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October/2011

## President's Message

I am especially excited about this issue of our newsletter as we have many exciting activities going on. As you know, our annual event is hosted every November, and this year we are pleased to be collaborating with the local MGMA chapter in bringing you the best healthcare seminar New Mexico has to offer. Our event this year is "Surviving Healthcare" on November 17 & 18 at the Sheraton Albuquerque Uptown. Please take a moment to peruse the agenda attached to this newsletter and get registered!



Additionally, this is the time of year that HFMA conducts their Member Satisfaction Survey to assess how well each chapter is doing to meet your needs as a member. Some of you may have already received an email from HFMA requesting your feedback so my hope is that this reaches you timely and that you will take a moment to reply and let us know that you appreciate all that we are doing to deliver the best quality education by indicating as such on the survey.

This year we are offering incentives to encourage participation in the survey in the form of three \$50 gift certificates. These will be awarded to individuals who complete the survey by the due date based on a random drawing. It only takes a few minutes to complete, and each year NMHFMA uses the survey response data to improve the content and delivery of our educational events and add value to your experience as a member.

I hope to see you all at the Surviving Healthcare conference in November. Until then, take care.

Sincerely,

Steve Figge

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## Waste Not, Want Not - Tuning Up The Revenue Cycle For Healthcare Reform

Are the people, processes and technology that make up your revenue cycle functions ready to take on healthcare reform? As we are all aware, the Patient Protection and Affordable Care Act includes a mandate that will require 30 to 40 million, currently uninsured individuals, to obtain health insurance coverage. With approximately 95% of the U.S. population covered by private or government-administered health insurance in 2015, the revenue cycle will be strained with the anticipated growth and expansion of healthcare demand. At the same time, healthcare delivery systems will be adapting to health insurance exchanges, payment reform initiatives, increased regulation and the transition to ICD-10-CM. It is now more critical than ever to examine and identify less than optimal revenue cycle workflows. Efficient infrastructure and processes, to ensure timely submission of a clean claim, which is paid in full on the first transmission, will be crucial for cash flow.

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Lean Manufacturing (Lean) is the perfect tool to actively engage team members to seek out and eliminate waste in the revenue cycle workflow. Lean is often mischaracterized as being a cost reduction strategy when, in actuality, it is a continuous process improvement system, that quite often reduces cost. I was exposed early in my career to the ideas of Dr. W. Edwards Deming, an American statistician and quality guru, whose principles became the foundation of the Toyota Production System (TPS) or Lean. Having attended graduate school in western Michigan, the headquarters for worldwide furniture manufacturers, Steelcase and Haworth, I had the opportunity to gain first hand insight into process improvement methodologies. As a Practice Administrator working in the healthcare sector, I had no idea how much value stream mapping and measurement of outcomes, in the manufacturing sector, would influence my approach to providing financial leadership to healthcare entities.

The main objective of TPS /Lean is to provide the best possible service to the customer through the elimination of all forms of waste. Let's start out by defining waste as anything that adds cost or time without adding value. Defining value is a little more difficult, so for the sake of simplicity, we will use the TPS definition of value, which is defined as something the customer is willing to pay for. The first step in eliminating waste from the revenue cycle is to develop a process map of how the current process really flows, starting with patient access through account resolution. Once you have a true depiction of the current process, each activity in the current process is identified as a value adding task or non-value adding task. There will be some non-value adding tasks that are necessary to meet business or regulatory requirements but do not add value. For example, submitting claims electronically through a clearinghouse is a necessary part of the revenue cycle but does not add value to the customer. Sending paper claims directly to the payor, when electronic submission is an option, does not add value to the customer or to the practice and would be considered waste.

So what exactly constitutes waste? Waste is identified as a non-value added task, not necessary for business or regulatory reasons. Lean philosophy breaks waste down into 8 categories. Once team members understand the 8 categories of waste, they can begin to identify and eliminate waste from the revenue cycle workflow.

The 8 categories of waste are:

OVERPRODUCTION	OVERPROCESSING
WAITING	UNNECESSARY INVENTORY
EXCESS MOTION	DEFECTS/ERRORS/RE-WORKS
TRANSPORT	UNDERUTILIZED PEOPLE

\* Overproduction refers to producing work or providing a service before it is required or requested. Examples of overproduction include redundant work, such as entering repetitive information on forms, printing extra copies of documents, and multiple team members performing the same task due to lack of clear ownership of the function.

\* Waiting includes anything that interrupts the workflow and causes a delay in the next processing step. Examples include patients waiting to see the provider, insufficient number of software licenses and waiting for charges to be entered in the EPM/EMR. Backlogs and bottlenecks in the process are usually associated with waiting.

\* Excess Motion is any movement that does not add value or reverses the process flow. Examples include patient registrars walking to the copy machine to make copies of patient information, looking for misplaced documents and inconsistent changing between computer screens when inputting data in EPM/EMR.

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\* Transport waste in the revenue cycle involves less than optimal flow of data and people. Examples include re-entering data between incompatible systems (EPM and clearinghouse); work being passed back and forth for clarification and outdated procedures/lack of clarity.

\* Overprocessing waste occurs when more steps than necessary, to add value to the customer, are included in the process. Examples include excessive paperwork, gathering irrelevant information and submitting duplicate claims to the payor.

\* Unnecessary Inventory includes the usual inventory items, as well as inefficient use of time. Examples include outdated forms/manuals, unnecessary e-mail/paperwork, and work in progress (outstanding encounters and discharged but not final billed claims).

\* Defects/Errors /Re-works are mistakes that were not corrected at the source and require additional attention. Examples include not obtaining the correct patient demographic information, not setting up payors in the clearinghouse and submitting claims to the incorrect payor.

\* Underutilized People are defined as not using team member skills to their potential. Lean work teams are seen as a resource to be developed and well trained in their functions (1). Examples of underutilization include the supervisor correcting patient insurance information in EPM, management not including the team members responsible for a task when evaluating process improvements opportunities and supervisor not training team members to use the functionality of EPM.

Teamwork and a common focus are essential elements to streamlining your revenue cycle workflow. Lean helps you look at your revenue cycle workflow from a holistic point of view, as opposed to individual steps. By mapping out your current process, you are able to see the interaction between all activities and identify where insufficient processes result in delays, duplication of efforts and errors or "waste." Applying Lean to your revenue cycle workflow will eliminate waste, which will accelerate cash conversion and liquidation of accounts receivable.

### References:

1. Dibia, I. and Onuh, S. (2010). "Lean Revolution and the Human Resource Aspects." *Proceedings of the World Congress on Engineering 2010 Vol III WCE 2010, June 30 - July 2, 2010, London, U.K.*

Victoria Bergmans is a member of the South Texas HFMA chapter and can be reached at 512.517.5074 or [victoria.bergmans@yahoo.com](mailto:victoria.bergmans@yahoo.com). *Article used with permission.*

## Save The Dates!

**November  
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## NM HFMA and MGMA New Mexico Joint Conference

Brochure

**December  
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## Becoming a (Financially Stable) System

Before Watauga Medical Center merged with two other hospitals to form the Appalachian Regional Healthcare System (ARHS), the 117-bed rural North Carolina facility had maintained a strong 5% operating margin and a comfortable amount of cash on hand. But soon after, the system ended a year \$10 million in the red with a bank's noose tight around its neck and the collapsing credit markets pulling it tighter.

To thrive in its newly systemic configuration, ARHS would have to improve internal operations and convince an increasingly skeptical market of its rediscovered stability. The efforts resulted in an investment-grade rating for the rural system and a more affordable debt structure designed to be easily adaptable to future system needs.

### *Relearning to Thrive*

As part of its strategic plan, Watauga joined with Cannon Memorial Hospital and Blowing Rock Hospital, two nearby critical-access hospitals, to become a system. Neither critical-access hospital was profitable on its own, so ARHS slid quickly into an operational downturn.

"When you change the whole complexion of operations, you can't keep doing the same thing and expect different results," said ARHS CFO Kevin May.

With no competitors the hospitals did not have the ability to increase revenue by taking market share. Instead they had to create efficiencies, cut expenses and improve revenue-cycle operations. Additionally, considerable attention was given to IT, with integrated software deployed to improve communication among departments.

Watauga also applied for, and received, sole community-provider status in 2009. "That brought the appropriate amount of Medicare reimbursement to Watauga and it was significant," May said.

The new system went from losing \$10 million in operations one year, to losing \$500,000 from operations the next, to earning about \$7 million — an \$18 million turnaround in two years on a \$140 million system-wide budget.

With their financials turned around, ARHS had the perfect opportunity to present its new face to the capital markets and revamp its entire debt structure.

### *Approaching the Markets*

Before its about-turn, ARHS had a 12-month letter of credit enhancing \$31.4 million of variable-rate bonds. The same bank that issued it also was the counterparty on an interest-rate swap, so the system had to renew its credit facility every year with a bank that held all the leverage. Almost at the same time came the credit collapse of 2008 and the LOC structure's terms and conditions became more onerous.

Besides being tied to a constantly-expiring letter of credit, Watauga Medical Center was the sole obligor on the existing debt. It was also providing financial support to Cannon Memorial and Blowing Rock hospitals, necessitating a debt structure that would allow for undisturbed flow of funds throughout the system.

Lancaster Pollard walked the newly established ARHS through creating an obligated group of all three hospitals. It then assisted the system in obtaining a credit rating, using the credit write-up to describe the hospitals' impressive turnaround. The obligated group structure, combined with the system's continued operational improvements, provided Standard & Poor's rating agency the assurance it needed to offer an investment-grade BBB+ credit rating.

The \$35.5 million refinance was structured with fixed-rate, tax-exempt bonds. With no

renewal risk, ARHS now has a stable debt structure providing flexibility to issue additional debt in the future.

*A Common Future, an Uncommon Task*

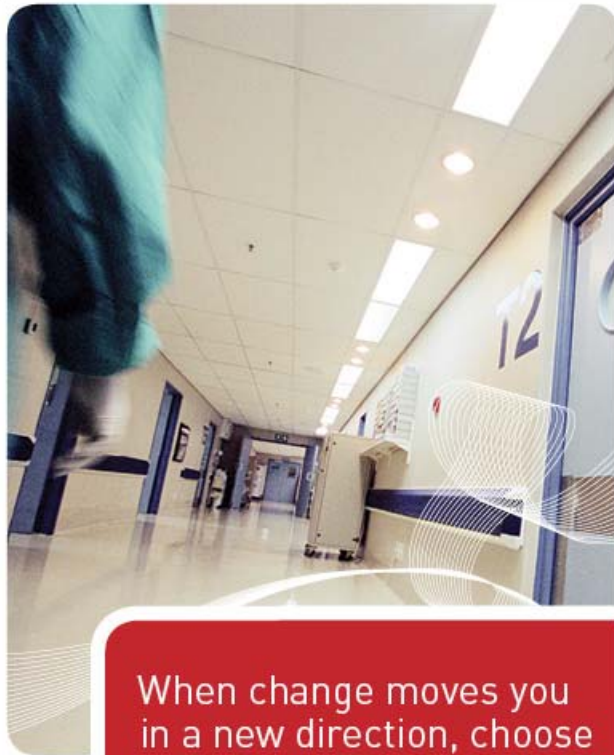
"Bringing new hospitals into a system, an affiliate agreement or creating a system as ARHS did, isn't like becoming brothers," May said. "It's more like becoming conjoined twins." Certainly, it's not something hospital leaders do every day, every year, or even every decade.

ARHS is still adjusting to its new form, but May offers several suggestions for hospitals that are considering becoming part of a system:

- Have a solid business plan.
- Be conservative in borrowing and realistic about how much the system can afford to pay back.
- Make sure the hospitals involved get to know one another's cultures, including medical staff, and operations.
- Engage outside experts to help integrate systems and services.
- Use debt rather than liquidity to finance projects, at least until the hospital has built a comfortable financial cushion.

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## Welcome to the Members who have Recently Joined the New Mexico Chapter

### New Members

- **Marc P. Blackman**, Accountant  
New Mexico Oncology Hematology Consultants
- **John Paul Montoya**, Revenue Manager  
University of New Mexico Cancer Center
- **Kelly D. Myers**  
Qforma
- **Stuart S. Schroeder**, Chief Financial Officer

ABQ Health Partners

- **Elizabeth Nations**, Senior Accountant  
Gila Regional Medical Center

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## Education Opportunities You Won't Want to Miss!

It's getting to be that time of year again! The holidays are close upon us and the end of the year is not far behind! But there are still a couple perfect opportunities to gain some great educational experiences. Don't miss the [Fourth Joint NMHFMA - MGMA Conference](#) on November 17 and 18. The conference is entitled "Surviving Healthcare" - something I think we can all relate to some days! Three keynote presentations and multiple options during three breakout sessions will offer something for every healthcare finance professional. This is a great opportunity to socialize and network with the members of both these great professional associations right before the busy holiday season. There's still time to register - hope to see you there!

Too busy to get out of the office? Then this conference might be perfect for you: The [HFMA Virtual Healthcare Finance Conference](#) beginning with live sessions on December 13 and 14 is back by popular demand with all new content. The conference is FREE to HFMA members! Non-member registration is \$155, which also includes membership for those new to HFMA. To learn more about this virtual educational opportunity or to register for free, please visit [www.hfma.org/virtualconference](http://www.hfma.org/virtualconference).

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## **NM Hospital Association Annual Meeting**

The NM Hospital Association's annual conference was held in late September. As usual, it was an interesting and engaging event. The NM Chapter of HFMA supported the conference by offering two break-out sessions the morning of September 29. The first consisted of dual topics - 'New Mexico State Tax and Credit and Incentives Overview For Health Care' and 'Accounting and Financial Reporting Update for Healthcare', both presented by Moss Adams. This presentation was followed by 'Valuation and Related Financial Reporting' presented by Ed Street from REDW. Barbara Lorschach, Senior VP, Member Relations at the American Hospital Association, gave a Washington update during lunch. Joy Johnson Wilson, with the National Conference of State Legislators, presented a current discussion of the impact of health care reform on the states and Greg Schwem ended the day with a lighter look at the healthcare industry. We appreciate the opportunity to offer educational content that's hopefully of value to the Chapter's members during this annual event hosted by the NM Hospital Association.

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## A Message From Region Ten Regional Executive JJ Carmody

I am not quite six months into my year as Regional Executive for Region X and already we have accomplished a great deal. Thus far we have had two face to face meetings as a group with the Presidents and President Elects from the various chapters in our Region. The first meeting was at the Leadership Training Conference last May in New Orleans. The second meeting took place in August in Punta Mita, Mexico. The

purpose of our Mexico adventure was the Region X Fall Presidents Meeting (FPM). Every year from Mid August to October, each Region is required to hold a FPM. The FPM is intended to take place at a location of the Region's choosing for one to two days in order to review various agenda items set forth by National HFMA as well as any Regional topics we feel warrant face to face discussion. As part of the FPM, National sends one staff person and one National Board Member to each Region's FPM. Also, all Presidents from each chapter in the Region are required to attend or send another officer in their place. President Elects are encouraged to attend as well. We were fortunate to be joined by Chris Sarrico, national board member and Dick Clarke, President and CEO of HFMA.

In general, The Region X meeting covered the following topics over the period of a day and a half:

*Overview and Update of HFMA Products and Services:*

HFMA staff provided an overview of HFMA products and services including: Map App revenue cycle benchmarking tool), Healthcare Leadership Conference (board meets with leaders from healthcare community). Discussed future with ACA and impact on reimbursement. HFMA does not lobby. Value Project (re-engineering processes) includes 17 organizations from around the system. Value report is available on website, including a web tool.

Dick reminded the group of the chapter membership survey which will take place in October/ November as well as of the February 28 due date for Morgan award nominations. Please be sure and participate. Your feedback is extremely valuable to us.

Dick also noted that HFMA membership and education hours have grown even with challenging economy.

*Update from HFMA Board of Directors Meeting:*

The Board of Directors representative presented an update in behalf of the HFMA Board of Directors. The Board strategic planning session was held August in concert with the Board meeting.

Discussion included Dick Clarke's upcoming retirement; a national firm has been retained to conduct a search for his replacement. Heather Etheridge, his assistant, will be retiring in October.

*Annual Review of DCMS and Chapter Operations:*

Each Chapter discussed items related to the Chapter Balanced Scorecard. This is the system National uses to assess chapter performance and ensure the continuing quality of membership across the country. Among the specific things discussed were Succession Planning, Social Networking, and Membership Growth.

*Local Chapter Successful Practices:*

The Regional Executive facilitated a discussion of successful chapter practices. Chapters shared best practices on the following: Education, Newsletter, Membership, and Certification.

*Regional Topics (as identified by chapter leaders) were also discussed by the group:* Chapters identified the following topics for discussion at this year's FPM:

Discussed future of Region 10 conference, the group selected May, 2013 in New Mexico for the next Region 10 Conference. The incoming Regional Exec-Elect, Eric Burgmaier, will be the chair for this conference. All chapters will select a member to participate on the conference team.

*Finalize Selection of 2012 Fall Presidents Meeting Dates and Location - Tentative Meeting Dates: August 18-20, 2012 @ Grand Hyatt in Kauai, HI.*

*Finalize Selection of the 2013-14 Regional Executive (aka 2012-13 RE-elect):*  
The chapter presidents-elect unanimously elected Eric Burgmaier to serve as the region's 2013-14 Regional Executive.

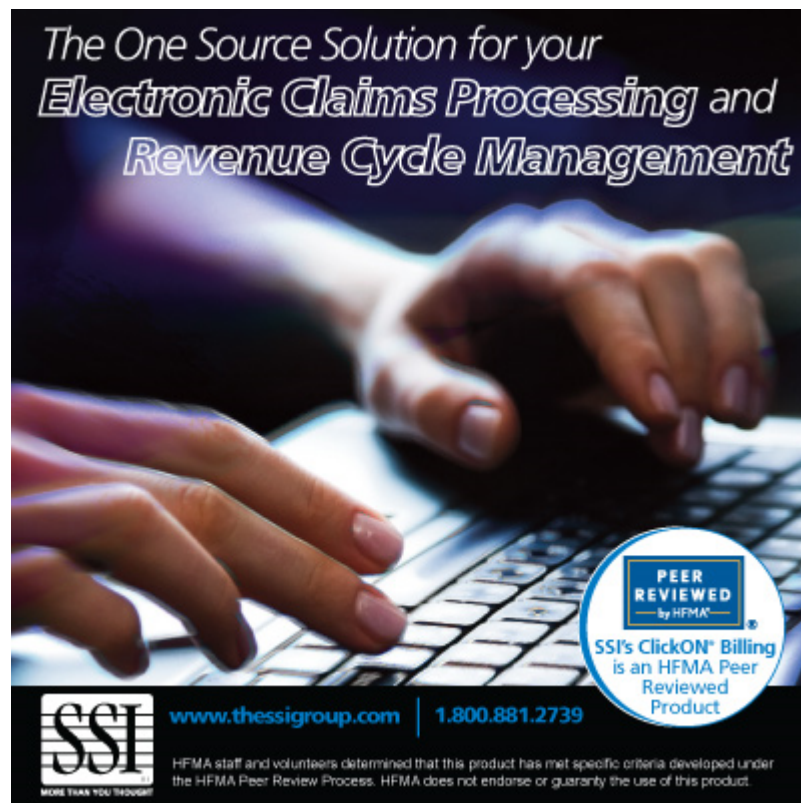
*Review Regional Operating Agreement:*

The chapter presidents reviewed the Regional Operating Agreement. The agreement was reviewed and signed by all chapter presidents.

Everyone in attendance was a tremendous asset and all assigned tasks were accomplished. I would like to thank the chapter representatives for their time and attention.

JJ Carmody  
HFMA Region X Executive

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**Call for Input and Participation**

The Newsletter Committee for the NM Chapter of HFMA invites you to provide your input and feedback on what you like about the newsletter and what you'd like to see changed. Are there topics about which you'd like to see articles? Are you aware of members or health care organizations in New Mexico that deserve recognition? We'd love to hear about them! We also welcome your participation in chapter activities - if you are interested in helping out with the quarterly newsletter or other chapter activities, please let us know. You can e-mail us at: [nmhfma@scltd.biz](mailto:nmhfma@scltd.biz).

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NM HFMA P&L Summary June 1, 2011 through September 30, 2011\*

**6/1/11 through 9/30/11**

	<u>YTD Actual</u>	<u>Budget</u>	<u>Variance</u>
<b>REVENUE</b>			
Total Program	280.00	25,500.00	-25,220.00
Total Other	7,500.00	29,000.00	-21,500.00
<hr/>			
Total Revenue	7,780.00	54,500.00	-46,720.00
<b>EXPENSES</b>			
Total Program	914.77	21,000.00	20,085.23
Total Leadership Conf	6,045.65	11,000.00	4,954.35
Total Other	4,561.74	15,100.00	10,538.26
<hr/>			
Total Expenses	11,522.16	47,100.00	35,577.84
<hr/>			
NET INCOME/(LOSS)	-3,742.16	7,400.00	-11,142.16

\*Actual numbers are year-to-date; budget numbers are annualized.

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