Winter 2018 Volume 49 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:

There is a time in December where many of us reflect upon the past year's accomplishments and plan for the new year ahead. Today is my time to do that. As I look back on our chapter's successes during 2018, I am reminded of the great educational offerings, wonderful peer networking and fun comradery we experienced this year. Our recent annual December meeting in Williamsburg incorporated all of this and more. I was pleased to hear so many positive comments about the speakers, topics, venue and the food. My thanks go out to the entire Board and to you, our members and friends, for attending, sharing and participating. A special "thank you" goes out to our Sponsors who make this all possible. Without them, we would not be able to bring you top notch education at a reasonable cost. *Merci beaucoup!*

Looking forward to 2019, I am happy to say that our Education Committee, lead by Dushantha Chelliah, has done an outstanding job at lining up our conference dates, venues and many speakers. We begin the year on March 7th with a wine tour followed by our Spring conference on March 8th, both in Charlottesville. On May 16th, we are delighted to partner with HFMA on a joint venture at Inova Fairfax Hospital. On September 6th, we travel back to Mary Washington Healthcare in Fredericksburg for our Fall conference and finish off the year at Kingsmill Resort in Williamsburg on December 4th through the 6th. We look forward to seeing you all at these events!

Your Board of Directors is pleased to be able to partner with HFMA, not only in May, but also on January 24th for a networking event. Please join us at Sedona Tap House in Fredericksburg for an informal, post-holiday get together at 5:30 pm. As you can see, 2019 is looking to be another wonderfully successful year for Virginia AAHAM.

How about you? What are you reflecting on today? What are you planning for in 2019? Whatever you are thinking about right now, please remember to be good to yourself. Don't dwell on what you cannot change. Plan for new challenges, opportunities, friendships and by all means, schedule some fun into your schedule. And remember, "You are never too old to set another goal or to dream a new dream." – C.S. Lewis

Merry Christmas, Happy Holidays and a Happy New Year to each of you. I look forward to seeing you in 2019!

Yours in AAHAM,

Lin

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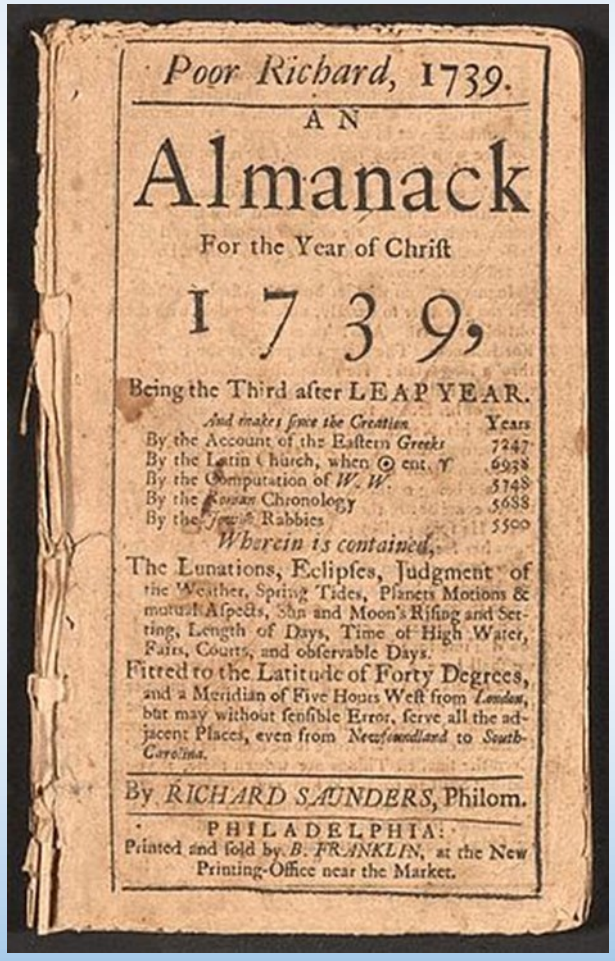
INTERIM MANAGEMENT

Peter Angerhofer



Poor Richard, 1739.

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Almanack

For the Year of Christ

1739,

Being the Third after LEAP YEAR.

And makes since the Creation Years

By the Account of the Eastern *Greeks* 7247

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Wherein is contained,

The Lunations, Eclipses, Judgment of the Weather, Spring Tides, Planets Motions & mutual Aspects, Sun and Moon's Rising and Setting, Length of Days, Time of High Water, Fairs, Courts, and observable Days.

Fitted to the Latitude of Forty Degrees, and a Meridian of Five Hours West from *London*, but may without sensible Error, serve all the adjacent Places, even from *Newfoundland* to *South-Carolina*.

By *RICHARD SAUNDERS*, Philom.

PHILADELPHIA:

Printed and sold by *B. FRANKLIN*, at the New Printing-Office near the Market.

Make sure there's nothing *fishy* about your Interim Managers

Writing in *Poor Richard's Almanack*, Benjamin Franklin is credited with coining the phrase, "Fish and visitors stink after three days." Like fish that begins to rot, having a houseguest for an extended period can be a challenge. New patterns of activity, sharing bathrooms or the TV remote, and just having somebody else puttering around in your kitchen gets old, and quickly.

In managing a revenue cycle, it often becomes necessary to invite in an extended houseguest – an interim manager. Prolonged illnesses, delays in filling vacancies, or short term projects can create the need for additional managerial experience. When that need arises, an internal candidate may not be available and if the need is great enough, many organizations look outside for short term help.

Like any houseguests, interim managers bring baggage, but they can also bring fresh perspectives and can inject new energy into an organization. In case you have the need for interim management, we'd like to offer some thoughts about the responsibilities of the houseguests who are about to set up shop in your spare room, about the downsides of interim management, and about how you can maximize the benefits you might get from an interim management role. With the right approach your interim director can come out smelling like a rose!

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INTERIM MANAGEMENT

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The primary responsibility of an interim manager is to take direction from leadership and execute those goals faithfully. Most often, that will mean just keeping the trains running on time. Staff scheduling, time cards, staff reviews, regular reporting, and communication with outside stakeholders will often tie up a large portion of the manager's time. But there may be other organizational priorities that need to be high on the list as well. As long as the communication of those goals is clear, the interim role should be focused on executing the tasks assigned by the leadership.

But an interim manager should also be frank about the state of the organization. It is certainly not always the case, but organizational turnover can be a sign of instability or disarray in the organization. If performance was poor under the now departed manager, there is no reason to expect it will magically get better under an interim and both sides in an interim relationship should be prepared to provide clear and honest evaluation, prepared to both speak and hear potentially hard truths.

And in that sense, the interim manager should be identifying opportunities for improvement. Recommending a multi-year implementation of a new system may not be feasible, but a good interim manager will identify opportunities that are within the scope of the role and within the timing of the role (or at least close to it.) Too many organizations largely promote from within, which creates a stale pool of ideas. A good interim manager can stir the pot of ideas and provide insight from other organizations.

Finally, whether it is related to a performance improvement effort or just day-to-day operations and whether it is imminent or at some unknown point in the future, an interim manager should be preparing for transition. For example, documenting processes during an interim period can provide a huge head start for the next permanent manager. Where specific decisions are made, capturing the thought process for the decision, perhaps along with alternatives considered, helps create an institutional history that can be passed along to future managers.

A good interim person will faithfully execute your priorities and perhaps add a few of his/her own, but bringing in an interim manager is change, and change can be a traumatic. **Without a doubt, interim roles come with costs.**

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The first and most obvious downside is financial cost. Chances are an interim person will cost significantly more than the person they are replacing. If you can find local talent with the flexibility to work in an uncertain role, you may minimize that difference, but in any case the incremental cost is likely to be material.

Those costs may not come just in direct outlays of cash. An interim manager is likely to need support and training in *your* processes -- some from the managers and staff below him/her, but also from executives above. A new houseguest won't know where you keep the sugar or the lawn mower and a new interim will likely come with little institutional knowledge or memory, only a shallow understanding of the politics and culture, and a set of priorities that may not match with other preferences across the organization.

The good news is that if you have chosen your interim manager wisely, those costs can be *more* than offset by the benefits. As a purchaser of interim services, there are a few ways you can improve the cost/benefit relationship.

As mentioned above, the interim manager is likely to come with his/her own ideas and initiatives, informed in part by successful operations in other organizations. Unburdened by institutional inertia ("But that's how we've always done it…") or past failures ("We tried that once…") an interim manager may be able to break through in ways a permanent manager would find difficult. Giving him/her the approval and standing to bring those ideas to life – to identify opportunities and pursue them – can greatly enhance the return you get from your investment.

For example, department budgets often get stale. A budgeting process often consists of "take last year's budget and add 5%." Or perhaps more often, cut 5%. But an interim manager affords an opportunity to revisit the budget with fresh eyes. In one recent interim role, we decided to review every line item in a departmental budget. We identified not only poor invoice approval/retention processes and overpayments, but also highlighted quick insights into cost saving opportunities, potentially improved contract terms, and previously undetected performance concerns. As a result, the client realized over $100k in annual budget reduction, $75k in returned overpayment and pointed to internal performance issues costing the client $48k annually in additional eligibility services. These savings alone more than paid for the interim costs.

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But new ideas and perspectives are just one source of performance improvement. In addition to the day-to-day management, make certain a handful of improvement opportunities are part of his/her core goals. Not only will these improvements help finance the additional cost of bringing an interim resource on board, but will also help the interim manager integrate into the permanent team – nothing breaks down barriers and builds relationships faster than work toward a shared goal.

If you have chosen an interim manager through a consulting firm or placement agency, you may be able to leverage related resources above and beyond the actual interim manager. That might mean formally engaging more resources, but it can also take the form of asking for advice or for some specific expertise. In most cases, if the expertise exists in the organization, the firm will be happy to provide a few free hours, either in the hope of selling more work or just as a way to sweeten the existing relationship.

Finally, a hard to quantify, but very real, benefit is executive leverage. A high caliber interim manager is likely to bring experience working at a strategic level. Executive experience means they may be able to offer insight and take on responsibilities that a permanent manager might find more difficult to handle, either because of competing demands on time and attention or internal politics. A high caliber interim manager may be well suited to represent and/or take on assignments previously reserved for more senior staff.

A managerial vacancy is never an easy situation, but too many organizations approach it as a rough patch that they "just have to get through" instead of seeing it as an opportunity. Bringing in an outside resource to fill a role can bring new ideas, can break down historical barriers, and can provide even greater coverage for the executive team. But organizations need to prepared for all the costs of such an effort, including the need to support the individual as they integrate with the rest of the organization.

If the individual is seen as a resource, and not an interloper, and if they are given the opportunity to make real change, rather than just seen as a caretaker, interim managers can provide significant benefits and even a positive ROI during a period of transition that otherwise might just be seen as a stretch of higher than normal costs. No matter the length of their stay -- whether for 3 months, 3 weeks, or 3 days, an interim role doesn't have to stink.

Peter Angerhofer is a principal at Colburn Hill Group www.colburnhill.com; he brings deep experience in operations, strategy and health policy to both the daily operations as well as long-term vision. Peter moves easily from working with line staff on performance improvement to C-suite discussions of strategic imperatives. Prior to forming Colburn Hill, Peter had been part of the original, pre-revenue start-up team of eight at Accretive Health, where he spent 10 years managing operations. Prior to Accretive, Peter worked for Deloitte Consulting and CSC/APM, as well as serving in health policy roles on Capitol Hill.

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Revenue Cycle Oversight of Vendors

Thomas D. Perrotta, CCCO

As a medical Provider, vendor oversight and auditing are key responsibilities.

Every year, the Consumer Financial Protection Bureau's (CFPB) level of scrutiny seems to be increasing. Like many internal vendor management programs which are in a state of various maturity levels, so too is the fashion by which the CFPB approaches the topic of oversight.

CFPB Guidance

The CFPB has not provided detailed requirements for managing third-party risk management. It has, however, highlighted conduct which fails to meet its expectations on a variety of vendor relationship issues, including nondisclosure agreements, confidentiality, auditing rights, vendor training, and others. Following however are some general guidelines for vendor risk management:

> To limit the potential for statutory or regulatory violations and related consumer harm, nonbanks should take steps to ensure that their business arrangements with service providers (vendors) do not present unwarranted risks to consumers. These steps should include, but are not limited to:

- Conducting thorough due diligence (audits) to verify that the vendor understands and can comply with Federal consumer financial law;
- Requesting and reviewing the vendor's policies, procedures, internal controls, and training materials to ensure that they are conducting appropriate training and oversight of employees or agents that have consumer contact or compliance responsibilities;
- Including in the contract with the vendor clear expectations about compliance, as well as appropriate and enforceable consequences for violating any compliance-related responsibilities, including engaging in unfair, deceptive, or abusive acts or practices;
- Establishing internal controls and on-going monitoring to determine whether the vendor is complying with Federal consumer financial law; and
- Taking prompt action to address fully any problems identified through the monitoring process, including terminating the relationship where appropriate.

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Compliance Management System (CMS)

To manage your third-party vendors well, it is important to take a strategic approach. These vendors are part of the life cycle of your company, and they represent you to your internal and external customers. That's why each organization must incorporate good risk management processes into its Compliance Management System (CMS). To do that, following are some "best practices" that facilitate successful vendor risk management.

- Match your vendor management model to the resources and structure of your organizational needs – How will you orchestrate vendor management? Will it be a centralized, internal resource, or decentralized throughout the organization based on departmental or division needs?
- Categorize existing relationships according to the role their services play in your organization– Collect information about all contracts already in place to ensure total coverage and determining any overlaps;
- Establish a selection process – Implement a standardized approach to vet and record information about each potential or current vendor.
- Maintain an on-going record – Beyond the initial vetting, implement a periodic review process that is triggered by specific events – renewal, key management or ownership changes, annual review, or others;
- Take a 'project management' approach – Evaluate the efficiency and cost-effectiveness of vendor relationships so you can make good decisions about maintaining the relationship or making a change when the opportunities arise; and
- Define the relationship parameters from the start – For long-term success and to preclude missteps, define the roles and responsibilities of the parties up front.

In addition to the above, it is also important to note that vigilance over and compliance of Protected Health Information (PHI) and Personal Identifiable Information (PII) is at the forefront of concern of many government regulatory agencies. This protection also includes the development, maintenance, and distribution/transmission of patient information.

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Vendor Auditing

A sound vendor audit provides answers to some very important questions, such as:

Is your vendor in compliance of your contract and Business Agreement (BA)?
Does your BA require updating to ensure compliance?
Can your internal processes use updating/improvement to strengthen internal and external compliance?
Do your remediation procedures help solidify your vendor relationships?

The word "audit" can be scary; however, they are essential to effective oversight. With that in mind it is always wise to remember the adage that says, *"expect what you inspect."* I didn't realize how important these words were until I managed a collection agency and had important regulatory and other oversight responsibilities. The only way to manage all facets of each department was to establish Key Performance Indicators (KPI) and audit the results regularly. This enabled our management team to constantly make the adjustments and decisions necessary to improve our services to our clients.

The following are key elements that comprise a strong framework for a proper vendor audit:

- First to decide the 4 W's (Why, What, When, and Where)
  - ◊ Why is the audit necessary?
  - ◊ What are we going to audit?
  - ◊ When or how often are we going to audit?
  - ◊ Where will the audit take place?
- Gather your key people and develop your audit topics
- Set time and place for the audit
- Conduct the audit
- Summarize areas of concern found in the audit
- Meet with vendor(s) to go over audit results
- Develop a remediation plan and establish a time frame to correct areas of concern

Follow-up and make sure remediation have in fact corrected identified areas of concern

Each facility is responsible for their risk management decisions. This places a premium on making compliance expectations clear to vendors. Below are some "best practice" areas to audit:

- Are Contract & Business Agreement's in compliance?
- Do collection vendors have proper state licensing?
- Do collection vendors meet all bonding requirements?
- Do collection vendors meet you minimum HIPAA requirements?
- Do employees of the collection vendors meet your minimum HIPAA requirements?

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- Do employees of the collection vendors meet your minimum HIPAA requirements?
- Does the agency's policies and procedures meet your minimum requirements concerning the FDCPA, FCRA, State Laws, Dispute resolution process/complaint management system (CMS)?
- Are you receiving payment files pursuant your contract?
- Do you have the most recent financial audit of your vendor?

Audit's and auditing are a time consuming but necessary evil in revenue cycle management. The awareness of what your vendors are doing will improve overall compliance, communication and performance.

Written By: Thomas D. Perrotta, CCCO
Vice President, Client Relations
Penn Credit Corporation

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Hospital Rating Agency Update: Balance Sheets and Business Combinations Provide Buffer in Difficult Operating Environment

Ritchie Dickey

Continuing a theme from last year, 2017 saw operating margins deteriorate because of long-term industry trends on the revenue side and rapid expense increases. Furthermore, capital spending needs remain high but mainly for shorter-lived assets such as IT, outpatient clinics and ambulatory services. Fortunately, 2017 was a better year than 2016 from a non-operating income perspective, as investment returns were good and the strong economy helped bolster contributions for many nonprofit health care providers. Industry forces continue to favor larger providers, leading to acceleration in mergers and acquisitions (M&A) and affiliation activity. The combination of good non-operating income and consolidation improved the balance sheet of most hospitals and systems, particularly the large and highly rated ones. This balance sheet strength is always considered an extremely important credit attribute but especially in an environment where unpredictable but certain changes are coming.

Each of the credit rating agencies (CRAs) issue an annual report that summarizes past performance and provides a forecast for the upcoming year. With approximately 95% of the world market share for credit ratings, Fitch Ratings (Fitch), Moody's Investor Service (Moody's), and Standard & Poor's (S&P) reports provide a wealth of information which systems and standalone hospitals can use to make meaningful comparisons to financial benchmarks and emerging trends.

Operating Performance

After three years of robust revenue growth from the end of 2014 through 2016, 2017 saw the winding down of increases attributable to Medicaid expansion resulting from the Affordable Care Act (ACA). All three CRAs reported revenue growth slowing rather dramatically. Meanwhile, the economic recovery that started nearly 10 years ago has slowly driven up labor costs in many service sectors. Health care is acutely affected by labor costs, as the supply of workers with the necessary skills or experience is limited, and consumer demands place a premium on quality and availability. In addition, pharmaceutical costs increased at a rate faster than inflation for the second consecutive year.

Moody's reported that the median expense growth rate slowed from 7.1% in 2016 to 5.7% in 2017, but the revenue growth rate was even slower, dropping from 6.1% to 4.6% over the same period. The CRAs all expect the negative operating factors to continue for the foreseeable future. In addition to the current expense challenges, demographic and consumer preference changes stand to dampen revenue growth for many years to come. Common themes among all three agencies include:

- Aging population and changing industry dynamics weaken payor mix. All three agencies noted that Medicaid expansion from 2015 through 2016 contributed to slight improvement in payor mix, as the proportion of self-pay declined. However, the population continues to age, leading to a conversion from commercial payors to Medicare. Both Medicare and commercial payors have pushed initiatives for value or risk-based payment plans, which if nothing else, create uncertainty of reimbursement. In addition, more employers are pushing their covered employees into high deductible plans, which can lead to a reversal of the decline in self-pay. Finally, "the current administration continues its efforts to chip away at key components [of the ACA]…including diminishing support of the exchanges and benefit reductions."[1] This weakening support for the ACA also contributes to a rise in the uninsured rate, which contributes to higher bad debt

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- Weak volume growth. Outpatient volume growth continues to exceed inpatient, but overall demand was very weak in 2017. Moody's notes that "median 1% growth in inpatient admissions marks the lowest rate of growth in three years, while outpatient growth slowed to 2.2%–down for the first time in five years." [2]
- Slow transition from fee-for-service. Although movement has been slower than anticipated, a gradual shift from fee-for-service to at-risk sharing and value-based compensation models is changing the industry. The consensus view is that the change will favor large systems that can develop and maintain infrastructure to adapt to a population health environment.
- Competition from specialized and non-traditional entrants. In addition to the decline in inpatient and outpatient growth, Moody's noted a decline in the growth of outpatient surgeries because of "an increasing supply of competing sites providing these more lucrative services." All three agencies emphasized the competitive threat from alternative providers. S&P commented that "the industry is also experiencing an unparalleled rise in nontraditional competitors aiming to provide care that is more consumer friendly, higher quality, and lower cost."
- Consolidation as a means to gain negotiating leverage and framework for population health. With the gradual shift from volume to value, the increased need for and opportunities to use technology, and the general uncertainty of future changes, more providers are seeking to affiliate with other players through a combination of horizontal and vertical integration, network collaboration and M&A. Networks will be important in gaining negotiating leverage from a revenue and expense perspective and enabling providers to have sufficient infrastructure to manage in an environment where population health and access are key aims.
- Management teams seek efficiency through varying strategies. As reimbursement mechanisms continue to change and margins get squeezed from both sides, it is imperative for organizations to adapt. Again, size offers an opportunity to achieve economies of scale, and the ability to afford stronger and deeper management teams. By focusing on expense efficiency and revenue cycle optimization, organizations can maintain acceptable cash flow.

Non-Operating Income and Cash Flow

Partially offsetting the difficult operating environment, investment returns were generally excellent in 2017 and many providers enjoyed above average charitable contributions. Consequently, overall earnings before interest, depreciation and amortization (EBIDA) margins were barely lower, despite the sharp decline in operating margin. The CRAs have observed a gradual reduction in debt burden in recent years, and the interest rate environment remained favorable throughout 2017. As a result, debt service coverage (DSC) was relatively unchanged from 2016 to 2017; although, some lower rated categories did see a decline. Median maximum annual debt service (MADS) coverage remained at 3.9x in 2017 for the S&P portfolio of health care organizations. It remains to be seen if non-operating income can continue to make up for operating challenges, but we can assume the U.S. equity markets will slow down.

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Ritchie Dickey

Liquidity and Capital Spending

The strength of non-operating income helped to offset declines in operating margin, resulting in another year of improved balance sheets. Fitch states that liquidity metrics, "by any traditional ratio are at an all-time high point in the sector."[3] The CRAs also noted that the sector has experienced a long-term trend of moderating leverage resulting in improved debt/ capitalization ratios. Capital spending remained above depreciation expense for the third year in a row, but average age of plant declined in many rating categories. For the most part, hospitals are shunning large replacement or expansion projects. However, capital expenditure remains strongest for the highest rated organizations, who "continue to try to lock in their business advantages—highlighted by continued spending on information technology, ambulatory care and population health infrastructure."[4]

Trends and Expectations

The following themes were common to all median reports:

•There are few signs that the expense pressures will abate in the near term, revenue growth will remain slower and operating margins will be challenged.

•The sector outlook is generally negative, but rating changes have been limited. Despite the headwinds facing the industry, ratings downgrades only slightly outpaced upgrades and the vast majority of ratings for all three CRAs remained stable. One reason for the ratings stability is that some highly rated systems acquired lower rated and struggling providers, thus there was a reduction in the number of low investment grade and non-investment grade organizations.

•Hospital management and boards must strive to control expenses, find growth opportunities, respond to threats from a variety of competitors and maximize competitive advantages. The skill, experience and creativity of health care management teams will be increasingly important to the overall success of an organization. Therefore, the CRAs, as well as creditors and investors, will be increasingly interested in regular interviews with management teams.

Comparison of Select Median Figures and Ratios

	Fitch 'BBB'			S&P BBB[1]		
	2015	2016	2017	2015	2016	2017
Sample Size	58	59	41	97	88	86
Net Patient Revenue ($000)	448,099	466,479	507,296	205,988	275,503	302,598
Operating Margin (%)	1.5%	0.9%	-1.0%	2.4%	1.2%	-0.3%
EBITDA Margin (%)	9.5%	9.3%	6.9%	10.7%	9.4%	8.0%
Days Cash on Hand	161.2	148.8	147.7	158.5	163.6	159.1
Cash to Debt	90.8%	93.1%	97.9%	115.5%	127.0%	131.3%
Debt to Capitalization	50.2%	50.2%	47.5%	36.0%	34.4%	34.3%
	Fitch 'A'			S&P A[1]		
	2015	2016	2017	2015	2016	2017
Sample Size	107	110	97	137	128	122
Net Patient Revenue ($000)	633,705	677,366	636,513	429,850	410,619	419,564
Operating Margin (%)	3.8%	3.0%	2.3%	3.6%	3.0%	2.1%
EBITDA Margin (%)	12.4%	11.3%	12.4%	13.1%	11.9%	11.7%
Days Cash on Hand	215.5	218	216.8	248.6	252.1	257.5
Cash to Debt	148.6%	150.6%	151.6%	189.9%	200.9%	211.6%
Debt to Capitalization	36.0%	36.5%	34.5%	30.8%	31.4%	26.1%

1 "U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios" 2016 and 2017 editions

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As we mentioned last year, S&P, Moody's, and Fitch all signaled that 2015 was likely to be as good as it gets for the hospital sector. Revenue growth in 2016 was better than expected, but extremely fast expense increases squeezed margins. The following year, 2017, was indeed a very challenging year from an operational perspective, as margins were compressed even further. On the other hand, many hospitals used the recent "fat years" to shore up their balance sheets. Today, liquidity and debt/cap ratios are at all-time strengths, while debt service coverage is within the range experienced since 2008. The significant buildup in liquidity over the last 10 years helps provide a margin of safety, as operating margins continue to compress.

As the expense pressure and anemic revenue growth will likely not abate in the near-term, hospitals must continue to focus on efficiency, while investing prudently in capital projects that enhance the patient experience and/or improve the availability and use of technology. The management teams that can adapt to the change from volume to value and embrace the goal of population health will be poised to succeed in the future.

Ritchie Dickey, CFA, is a vice president with Lancaster Pollard in Atlanta. He specializes in hospital and senior living finance structures and has completed over $617 million in closed transactions.

[1] "U.S. Not-For-Profit Acute Health Care Ratios: Sector is Buffeted by Disruption, Yet 2017 median Trends Remain Unchanged from Last Yea" (S&P Global Ratings, www.spgglobal.com/ratingsdirect)

[2] "Medians-Operating pressures persist as growth in expenses exceeds revenue" (Moody's Investor Service")

[3] "2018 Median Ratios for Nonprofit Hospitals and Healthcare Systems" (FitchRatings, www.fitchratings.com)

[4] "U.S. Not-For-Profit Health Care System Median Financial Ratios — 2017 vs. 2016" (S&P Global Ratings, www.spglobal.com/ratingsdirect)

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First Name	Last Name	Org Name	Certification
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Faith	Bruker Maryman	Augusta Healthcare	CRCS-P
Kathleen	Brunette	Mary Washingon Healthcare	CRCS-I
Sandra	Burnett	Children's Hospital of The King's Daughters	CRCP-I
Peter	Carlson	Inova Health System	CRCS-P
Claudia	Chevarria	Inova Health System	CRCS-P
Diane	Gorney	Children's Hospital of The King's Daughters	CRCP-I
Keela	Gregory	Children's Hospital of The King's Daughters	CRCP-I
Jacqueline	Janssen	Inova Health System	CRCS-I
Iris	Johnson	Inova Health System	CRCS-P
Mehak	Khokhar	Inova Health System	CRCS-I
Benson	Ky	Inova Health System	CRCS-I
Erin	Landes	Augusta Healthcare	CRCS-P
Janet	Lipe	VCU Health System	CRCS-I
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Highlights from the Winter Meeting

The Kingsmill Resort in Williamsburg is a beautiful location and the annual conference was jam-packed with education and fun as usual. Wednesday included speakers Jay Andrews, Tim Moore, and Marcy Marquis as well as networking with our corporate partners and the President's Reception on Wednesday evening.

Thursday we heard from George Buck, Beth Kevit and Andrew Minten, Charlie Smith, and Erica Franko. We had our annual business meeting and awards ceremony, and ended the day with the keynote speaker, Charles Marshall and an engaging discussion with the PFS Director Panel. Participants were from UVA, Inova, Fauquier Health, and VCU. Thursday The Winter Party Thursday evening and was a fun night of entertainment that included dancing and bingo and a photo booth for making memories we won't soon forget.

Friday we had the privilege of hearing from speakers Brian Graver, Paula Hathorn, and Jonathan Wiik. We ended the conference after door prizes and are looking forward to our next Williamsburg event.

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NETWORKING EVENT!

VADC HFMA and the VA Chapter of AAHAM Networking Event

VADC HFMA will enjoy some appetizers and drinks with our friends from the Virginia Chapter American Association of Healthcare Administrative Management (AAHAM)

Date: January 24, 2019

Time: 5:30 PM – 7:30 PM

Location:

Sedona Taphouse

591 William Street

Fredericksburg, VA 22401

Website

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CHANGE HEALTHCARE

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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.

Please submit all applications to Pam Cornell by email at pam.cornell@mwhc.com or mail the application to Pam Cornell 2300 Fall Hill Ave Suite 313 Fredericksburg, VA 22401 no later than January 30th. Awards will be presented at the March AAHAM meeting to be held on March 8, 2019 in Charlottesville.

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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

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.