperson: Vendor Awards Committee)

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Manager of Patient Financial Services

Sentara Halifax Regional Hospital

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Email: linda.conner@halifaxregional.com

Appointed Board Member

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

Revenue Integrity

HCA - RSSC Capital Division

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Appointed Board Member

(Committee Chairperson: Certification Committee)

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# Virginia AAHAM Executive Board 2018-2019

**Appointed Board Member**

**(Committee Chairperson, Sponsorship Committee)**

**Thomas Perrotta**

**Vice President of Client Relations, CCCO**

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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. I hope that you will consider supporting Virginia AAHAM this year. —***Dale***

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**Mark your calendars!**

**Upcoming VA AAHAM events:**


**2018 Annual Meeting and Conference, Williamsburg, VA.**

**Dec. 5-7 2018**

**Go to our web site for more information and registration:**

The Virginia Chapter of AAHAM
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## 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.

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