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<td>Back Cover – Full Page Color</td>
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<td>NA</td>
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<th>Issue Date</th>
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OBJECTIVE

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

As you receive this issue, I am at the mid point of my term as Chapter President and, with six months to go, there are still several goals to accomplish. In October, the annual institute was the most attended and successful in the thirty-two year history of the event. I want to thank the Co-Chairs of the event, Tracy Davison-DiCanto and John Brault and the full committee for all of the time, coordination and determination they devoted in making it successful. In addition, I would also like to thank the vendors for their support, and the speakers for their excellent presentations.

The Institute may be completed; however, there is still a number of activities going on in the chapter. Some upcoming events include:

• The quarterly Chapter meeting on January 13, 2009 at the Woodbridge Hilton. This is a joint meeting with the NJ Chapter of AAHAM and our PFS and PAS Committees.

• The quarterly Chapter meeting on March 10, 2009 at the Woodbridge Hilton, presented by the Chapter’s CARE Committee.

• The Chapter Golf Outing on May 7, 2009 at Fiddler’s Elbow.

• The Education Committee continues to find topics and speakers. Keep a lookout for details in the Chapter’s Pulse weekly e-mail.

Other projects in process:

• The Chapter’s website will be getting a face lift in the very near future.

• Conducting our first ever webinar coordinated by our Education Committee.

• Planning a New Member Breakfast early in 2009.

• Recruitment of committee chairs and co-chairs for the 2009/10 Chapter year.

• Selection of topics for submission to National HFMA for Yerger Awards by April 1, 2009

Finally, on behalf of the Officers and Board of Directors, we wish you a very happy and healthy holiday season and a wonderful 2009!

Sincerely,

Joe Dobosh, MBA
President, New Jersey Chapter of the Healthcare Financial Management Association
Dear Readers:

We do not often have the opportunity to reflect upon the contributions of a single person in changing and shaping health care policy within New Jersey, let alone on a national level. This year-end issue includes a tribute to the late Joanne Finley, M.D., M.P.H., who served as New Jersey Commissioner of Health from 1974 through 1982. I am very grateful to current Commissioner Heather Howard and her staff for quickly responding to my request for an “official” Department of Health and Senior Services biography and photo, to John Dalton for alerting me to the sad news of Dr. Finley’s death and emphasizing the significance of her life, and to John Reiss for all of his help in putting together the tribute. I also appreciated and was moved by each contribution submitted by those who worked with Dr. Finley in New Jersey.

I had not yet begun my own career as a New Jersey health care attorney when Dr. Finley concluded her tenure at the Department, but, shortly after I chose health care law over tax law (at the wise suggestion of former Commissioner Len Fishman, then a partner at the firm I would join) in 1989, I began understanding the impact of Dr. Finley’s work. Now, nearly twenty years later, and long past the demise of the New Jersey rate setting system, I am awed by the depth and breadth of the health payment reform legacy Dr. Finley has left behind.

Speaking of legacies, it is with great excitement, anticipation, and relief (yes, all three) that I announce the imminent re-design of our Chapter’s website. My publications committee co-chair, Al Rottkamp, has demonstrated a tenacity and generousness of time and effort not often seen in volunteers, let alone highly skilled, extremely busy volunteers, and the Chapter Board has approved his recommendation for website upgrades. I am optimistic that I will be writing to you in early 2009 with details on the improved look and functionality of our New Jersey Chapter website! Thank you, Al, Laura Hess, John Manzi, Joe Dobosh, Tracy Davison-DiCanto, Brian Sherin, and the other Board and publications committee members who have helped launch this project.

Regards,

Elizabeth G. Litten
Editor
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From September 5-14, 2008, three New Jersey chapter members and two guests participated in an HFMA delegation to Russia for a professional interchange with their Russian healthcare colleagues. Sponsored by People to People, the 39 person delegation was led by Joyce Zimowski, Senior Vice President at Unity Health System, Rochester, NY and Dr. Joe Abel, Director of Professional Development at HFMA, Westchester, IL. In total, there were 28 delegates and 11 guests, including five delegates and one guest from HFMA-UK. Founded by President Eisenhower in 1956, People to People International’s driving purpose is to enhance international understanding and friendship through educational, cultural and humanitarian activities involving the exchange of ideas and experiences directly among peoples of different countries and diverse cultures. Last year, HFMA President Richard Clarke led a similar delegation on a visit to China.

Delegates spent two days meeting with professional colleagues in Moscow followed by two days visiting a district hospital and private clinics in St. Petersburg. The schedule also allowed time for cultural activities including tours of Red Square and the Kremlin in Moscow and the Hermitage Art Museum and Peterhof, the summer residence of the tsars, in St. Petersburg. For many, the cultural highlight of the trip was a Friday evening performance of Tchaikovsky’s “Swan Lake” ballet at the Hermitage Theater. Garden Staters included Cheryl Cohen and Frank Kimchick, Ann and John Dalton, and Janet Turso. The purpose of this article is to summarize the professional interchange and to provide insights into the challenges and opportunities facing Russian healthcare since Mikhail Gorbachev’s “perestroika” precipitated the 1991 collapse of the Soviet Union.

The Russian Federation as a Nation

Even without the former Soviet socialist republics, the Russian Federation is the largest country in the world, and one of the most sparsely populated. Stretching from the Baltic Sea in the west to the Bering Sea in the east, Russia spans 11 time zones and is twice the size of the United States. Its population of 143 million (less than half that of the U.S.) is declining at a rate of 800,000 per year and is projected to drop to 125 million by 2025 according to the Center for Strategic and International Studies. With 10 million people, Moscow is the Federation’s capital and largest city. Adding in 5 million who reside in the surrounding region, Moscow
accounts for more than ten percent of Russia’s population. Located on the Gulf of Finland at the east end of the Baltic Sea, St. Petersburg is Russia’s second largest city with 4.7 million residents, and endures sub-arctic winters.

While the Russian birth rate is comparable to that of other European countries, its population is declining more rapidly due to its higher death rate. Unlike the United States, free medical care is a constitutionally guaranteed right for Russian citizens. The Table below compares 2006 life expectancy at birth for Russia, the United States and the United Kingdom as reported in World Health Organization statistics:

<table>
<thead>
<tr>
<th>Life Expectancy at Birth (years)</th>
<th>Russia</th>
<th>U.K.</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Life Expectancy</td>
<td>60.1</td>
<td>77.0</td>
<td>75.5</td>
</tr>
<tr>
<td>Female Life Expectancy</td>
<td>73.2</td>
<td>81.3</td>
<td>80.4</td>
</tr>
</tbody>
</table>

National Research Institute of Public Health

The delegation’s first meeting was at the National Research Institute of Public Health of the Russian Academy of Medical Sciences in Moscow. Founded in 1944, its main objective is implementation of research projects in public health, healthcare economics and management, and introduction of the best healthcare business practices. Academician Shepkin and his staff led the delegates through a two part presentation, focusing first on an overview of the Russian healthcare economy, then moving to a discussion of key health indicators and the need for quality assessment and quality improvement.

Shepkin noted that Russia currently ranks towards the bottom of the list of developed nations with regards to healthcare outcomes, a principal reason for healthcare reform becoming one of four major government initiatives. Funding for this sector is being increased at a rate greater than the rate of growth in the federal budget. The National Research Institute is delving into 12 research program areas, and Shepkin walked the delegates through one that is receiving a lot of focus: reducing mortality from cardiovascular disease. Shepkin pointed out that three conditions account for 83.2% of deaths in the Russian Federation:

1. Cardiovascular diseases – 56.9%;
2. Tumors (cancer) – 13.2%; and
3. External reasons (accidents) – 13.1%.

He complimented the U.S. for discouraging tobacco use, noting that smoking and alcohol abuse are two leading reasons for Russia’s poor health status. He expects that the Research Institute’s work should result in raising the average life expectancy to 70 years for men and 80 years for women by 2020. Normal retirement age is 60. Mortality rates for cancer are considerably higher than Western Europe due to late diagnosis, with cancer being at an advanced stage when discovered, and the lack of contemporary treatment methods.

Shepkin concluded by citing the three primary issues facing Russian healthcare:

1. the amount and level of healthcare guaranteed by the government and expected by citizens is not in line with the financial resources available;
2. medical providers are frequently under-equipped and poorly trained; and
3. the medical insurance system needs reform.

Professor Lendenbretton then discussed the status of the healthcare system. The healthcare sector currently employs 600,000 professionals, or 40 per 10,000 population, with 29 per 10,000 being clinical professionals. More than 3,000 hospitals and clinics have shut down during the past 15 years, leaving the country with 5,000 hospitals and 6,000 clinics. There are 32 million inpatient admissions annually with an average length of stay of 13-14 days, which includes the admitting exam and post-acute convalescent period. Also included in the average length of stay calculation are psychiatric and tuberculosis cases, which account for 15 percent of the occupied beds on any given day.

He pointed out that financing for Russia’s healthcare system basically comes from taxpayers, whether through employer contributions to the Federal Compulsory Health
Insurance Fund, individual payments (both official and illegal), and group and individual health insurance. The official portion of individual payments is patient co-payments as a percentage of charges for the service. The illegal payments are those made directly to a physician to gain better access to care.

Professor Lendenbretton expressed his opinion that higher levels of financing result in better care as measured by life expectancy, adult and infant mortality, and other key health indicators. He supported his opinion with World Health Organization (WHO) data showing that, for countries that spend less than $800 per capita, infant mortality rises. He is hopeful that the increased levels of spending will improve Russian health status as incentives are provided for better quality care, not just higher volumes of encounters. The table below compares per capita health spending and expenditures as a percentage of gross domestic product for Russia, the United Kingdom and the United States in 2003:

<table>
<thead>
<tr>
<th>Health Spending, 2003</th>
<th>Russia</th>
<th>U.K.</th>
<th>U.S.</th>
</tr>
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<tbody>
<tr>
<td>Per capita health spending</td>
<td>$400</td>
<td>$2,317</td>
<td>$7,711</td>
</tr>
<tr>
<td>Health spending as % of GDP</td>
<td>5.6%</td>
<td>7.8%</td>
<td>15.2%</td>
</tr>
</tbody>
</table>

Following the Research Institute staff presentations, John Dalton reviewed some U.S. key health indicators, placing major emphasis on the five leading chronic care conditions. Dalton noted that 90 percent of U.S. health expenditures on adults (excluding dental care, medical equipment and supplies) are spent to treat persons with chronic conditions. Asthma is the leading chronic condition. He pointed out that obese individuals are at higher risk for the next four conditions (hypertension, osteoarthritis, heart disease and diabetes). Dalton stated “We Americans are getting bigger every year,” referencing recent data that the percentage of obese Americans has increased from 15% of adults in 1980 to 30% in 2007. Chris Calkins, Chairman of HFMA-UK, reviewed similar data for the U.K., noting that health care accounts for 34% of government expenditures. The average waiting time from a general practitioner referral to first treatment is 18 weeks.

**Federal Compulsory Health Insurance Fund**

On Tuesday, the delegation met with the Federal Compulsory Health Insurance Fund (CHIF) to obtain insights into how Russian healthcare is financed. The Fund’s Director pointed out that Russian citizens have a constitutional right to “free medical care of proper quality.” Established in 1993 by federal legislation, the Fund is supported by a single social tax on employers and self-employed individuals that amounts to 3.1 percent of wages and salaries. The tax revenues are split between the Federal Fund (1.1%) and regional funds (2.0%) in each of the federation’s 85 regions. The CHIF received $7 billion last year, and that amount is scheduled to double over the next three years. It is the primary channel for medical insurance to employed citizens. Medical insurance for unemployed citizens, retirees and children is funded by contributions from the regional authorities, and the per capita amounts allocated vary widely among the regions.

Over 140 million people are covered, nearly 100 percent of the eligible population. The mixed funding source requires significant interaction with regional authorities. More than 60 percent of the population covered is not employed (i.e., retirees, children, non-working parents). The Director discussed the need for the CHIF to set standards or benchmarks for specific medical services, and to compile records on individual’s use of health services. The CHIF is working closely with the Ministry of Health which is developing a strategic plan for Russian healthcare through 2020. In so doing, they are studying the models used in other developed nations and evaluating experience under various models.

In reforming Russia’s healthcare system, a change is needed from financing institutions to funding specific services. That will require developing a system of medical and economic standards to benchmark costs. Second, resources are needed to track payments that are adequate to cover the cost for services provided and to confirm that services provided are necessary. CHIF staff believes that this would eliminate the unofficial gratuity payment system. CHIF staff are quite familiar with the U.K.’s National Health Service (NHS) and appeared to be leaning towards that model. Their perception of the U.S. system is that it is very expensive, but they like the freedom of choice feature.

A highly interactive question and answer session provided a clearer understanding of the challenges and opportunities facing our Russian peers. Observations made included:

- ✓ Russia does not have high quality healthcare yet; however, the economy has been growing at a rapid pace, and that helps provide increased funding for healthcare; continued on page 10
Putin has made healthcare an integral part of evaluating the performance of regional governors;

- We are trying to improve healthcare quality and one of the ways is through surveys;
- Doctors are doctors everywhere – they are spendthrifts;
- Behavioral health services are funded at the regional level, not by the CHIF, as is funding for drug abuse and sexually transmitted diseases;
- We are seeing competition among insurance companies to expand their covered lives, but they can’t influence quality at present;
- The number of visits or number of patient days do not always reflect the quality of services received; we need to develop a common denominator for the unit of service rendered that reflects patient acuity and the intensity of services provided;
- If a physician errs, the injured party cannot sue for malpractice since there are no benchmarks;
- IT systems are poorly developed in many regions; this now is becoming a major priority;
- It has been difficult recruiting people to work in the healthcare sector.

Phyllis Cowling, FHFMA, President and CEO of United Regional Health Care System. Wichita Falls, TX, made a presentation on how healthcare is funded in the United States, and was followed by Chris Calkins who made a similar presentation on NHS funding in the U.K.

The concluding discussion provided illuminating insights into the cultural context within reform is proceeding. Seventy years of Soviet rule produced in a culture where individuals are reluctant to stand up for their personal rights. Older Russians are accustomed to having decisions made for them. Russia needs to develop competition among providers and implement incentives to improve quality. Clearer standards are needed to specify government obligations with respect to healthcare access, amount of care and quality, while recognizing that the government can’t provide everything.

Vsevolozhsk Central District Hospital

Wednesday morning, the delegation departed St. Petersburg by bus to visit the Vsevolozhsk Central District Hospital, 10 kilometers east near Lake Lagoda in the Leningradsky Region (St. Petersburg was Leningrad during Soviet times). The surrounding countryside was flat, with an occasional single family home and plenty of communal living. The roads were in good condition, but there was only one two lane road to Vsevolozhsk, and it had a lot of traffic. The delegation was dropped off at a building that looked as if it had been built prior to World War II. We later learned that it was built in 1982 towards the end of the Soviet era. None of the delegates would have identified it as a hospital building. The city was in the midst of a sewer outage, but Hospital staff had kept a few toilets available for delegates needing to use the facilities after the long bus trip.

Dr. Tatiana P. Zebode, Chief Physician and Hospital Administrator of the Vsevolozhsk Central District Hospital welcomed the delegation and provided an overview of the hospital’s organization and operations. Dr. Zebode has been working within the healthcare system in this district for 30 years and noted with pride that the hospital is located on the “Road of Life,” the supply line to Leningrad during the 900 days of the Nazi siege. She was joined by the District’s Director of Social Services, who oversees education, health and welfare in the District. The hospital is one of the oldest medical institutions in the Leningradsky Region. It started in 1884 as a clinic,
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but has grown into a full service community hospital serving 217,000 people (179,000 adults, 37,600 children) in the Central District’s 20 municipal areas. The local economy includes a Ford plant and a Nokia tire factory, small manufacturers and agribusiness.

Healthcare consumes 40% of the Region’s budget of 4 billion rubles ($160 million), of which the hospital receives 500 million rubles ($20 million), accounting for 15% of the hospital’s annual budget. Roughly 60% of the hospital’s funding is provided from the CHIF, with the remainder coming from patient payments. Prior to 1994, when the CHIF was created, 100% of the hospital’s funding came from the region. The hospital budget is allocated as follows: 75% wages and salaries; 10% materials purchases; 10% inpatient nutrition; the remaining 5% is for everything else, excluding equipment. The hospital is reviewing the opportunity to outsource certain departments, such as housekeeping and laundry, to reduce expenses.

Capital expenditures are funded separately. Last year, 30 million rubles ($1.2 million) came from Moscow, 12 million rubles ($480,000) came from local government and 8 million rubles ($320,000) came from various grants and programs.

Dr. Zebode described the four levels of care provided in the Russian delivery model:

1. Health Station (13 in the district) – staffed by one doctor and one nurse, health stations are established when a settlement reaches a population or 500;
2. Ambulatory Center (8 in the District) – services include general practice, gynecology, pediatrics and dentistry.
3. Polyclinic (6 in the District) – typically staffed by 25 specialists including ophthalmology, gastroenterology, etc., can perform blood tests and electrocardiograms; and
4. Hospitals (3 in the District) – the hospitals have a total of 990 beds and deal with all major specialties at more acute stages of illness.

Dr. Zebode noted that the Hospital’s proximity to St. Petersburg has facilitated recruitment of specialists for most major specialties. There are 280 doctors in this facility, 550 in the entire region. Additionally, there are 1,500 middle service personnel, whose salary structure is quite low. There is a shortage of these middle service personnel. As a point of reference, the average salary for workers in Russia is $1,000 per month. Recently, the physicians’ entire salary structure was revamped, from a level, low salary, to achievement, results based pay. Physicians can earn quarterly bonuses based on outcomes.

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Dr. Zebode noted that the Hospital’s proximity to St.
disease, noting that most of the improvement must result from patient education and lifestyle changes. She also noted that there has been some medical malpractice activity in the region though this is still rare. In these suits, the medical provider entities have been found liable and paid for mistakes. The presumption is that the patient is always right. National standards would help mitigate hospital liability.

Legal immigrants can become eligible for participation in the medical insurance programs. Illegal immigrants have to pay for services. However, the hospital is required to provide treatment in emergency situations. When asked where immigrants come from, Dr. Zebode responded, “Uzbekistan, Tajikistan, Ukraine – republics of the former Soviet Union. They come here because life is better!”

The delegation concluded the professional exchange with a tour of the hospital that produced a clear appreciation of the challenges facing Russian healthcare. Older delegates likened the facility to a U.S. community hospital pre-Medicare. The technicians in the X-ray suite wore radiation badges to monitor exposure, but the equipment was antiquated. The day hospital housed four beds in each patient room. The beds resembled cots, and an IV pole hung next to each bed. A tour of the surgical floor led past a small, minimally equipped nursing station and six-bedded rooms. Again, the beds resembled cots, and, when oxygen is needed, a cylinder is wheeled in and hooked up. IT support is minimal. High tech equipment is lacking. The impression formed was that of health care professionals struggling daily to provide needed care under challenging conditions.

As the tour concluded, Cheryl Cohen mentioned that the delegation was pleased to see two women holding such important positions. With a smile that lit up the room, Dr. Zebode responded, “Only a woman would take on a job this tough.”

**MEDI Clinic, St. Petersburg**

Thursday morning, the delegates visited and toured the MEDI Clinic facility on upscale Nevsky Prospect, St. Petersburg’s equivalent of Chicago’s “Magnificent Mile.” Following the tour, the delegates met with executive staff of the clinic and the MEDI Company Group. The privately owned company consists of 18 clinics that provide dentistry, cosmetology, plastic surgery, laser surgeries and family medi-
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When Might You Need an A/R Swat Team?

by Jim Yarsinsky, CPAM

An accounts receivable (A/R) crisis slowly creeps up at most hospitals, even though signs are evident that the revenue cycle is lagging and breakdowns in workflow and processes are numerous.

But, it usually takes some singular event or development that proves, once and for all, that receivables are getting out of hand and immediate, help is needed to reduce A/R – and rejuvenate a flagging A/R process.

Signs You Need Emergency A/R Help?

There are many signs that point to the need for a concerted, focused effort to work down aging receivables. Perhaps the starkest sign of all is when 28 percent or more of your A/R has aged more than 90 days (an industry benchmark). Before you ever get to this point, however, look out for other warning signals that your A/R is creeping up to an unmanageable state:

• **Your A/R accounts are timing out regularly.** Third party insurance carriers set deadlines for filing claims and if you don’t submit in time, you won’t get paid. If you don’t submit in time, or properly, the amount of unclaimed reimbursement will creep up to a “breaking point.”

• **Cash flow problems.** You’ve just flipped the calendar and year-end is nearing and your cash flow is not where it should be – and your A/R days are 10-14 days higher than last year. This is the time you need to quickly, systematically lower your A/R and improve cash flow – not to mention improve your bond rating and show the hospital board that things are under control.

• **Computer conversions gone awry.** Switching to new software or even more involved computer conversions wreak havoc on accounts receivable. Traditionally, A/R days spike up 10 A/R days outstanding due to conversions and take awhile to come back down to pre-conversion levels.

Other important, yet less blatant signs include: high staff turnover rate, growing number of denials, a breakdown in the patient registration process, and simply, just an immense volume of unmanageable claims for the patient financial services staff.

Arming the A/R Swat Team

Handling an A/R crisis should be swift, focused and handled by a pool of resources that are focused on accounts that are the source of the A/R crisis. In other words, tackling aging A/R should be a separate project and not added to the staff’s current workload.

Here’s a step-by-step approach to quickly lowering your A/R:

1) Appoint the most seasoned patient financial services professionals to work on high dollar accounts.

2) Work aged accounts in descending dollar order.

3) Gather all untimely-filed accounts — determine which ones can be appealed and, most importantly, determine those that have little chance of payment and write them off.

4) Re-bill as many claims as quickly as possible.

5) Work with large groups of accounts simultaneously. For example, gather 50 accounts from the same payer, contact the payer and ask them about them all at once. Caution: don’t work one claim after another.

6) Leverage your provider representative to help you get paid.

While some of these steps seem obvious, most patient financial service departments just don’t have the manpower resources to handle an A/R emergency.

Focused A/R Team Pays Off

Some hospitals will decide to manage A/R emergencies themselves, but this is often difficult and unrealistic with existing workloads. Rather than outsourcing — and having to work with off-site staff on separate computers and systems — many hospitals opt to “in-source,” bringing in a dedicated, professional team of patient financial services experts and directors to work on-site and execute an A/R swat team approach.

An Expeditive Case Study

For Charles J. Santangelo, Executive Vice President/CFO for Susquehanna Health in Western Pennsylvania, in-sourcing was a blessing in disguise when his department underwent a computer conversion that began adversely impacting A/R. Mr. Santangelo’s department decided they needed a six-person Expeditive team to come in and handle a massive A/R cleanup. Eight months later, not only was A/R under control, but cash was not just flowing, but gushing.

“The results produced from the efforts of Expeditive and our patient account teams were that Susquehanna Health...”
Hospitals collected $18.7 million of targeted A/R over the course of the project. Staff members were professional, friendly and worked well with the Susquehanna Health Patient Accounting staff,” says Mr. Santangelo.

During the course of the effort, the lead Expeditive person worked with Mr. Santangelo to keep him abreast of progress; weekly and monthly reports showed money coming in, accounts resolved, and detailed A/R summaries by payer and descending balance.

**Stop Wheel Spinning**

When A/R ages to the point of no return, hospitals need to recover cash quickly and work down aging receivables. Hiring an in-sourced “swat team” allows CFOs and directors to oversee an A/R operation that can quickly get into the system, resolve issues with laser focus and get out with more cash in hand and a rejuvenated and improved revenue cycle.

**About the Author**

Jim Yarsinsky, CPAM, is president of Expeditive, L.L.C. He can be reached at jyarsinsky@expeditive.com.

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**Tips for Moving On**

Once you’ve employed a “swat team” to handle out-of-control A/R, your department can work on more long-term issues to lower accounts receivable, such as:

- Develop job aides and scripts for employees to help them resolve key accounts (promptly).
- Institute daily work drivers, which are reports given to all of your follow-up staff, showing outstanding accounts and a time frame in which they should be resolved.
- Always put your most skilled and experienced staff on the highest-dollar accounts.
- Have management review performance on follow-up work in process.
- Prioritize work.
- Train employees (account follow-up staff should also know which accounts to focus on).
- Establish work volume and quality goals.
- Vigorously pursue the collection of all A/R in excess of 45 days.
The 1970s were sentinel years in health care in New Jersey, witnessing the implementation of the Health Care Reform Act (1971) and giant leaps in health planning and facilities licensure. These efforts were directed by the then Commissioner of the New Jersey State Department of Health, Dr. Joanne Finley, who passed away on October 22nd in Townsend, Maryland.

Dr. Finley, the first woman State Commissioner of Health, was appointed by Governor Brendan T. Byrne and took office on June 17, 1974. Antioch College awarded her baccalaureate degree in public administration and economics with honors in 1944. Following graduation, she was administrative assistant to Congressman George E. Outland of California and served as his campaign manager in 1948.

In 1951, she received her Master of Public Health degree from Yale University of Medicine. For several years she was health education director for a Maryland health association and was field training supervisor of graduate students in sociology at the University of Maryland. Prior to receiving her medical degree from Case-Western Reserve University in 1962, she also was executive director of an organization promoting prenatal and postnatal education of parents in metropolitan Washington, D.C. She was board certified in Preventative Medicine and Public Health.

For more than five years, beginning early in 1963, Dr. Finley filled positions of increasing responsibility in Ohio. She was research director of the Cleveland Health Goals Project, medical deputy commissioner and acting commissioner of health for that city, and project director for one of the first neighborhood health centers funded by the Office of Equal Opportunity.

She served as director of health planning for the Philadelphia Department of Public Health, and later she was vice president for medical affairs for the Blue Cross Association of Greater Philadelphia; director of public health in the New Haven Department of Health, Connecticut, and a faculty member of the Yale University School of Medicine's Department of Epidemiology and Public Health.

JOANNE E. FINLEY, M.D., M.P.H.: RECOLLECTIONS AND REFLECTIONS

I met Joanne at her first meeting with the State Health Planning Council. As President of the Comprehensive Health Plan Agency of New Jersey, I served ex officio on the Council. Joanne was brimming with ideas for changes to the State's health planning system, certificate of need and, of course, for implementing the system for making payments for New Jersey hospitals and nursing homes. During the summer of 1974, probably because I was the only economist serving on the public bodies with which Joanne was involved at the time, she asked me to participate in or chair various committees looking at several of her ideas. When she was Health Commissioner for the City of New Haven, she had been in contact with John Thompson, Bob Fetter and their crew at Yale who were developing diagnosis (which they called diagnostic) related groups to identify outliers in treatment patterns. Their goal was to see why some patients appeared to get excessive resources devoted to their care. Joanne, in her inimitable way, asked the question “Well, could that be used for payment?”, and sent me up to the Yalies to find out.

After spending a couple of days at Yale being walked through their DRG methodology, I reported back to Joanne that, while most of the DRGs were not statistically stable, I thought that with appropriate payment methodologies, they could be used as a measure of resource use for patient care, and therefore for costing such care. Joanne, Dave Wager and I spent continued on page 18
many hours talking through whether it was a good idea, and Joanne decided that we should apply for one of the grants from the Bureau of Health Services in the Social Security Administration (which was running Medicare at the time) to see if we could fund an experimental payment methodology based on the DRGs. The rest is history, thanks to the devoted efforts of a large number of folk who worked on the project after we obtained the grant, headed by Michael Kalison, who developed the details for the system over the next several years.

What may be less well known is that was only one small aspect of Joanne’s interest in developing systematic approaches to public health in the State. Not only was she an enthusiastic supporter of population-based health planning, long banished from the scene but a useful way of identifying the needs of potential patients (and appropriate wellness programs), but she was a great advocate of implementing health planning through the certificate of need program. As with many things, she experienced ups and downs in her efforts to implement certificate of need, the most notable down being her failure to impose it on physician-based facilities, and her most notable success being the approval of certificates of need before a hospital could close or move its location. She was a devoted advocate for underserved populations, and her efforts to keep hospitals in underserved areas using CON were notable. She also succeeded in closing the first hospital in Morristown, New Jersey as a result of months of negotiations.

On the more traditional public health side, Joanne was interested in bringing to bear the tools of health planning and resource allocation to the public health care programs. For example, she wanted to see health planning methods used to integrate etymological studies with public health programs, including vital statistics.

While Joanne is probably best remembered for her innovative work in introducing DRGs as a payment methodology, the breadth of her interest in changing the way all public health services were provided was truly astounding. She was one of the smartest people I have ever met, and beneath a somewhat acerbic exterior, she had a heart of gold.

John B. Reiss, Ph.D. JD
Partner, Saul Ewing LLP

Dr. Finley achieved national notoriety for New Jersey when she heard of the work of two Yale professors, Robert Barclay Fetter and John Devereaux Thompson whom she brought to New Jersey to introduce their revolutionary concept of paying for health care by diagnosis type (Diagnostic Related Groups or “DRGs”). Dr. Finley’s interest became the impetus for the Federal TEFRA law (Tax Equity and Fiscal Responsibility Act) and resulted in the first application of such a DRG system to all payers in our state (Chapter 83). Under Dr. Finley’s leadership, New Jersey became a “laboratory of democracy” that tested the DRG experiment and its success led to its adoption nationally in the federal Medicare program where it survives to this day.

This did not make her a popular Commissioner - change is always difficult - but her actions were indeed transformational, resulted in a stable hospital financial climate and, viewed in the context of our current hospital fiscal crises, perhaps a wiser course.

I served as Deputy Commissioner of Health from 1987 - 1990 and was responsible for administering the DRG system in New Jersey during its heyday. I had a front row seat to watch New Jersey’s DRG system lead to the adoption of the critical premise that no New Jerseyan should be denied acute care based upon their ability to pay for that care and the implementation (under Dr. Rick Goldstein’s and Dr. Molly Coye’s administration) of New Jersey’s Uncompensated Care Trust Fund - the harbinger of today’s Charity Care program.

Although we no longer use DRGs for all payers in New Jersey, without Dr. Finley’s foresight and hard work, the reforms we are considering today to provide universal access to health care for all New Jersey citizens would be elusive and well beyond our reach. If we are successful, Dr. Finley’s vision will deserve a significant part of the credit.

Dave Knowlton
President & CEO, New Jersey Health Care Quality Institute

When Governor Byrne appointed Dr. Finley to serve as his Commissioner of Health, this Philadelphia pediatrician left Independence Blue Cross to take on the unenviable task of implementing the 1971 health care reform act which had been enacted during Governor Cahill’s term. Dr. Finley not only complied by implementing SHARE to set 1974 payment rates for Blue Cross and Medicaid, she also had the vision to invite John Thompson and his Yale colleagues to discuss a whole new concept of paying by the case for particular diseases. Professor Thompson convinced us that “If General Motors can cost out cars, hospitals can cost out patients.” That hypothesis became the basis for a Medicare waiver that resulted in New Jersey implementing all-payor DRGs beginning in 1979. I remember it well – I had just been promoted to manager at Haskins & Sells (now Deloitte) and was assigned to the DoH as Project Manager where I spent 1974-77 in Trenton responsible for the design and implementation of SHARE and the conceptual design of the all-payor DRG system. While Dr. Finley could be headstrong and abrupt, and had an adversarial relationship...
with Jack Owen and NJHA, her role in New Jersey was indeed transformational. Indeed, Medicare’s subsequent adoption of DRGs as the basis for its Prospective Payment System transformed hospital payments nationwide.

To give you some idea of how times have changed, I always dreaded meetings with her, not because she could be stubborn and hard headed, but because she chain smoked filtered Kools – in her office. The longer the meeting, the thicker the blue haze.

John Dalton
Senior Advisor, BESLER Consulting

We have all experienced times in our lives that when you are in “it” you don’t really know the significance of “it” until many years later. This was my experience with Joanne Finley. I was 22 years old – just out of college and starting my graduate studies in Economics. I was hired at the NJ Department of Health as a project staff person for a demonstration project to develop a prospective payment system based on case mix. We now all know that this was the springboard for Medicare’s IPPS. We certainly did not know that at the time, but Joanne Finley did. She had the vision and surrounded herself by the talent – Dave Wagner, John Reiss, Mike Kalison and later Bruce Vladeck – to make it happen. Since this was my first professional experience, I did not realize how unusual all this was. It was 1977 – healthcare was still very male dominated and I was given the opportunity to work for a professional woman that would show me that anything was possible if you were passionate about your work and stayed focused on the goal. I valued Joanne as my mentor and am grateful for the confidence she had in me. She has no doubt left her mark in health policy, but she also has influenced so many of us in our chosen careers. She will be greatly missed.

Jo Surpin
President, Strategic Health Alliance, LLC

I think we all appreciate the enormity of the task that Dr. Finley faced in bringing an experimental case rate system to New Jersey and using it as the basis for hospital reimbursement in the state and ultimately nationally. What may get lost in a review of her achievements is the fact that in pursuing an “all payer” system that included uncompensated care as part of the financial elements of a hospital, Dr. Finley was able to avoid New Jersey developing a two tiered system of hospital care—one for the rich and one for the poor. “Equal access to high quality care regardless of payer source” was a key element of Dr. Finley’s agenda and one that she arguably achieved during her tenure.

Paul R. Langevin, Jr.
President, Health Care Association of New Jersey

Joanne Finley was an extraordinary visionary who care most about seeing to it that everyone had access to the highest-quality medical care possible. Her public persona never adequately reflected her wisdom, her compassion, her empathy, or her considerable wit. She could be difficult to work for, but we knew how desperately she cared.

Bruce C. Vladeck, Ph.D.
Senior Health Policy Advisor/Executive Director,
Health Sciences Advisory Services
Ernst & Young LLP

Shortly after she appeared for me as a witness in a rate case involving Blue Cross, Dr. Finley sent along her application for a Medicare demonstration of “payment by the case”, and asked me to consider heading up the team that would develop this system. Dr. Finley, who had been a student at Yale, recognized the significance of an academic idea (that had enjoyed limited application in the area of utilization review). She wanted to transform DRGs into a payment system that would function in the real world. To accomplish this, she placed her confidence in a number of people, from the team of skilled senior administrators who overcame political obstacles, to the talented young people that I had the privilege of working with on the methodology. All of these individuals made important contributions to the success of this venture. Indeed, one of Dr. Finley’s talents was her ability to attract individuals with the skill sets necessary to bring her ambitious idea to life. And all of these people shared something in common: excitement over the basic idea, and the opportunity to be part of important change. Indeed, DRGs became the fundamental building block of a new language for the health care industry. But for all of these contributions (including my own), she must get the credit for seeing the vision, and for the fundamental act of will: Before Joanne Finley, hospitals were reimbursed for their costs by the day; after Joanne Finley, IPPS.

Mike Kalison
Partner: Kalison, McBride, Jackson and Murphy, P.C.
Chairman, Applied Medical Software, Inc.

A special note of thanks to Commissioner Heather Howard for her assistance and support in the collection of information for this tribute.
**Who’s Who in NJ Chapter Committees**

2008-2009 Chapter Committees and Scheduled Meeting Dates

For more information on our committees, including each committees’ goals and objectives, please visit our website at www.hfmanj.org. NOTE: Committees have use of the NJ HFMA Conference Call line. The call in number is (866) 459-4772.

If the committee uses the conference call line, their respective attendee codes are listed with the meeting date information below.

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<th>COMMITTEE</th>
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<th>SCHEDULED MEETING DATES/TIMES</th>
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<td>Mike Alwell</td>
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<td>9:00 AM</td>
<td>Mike <a href="mailto:Alwell@atlantichealth.org">Alwell@atlantichealth.org</a></td>
<td>973-656-6949</td>
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<td><a href="mailto:arothkamp@asl.com">arothkamp@asl.com</a></td>
<td>9:15 AM</td>
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Ask the Ethics Guy®!
Downsizing 101

by Bruce Weinstein, Ph.D., The Ethics Guy®

Part 1: When You Have to Do It

Most discussions about downsizing focus on the legal, economic, or psychological issues raised by this practice. These are essential concerns, but we rarely consider how or why downsizing is also an ethical issue. The next two columns are an attempt to redress that problem. Here, we’ll consider your ethical responsibilities if you are the one charged with giving the bad news. In the second column, we’ll look at what you ought and ought not to do if you are the one being downsized.

WHAT’S IN A NAME?

Downsizing refers to a company’s decision to reduce its workforce for reasons other than poor performance, criminal conduct, or unethical behavior on the part of those being let go. The word is a euphemism meant to soften the blow as much for the company as much as it is for the soon-to-be eliminated. There is nothing wrong with making a difficult task easier to bear. In fact, there are good ethical reasons for doing so, as we’ll soon see. Still, there is no getting around the fact that downsizing is a type of layoff, with all that this implies. The ethical manager will keep in mind what is really going when he or she is charged with letting good people go.

WHY DOWNSIZING IS AN ETHICAL ISSUE

Anytime we’re faced with a decision that can affect the rights or well-being of others, we’re looking at an ethical issue. No matter how strong the justifications for reducing the workforce are or seem to be, laying off loyal and productive employees is an upsetting experience for all concerned, and those on the receiving end face not just financial but psychological injury.

How so? For many of us, the workplace isn’t just a place for work; it’s where we develop and maintain some of the most important relationships we have. During the week, we spend more time with co-workers than with our families, and for better or worse, work is how many of us define ourselves and give meaning to our lives. Getting laid off compromises all of these things, so managers should think of downsizing as a deep and painful trauma for those being let go, and not as a mere set-back or reversal of fortune.

Yes, downsizing has legal implications, and it is understandable that companies want to minimize their liability when they downsize. Yes, there are economic matters to consider, which makes downsizing a management issue, too. But at its core, downsizing is an ethical issue, and the good manager is concerned not just with protecting the company’s financial and legal interests but with honoring the dignity and integrity of the human beings who work on the front lines and who are the lifeblood of the organization.

DOING IT THE RIGHT WAY

I propose the following management guidelines for downsizing ethically:

1. DO IT IN PERSON.

This seems obvious thing to do, but I’m surprised by the number of reports I’ve heard about employees who were downsized on the phone or by e-mail. Managers who use this method claim it makes the whole thing easier to deal with. Yes...but for whom? Certainly not for the employee being let go. As uncomfortable as it is to end someone’s employment, the right thing to do is to have a private conversation with him or her in person. The ethical principle of respect for others requires nothing less.

2. DO IT PRIVATELY.

Respecting others means honoring their wishes and values, and it is reasonable to assume that most people would prefer to have troubling news delivered in private. This means in your office, with the door closed. I’ve heard of managers who broke the bad news at the employee’s cubicle within earshot of everyone in the vicinity. Again, one would think that this would be a matter of common sense and common decency, but apparently neither is all that common.

3. GIVE THE PERSON YOUR FULL ATTENTION.

Interrupting the conversation to take phone calls, check your BlackBerry, or engage in other distractions isn’t just rude. It tells the other person that the matter at hand isn’t all that important to you and is yet another violation of the principle of respect. The impulse to turn your attention to less troubling matters is understandable, but along with the privileges of being a manager come responsibilities, and downsizing with integrity is one of the most important obligations you have.

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4. BE HONEST, BUT NOT BRUTALLY SO.

Must you always tell the truth, the whole truth, and nothing but the truth? Yes, if you’re giving sworn testimony in a court of law, but beyond the courtroom the duty to tell the truth is constrained by the duty to minimize harm. In practical terms, this means being forthright with the employee but also choosing with the care the words, tone of voice, and demeanor you use. Compassion – literally, ’suffering with’ someone–honors the dignity of your employee and speaks to the better part of your nature.

We can’t always make things better, but we shouldn’t make things worse.

5. DON’T RUSH.

A shock takes time to absorb. Imagine that your physician tells you that you have a serious illness. Wouldn’t you expect him or her to allow the news sink in, rather than to summarily dismiss you and call for the next patient? Being let go isn’t as serious as getting a diagnosis of cancer or heart disease, but it is still a major, life-changing event. You owe your employee the space to absorb the information, and you may have to explain more than once what is happening and why. You would demand nothing less if it were happening to you, and you would be right to do so.

YOU VS. THE COMPANY

These guidelines assume that the organization has good reasons for downsizing—but what if you don’t see things this way? For example, suppose your company believes that it is necessary to shift its customer service jobs overseas, and you believe that doing so is both unethical and bad for business. In this case, you not only have a right to object; you have an ethical obligation to object.

Does this mean that you should be prepared to give up your job on moral grounds? Not necessarily. Depending on your personal circumstances, your duties to your family or to yourself might justifiably override the value of making a statement by quitting. Even if you are committed to keeping as many jobs in the U.S. as possible, this goal will take time to achieve, and it may be easier to do so from within the company than from the outside.

The bottom line is important, but so are the values of respect, compassion, and simple human decency. The good manager takes all of these into account—always.

About the Author

Dr. Bruce Weinstein, The Ethics Guy, is a corporate ethics trainer and writes the ethics column for BusinessWeek.com. He appears regularly on CNN. For more information, visit TheEthicsGuy.com.
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FOCUS: How did you get started? What is your educational and professional background?

RICH: I graduated from Bryant College (now known as Bryant University) with a BS in Accounting. I have worked in the healthcare industry my entire career starting with the State of New York performing Medicaid Audits. After completing the CPA exam, I worked for Ernst & Whinney (Newark, NJ) on their Healthcare audit team. I was recruited by Solaris Health System (formerly JFK Health System) in 1986, and have spent the past 22 years working for Solaris.

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

RICH: I knew I wanted to be in the accounting field, but I never envisioned being in the Healthcare industry. Ernst & Whinney’s healthcare practice consisted of small number of audit clients in the early 1980’s, so most of us just starting out in public accounting were not eager to be assigned to Healthcare. The firm’s goal was to be a major audit firm in NJ, so I knew resources would be dedicated to building the healthcare practice. E&W started recruiting Senior Executives from other accounting firms, which lead to significant growth of the healthcare practice. It was exciting to be part of this growth, so I committed to being in healthcare full time, which eventually lead to the opportunity at Solaris.

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

RICH: The healthcare industry today requires today’s CFO to have skills and involvement in areas broader than the traditional financial skills. I believe that financial executives need to learn the specifics of the healthcare industry, and understand what drives the value in this business. The changing landscape requires the balance of maintaining financial goals with the need to ensure resources are available to fulfill the mission for the long term. CFOs need to embrace the commitment to quality/safety as transparency and consumerism continue to increase. The CFO must help senior management in clinical operations accomplish their operating imperatives within the constraints of the financial pressures facing the organization.

FOCUS: What are you hospital specifics—part of a system? Describe your location, demographics and services of your hospital

RICH: Solaris Health System, located in Edison is a $500 million organization that consists of JFK Medical Center with 399 acute care beds and 94 rehabilitation beds, four Long-Term Care facilities (totaling 692 beds) and Shore Rehabilitation Institute (40-bed facility in Brick, NJ) which is jointly owned with Meridian Health System. Muhlenberg Regional Medical Center in Plainfield, closed as an acute care facility in August 2008, but a Satellite Emergency Department (SED), Outpatient Services, Home Health Care, and the Schools of Nursing and Medical Imaging remain on the campus. The hospital provides a full range of acute care services and is known for the NJ Neuroscience Institute, Hospice services, Bariatric services and rehabilitation’s Center for Head Injuries.

FOCUS: Can you tell us about your hospital’s a) turnaround, B) new building, C) new infrastructure, d) new procedures offered?

RICH: Solaris has recently completed the process of closing Muhlenberg as an acute care provider, and we are now in the process of transitioning JFK to becoming more of a Regional Medical Center, taking care of the Edison and Plainfield communities. While all inpatient services will be provided at JFK in Edison, the Plainfield campus will continue to operate the SED and an Outpatient Ambulatory Care Center. The School of Nursing and Radiology recently moved into a new facility on campus which now offers housing for students attending the school. JFK is beginning the building process on the Edison campus of expanding the Emergency Department, inpatient unit (40 beds) as well as outpatient services (cardiac services).

FOCUS: What types of financing are utilized to meet the hospital’s goals?

RICH: The System has recently utilized the Variable Rate Comp Program issued through the New Jersey Health Care Facility Financing Authority (NJHCFFA) for capital expansion
FOCUS: What are your professional memberships?

RICH: I am a member of HFMA and the State Society of CPA’s for both NJ and NY.

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

RICH: While I do enjoy skiing, a warm beach side resort is preferable. With my wife Josephine by my side, my three children (not sure they would be willing to go along), golf clubs, plenty of nice cigars, and Coronas are all I would need.

Member Spotlight:
Michael Alwell, FHFMA

by James Yarsinsky, CPA

FOCUS: Mike – please provide us with a short bio on yourself.

MIKE: I started my career in healthcare in 1984 when I was hired as a phlebotomist at Morristown Memorial Hospital. After a couple of years in the lab, I moved from the clinical side of healthcare to the business side, accepting an entry level position in the budget office. Over the years, I advanced through the ranks of the finance department where I held positions in budget & reimbursement, cost accounting, and managed care contracting. With the creation of Atlantic Health System in 1996, I moved into the position of Director of Finance at Morristown Memorial. In 2000, I was promoted to the corporate position of Director of Financial Compliance with responsibilities at all Atlantic Health facilities.

I am a member of the Morris County Chamber of Commerce Government Affairs Committee, and NJHA’s Corporate Compliance Constituency Group.

Since joining the NJ Chapter of HFMA in 1995, I’ve served on or chaired a number of committees and sub-committees and obtained the FHFMA designation.

I have an undergraduate degree in Finance from William Paterson College and a Masters in Public Administration from Fairleigh Dickinson University. I live in Whippany, NJ with my wife and two children.

which I hope to start playing on a more regular basis. In the summer I enjoy relaxing down the shore or by the pool.

FOCUS: What are your professional memberships?

RICH: I am a member of HFMA and the State Society of CPA’s for both NJ and NY.

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

RICH: While I do enjoy skiing, a warm beach side resort is preferable. With my wife Josephine by my side, my three children (not sure they would be willing to go along), golf clubs, plenty of nice cigars, and Coronas are all I would need.
proper use of ABNs and outpatient observation services. To respond to the introduction of MS-DRGs, last year I implemented a system-wide physician documentation improvement program. I am now in the process of meeting with the various physician groups to report on the successes of the program and to educate the medical staff on Medicare’s Present on Admission documentation requirements. I am also responsible for the oversight of the Medical Records departments at both sites, and have recently taken on the responsibility of managing a two year project aimed at decreasing length of stay at one of Atlantic’s acute care facilities.

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

**MIKE:** For me, every day brings something new. One of the biggest challenges that I actually enjoy is to be able to stay on top of the ever changing Medicare regulations and developing ways to explain those changes to different audiences. I may find myself having to address observation issues with case managers in the morning, then presenting the implications of POA to the Medical Executive Committee that evening. The next day I may be talking about the billing and coding of specialty braces with rehab managers then speaking about MS-DRGs at a hospital Advisory Board meeting. Throw in a few phone calls from the business office or a clinical department asking about CCI, LCD, or NCD edits or chargemaster issues on top of that and I’d say I had a good day.

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

**MIKE:** The one suggestion that I can give to anyone interested in entering healthcare finance and compliance is to stay abreast of current trends and regulatory changes in the industry. The rules of today will most certainly be different a year or two from now. It is extremely important to keep current through newsletters, websites, journals, and networking within the industry.

**FOCUS:** What are your hobbies and outside interests?

**MIKE:** In my spare time??!

I’ve been telling myself for a long time that I want to start a regular exercise program, but I haven’t taken the idea beyond walking the dog in the morning.

I have been doing community service since I was 15 years old when I joined a local first aid squad. While I don’t get up at 2:00 am any more for first aid calls, I still believe that keeping active in the community is very important. Today I serve as a member of the Hanover Township Public Schools Board of Education.

Most weekends you will find me shuttling my children between soccer games, or other activities if I’m not mowing the lawn or working on a home improvement project.

**FOCUS:** Thank you for taking the time out of your busy schedule to be interviewed for this edition of Member Spotlight.

**MIKE:** Thank you for thinking of me, Jim.

**About the Author**

Jim Yarsinsky, CPAM, is president of Expeditive, a BESLER affiliated company. He can be reached at jyarsinsky@expeditive.com.

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Don’t forget to check our website often for the latest news and information:

**www hfmanj.org**

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Wishing you and your families all the best this Holiday season and in 2009!

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</tr>
</thead>
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<tr>
<td>Alina Moran</td>
<td>NYC Health &amp; Hosp. Corp.</td>
<td>Senior Director</td>
<td>(212) 788-3688 <a href="mailto:alina.moran@nychhc.org">alina.moran@nychhc.org</a></td>
</tr>
<tr>
<td>Doris Donnerstag</td>
<td>Shore Memorial Hospital</td>
<td>Financial Analyst</td>
<td>(609) 653-3810 <a href="mailto:ddonnerstag@shorememorial.org">ddonnerstag@shorememorial.org</a></td>
</tr>
<tr>
<td>Karen Van Dexter</td>
<td>Shore Memorial Hospital</td>
<td>Systems Procedure Analyst</td>
<td>(609) 653-3256 <a href="mailto:kvandexter@shorememorial.org">kvandexter@shorememorial.org</a></td>
</tr>
<tr>
<td>Jeremy Arnold</td>
<td>Ernst &amp; Young LLP</td>
<td>Audit Manager</td>
<td>(212) 773-5486 <a href="mailto:jeremy.arnold@ey.com">jeremy.arnold@ey.com</a></td>
</tr>
<tr>
<td>Johanna Lee</td>
<td>Cooper University Hospital</td>
<td>Mgr Product Support</td>
<td>(856) 382-6565 <a href="mailto:lee-johanna@cooperhealth.edu">lee-johanna@cooperhealth.edu</a></td>
</tr>
<tr>
<td>David Teichman</td>
<td>Englewood Hospital &amp; Medical Center</td>
<td>Internal Auditor</td>
<td>(201) 894-3559 <a href="mailto:david.teichman@ehmc.com">david.teichman@ehmc.com</a></td>
</tr>
<tr>
<td>Joseph R. Zazzera</td>
<td>A.M. Best Company</td>
<td>Managing Senior Financial Analyst</td>
<td>(908) 439-2200 <a href="mailto:joezazz1@verizon.net">joezazz1@verizon.net</a></td>
</tr>
<tr>
<td>Kim Karasiewicz</td>
<td>Deloitte Financial Advisory Services LLP</td>
<td>Manager</td>
<td>(212) 436-7545 <a href="mailto:kimk734@comcast.net">kimk734@comcast.net</a></td>
</tr>
<tr>
<td>Christopher F. Kelly</td>
<td>Besler Consulting</td>
<td>Director, Business Development</td>
<td>(732) 839-3888 <a href="mailto:cfkelly@beslerconsulting.com">cfkelly@beslerconsulting.com</a></td>
</tr>
<tr>
<td>Joseph DiRienzo</td>
<td>Aetna Of Northern New Jersey</td>
<td>Vice President, Network</td>
<td>(973) 244-3856 <a href="mailto:dirienzoj@aetna.com">dirienzoj@aetna.com</a></td>
</tr>
<tr>
<td>Carol McKenzie</td>
<td>CHN PPO</td>
<td>Contract Manager</td>
<td>(800) 225-4246 x6587 <a href="mailto:carol.mckenzie@chn.com">carol.mckenzie@chn.com</a></td>
</tr>
<tr>
<td>Heath Foor</td>
<td>The Children’s Hospital of Philadelphia</td>
<td>Director of Budgeting</td>
<td>(267) 426-6165 <a href="mailto:ha4foor@gmail.com">ha4foor@gmail.com</a></td>
</tr>
<tr>
<td>Lisa Santoro</td>
<td>CHN PPO</td>
<td>Assistant VP of Network Operations</td>
<td>(800) 225-4246 x6313 <a href="mailto:lisa.santoro@chn.com">lisa.santoro@chn.com</a></td>
</tr>
<tr>
<td>Cecilia Moseler</td>
<td>Aetna Health</td>
<td>Network Manager</td>
<td>(201) 224-2150 <a href="mailto:moselerc@aetna.com">moselerc@aetna.com</a></td>
</tr>
<tr>
<td>Francis Lamorte</td>
<td>Alpha Healthcare Consultants, LLC</td>
<td>Managing Senior Financial Analyst</td>
<td>(973) 202-8971 <a href="mailto:lamortef@comcast.net">lamortef@comcast.net</a></td>
</tr>
<tr>
<td>David Desantis</td>
<td>President</td>
<td></td>
<td>(908) 672 0275 <a href="mailto:David.DeSantis@comcast.net">David.DeSantis@comcast.net</a></td>
</tr>
<tr>
<td>Jamie Pesci</td>
<td>Christian Health Care Center</td>
<td>Director HIM</td>
<td>(201) 848-5845 <a href="mailto:jpesci@chccnj.org">jpesci@chccnj.org</a></td>
</tr>
<tr>
<td>Annette Annuzzi</td>
<td>Virtua Medical Group</td>
<td>Assistant Vice President</td>
<td>(856) 355-0361 <a href="mailto:aannuzzi@virtua.org">aannuzzi@virtua.org</a></td>
</tr>
<tr>
<td>Margaret Highberger</td>
<td>Wachovia Bank</td>
<td>Healthcare Sales Consultant</td>
<td>(856) 833-1246 <a href="mailto:margaret.highberger@wachovia.com">margaret.highberger@wachovia.com</a></td>
</tr>
<tr>
<td>Paul K. Degrado, Esq.</td>
<td>Paul K. Degrado And Associates, LLC</td>
<td>Attorney</td>
<td>(201) 678-9007 <a href="mailto:PaulDegrado@Degradolaw.com">PaulDegrado@Degradolaw.com</a></td>
</tr>
<tr>
<td>Susan M. Davis</td>
<td>KPMG LLP</td>
<td>Director</td>
<td>(973) 912-6438 <a href="mailto:susandavis@kpmg.com">susandavis@kpmg.com</a></td>
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Let us know more about you. New (and old!) Members are invited to complete a New Member questionnaire. If you haven’t received a copy, please contact Rosemary Nuzzo at Rosemary.Nuzzo@Atlanticare.org.
The HFMA Value Proposition

by Thomas Albanesi, Jr. FHFMA, CPA

I was recently asked by Region 11 Regional Executive Walt Luke to write an article about the value of HFMA. Apparently, Region 11 has some chapters that are losing members because some employers don’t believe there is much value in their employees being members of HFMA. I’m going to try to provide you with some talking points to address this challenge.

Before you can attempt to educate your employer on the value of HFMA, you first need to assess whether you’re getting as much value out of your membership as you could be. Do you even look at your copy of hfm magazine when it’s delivered, or is it tossed into a pile with all the other reading materials you don’t read? Why is hfm different, and why should it be placed on top of your reading materials ahead of all the others? Easy—it’s the one monthly magazine that covers your industry from A to Z. It is full of insightful articles, commentary, and tools that can help you excel in your job. Many of the articles are written by your peers, who are offering their ideas and expertise to their fellow healthcare finance professionals.

Other sources of information in hfm are the display ads. Healthcare vendors know that hfm has the exact audience they are looking for, and they spend big bucks on these ads. New products, new solutions, and customized answers are often debuted in these ads. If you’re seeking a solution to a challenge at work, the answer may be in an ad in hfm.

Are you using the HFMA web site at www.hfma.org? It’s packed with information that can help you and your employer solve challenges at work. If you haven’t logged in for a while, do so today. It’s easy to use and it is searchable. The content is continuously updated for late-breaking healthcare issues. Unlike the results produced by using a generic web browser (which can be potluck at best), the content on the HFMA web site has been vetted for its applicability to the field of healthcare finance.

What about the online member directory? It’s a valuable tool that provides quick access to your peers both in your chapter and across the organization.

If you’re not an active member, either get active or don’t be shocked when your boss informs you that your membership dues won’t be covered. Better yet, get involved in your chapter. I was a classic HFMA wallflower who looked at my shoes anytime the chapter was soliciting volunteers. I was quite reluctant to volunteer. But once I did, the value of my membership soared! I was viewed much differently by my peers, and to this day I enjoy a level of respect in my chapter that I would have never attained without becoming an active volunteer. It’s so true—you’ll get much more out of HFMA if you put something into it.

Now that you’ve assessed your own efforts to derive value from your HFMA membership, let’s start on your employer. First, explain to your employer what HFMA is: the premiere membership association for healthcare finance professionals. An organization whose vision is “to be an indispensable resource for healthcare finance.” An industry leader that doesn’t just report healthcare news, but is helping to create the future of health care.

The best way to demonstrate the value HFMA brings to employers who pay our dues is to give tangible examples of the times you’ve used HFMA resources to solve a problem or learn something valuable. Show your boss the in-depth articles in hfm. Introduce him or her to the web site and to the quality and depth of resources that are listed. Share how the online member directory has been a resource to you in solving a problem. Show an agenda from an upcoming meeting, and highlight the line-up of industry experts who will be presenting. Better yet, get your boss to accompany you to an upcoming meeting and see the value first-hand. Or speak with the program committee about getting your boss a presenter’s role at an upcoming meeting.

Any human resources consultant worth a hoot will tell you that an educated workforce is critical in today’s fast-moving information age. Explain to your employer that there is no better organization than HFMA to keep you informed about the latest developments in healthcare finance. Forward to him or her pertinent e-mail alerts we receive on breaking issues, as well as the “Weekly News Highlights” e-mail that summarizes (with links for expanded analysis) critical developments in the healthcare industry.

Finally, make a value comparison with other resources your organization consumes. Suppose your annual HFMA budget consists of $3,000, which covers your dues, a few chapter meetings, and perhaps ANI. Compare that with the cost of engaging a consultant for one day and make a value comparison! I’m not knocking consultants; I used to be one earlier in my career. My point is that HFMA is an incredible year-round value for healthcare finance professionals.

About the Author

Thomas Albanesi, FHFMA, CPA, is vice president, corporate finance, West Penn Allegheny Health System, Pittsburgh, and a member and past president of HFMA’s Western Pennsylvania Chapter. He is also a member of the HFMA National’s Board of Directors and chair of HFMA’s 2008-09 Regional Executive Council.
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**Hospital Finances during Difficult Economic Times**

In what ways is the current economy affecting New Jersey hospitals?

New Jersey hospitals are facing a tremendous financial crisis. Healthcare in general is inherently expensive. Hospitals must pay exorbitant amounts of money in order to upgrade their equipment and construct new facilities. These upgrades result in better patient care and an ability to serve larger numbers of patients. However, in light of volatile economic times, hospitals are faced with unpredictable cash flow and are finding it difficult to keep plans for growth and upgrades on the table.

In this economic climate, banks are lending less. With as many as two thirds of patients either uninsured or covered by Medicare/Medicaid—which offer delayed payments or rates that can be well below the hospital’s actual costs—banks are even more reluctant to provide financial assistance.

A rising unemployment rate translates to more people now without insurance. As a result, there are not only increased instances of nonpayment, but there has also been a reduction in discretionary health care. Many consumers have opted to delay medical procedures until the economy improves. These precautions have expectedly hurt sales and profit growth at hospitals.

Public and private hospitals are suffering an additional loss, as taxpayer philanthropic support fails to keep up with the increasing cost of caring for the uninsured and underinsured. Some hospitals are finding it very hard to even keep their doors open. Within the last 18 months, eight NJ hospitals have closed and five have filed for bankruptcy. And 15 years ago, NJ had 112 acute care hospitals; today there are only 74, with half of those losing money last year.

Variable rate demand bonds that were a good deal for the healthcare industry for much of the past decade because their rates were significantly below fixed-rate bonds are now being affected. The interest rates hospitals are paying, which can change on a weekly basis making them highly volatile and unpredictable, have now shot up significantly. While they were previously in the range of just 3 or 4 percent, they may be as high as 10 percent.

Of course, these financial constraints have had a considerable impact on patients as well. With a limited budget, many hospitals have found themselves short staffed and unable to repair or replace damaged equipment, which has resulted in overcrowding. This has led to lengthy delays in the waiting room and pharmacy, and patients possibly waiting 24 hours before they are moved to intensive care. Hospitals have been forced to discontinued some services altogether in order to survive, and there are long-lasting waits for appointments due to the staff shortage.

To add to all of this, New Jersey hospitals are in the shadow of impending RAC program reviews in the fall of 2009, which could add more stress to the bottom line when the Centers for Medicare and Medicaid Services (CMS) look to recoup Medicare overpayments.

What can a hospital do in these difficult economic times?

First and foremost from an accountant’s perspective, wasteful spending must be identified and minimized. According to recent studies, wasteful spending in the health system has been calculated at up to $1.2 trillion of the $2.2 trillion spent in the United States, with unnecessary or inappropriate tests and procedures being the biggest problem. These common inefficiencies can add up. CFOs and Directors of Finance, with possible assistance of outside professional guidance such as an external auditor, must work to identify areas of excess in order to reduce these expenditures.

According to another national study, approximately 65 percent of all bad debt is the result of insured patients, not uninsured patients. This is due to the frequent non-collection of upfront payments such as co-pays, co-insurance, deductibles and other out-of-pocket costs. The average outstanding insured patient portion ranges from $700-$1,100, depending on geography. Implementing the right software to track and alert staff to proper payment is crucial, as is training of staff on the execution of this software.

The RAC program being implemented in New Jersey hospitals is inevitable. In preparation of this review, and for the benefit of your facility in general, it would be wise to conduct your own internal audit of documentation practices to ensure accuracy and minimize risk of RAC recoveries. As discussed in
last month’s Focus on Finance column, a hospital may want to organize a RAC committee that would be responsible for reviewing samples of data on claims, admissions, documentation and coding, in order to identify repeated errors. All findings should be shared with your compliance officers, legal counsel and external auditor/accountant in order to address these issues and assess and mitigate risk.

Finally, the healthcare industry collectively must support legislators and policymakers who support efforts to expand health insurance opportunities in New Jersey in order to reduce the number of uninsured.

About the Author
Joseph J. Perez, CPA, is a Partner in the New Brunswick office of WithumSmith+Brown, Certified Public Accountants and Consultants. If you have further questions, Joe can be reached by e-mail at jperez@withum.com.

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•Certification Corner•

Strong Turnout at this Year’s Certification Coaching Course

We are pleased to announce that eleven (11) members participated in the Certification Coaching Course at this year’s HFMA Annual Institute. Special thanks to all coaches and good luck to all participants!

Special Note:
New Certification Exams for 2009-2010

Please note that the current Core and Specialty Exams will be replaced with updated versions as of January 1, 2009. If you have already begun preparing to take the course and are using the current Study Guide(s), be sure to take your exam before December 31, 2008.

Test your Knowledge:

Obtaining the patient’s personal, demographic, insurance, and financial information should occur during:

A. Account follow-up
B. Discharge
C. Preadmission
D. Admission

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

NJ Chapter Certification Contacts:
Jeff Noonan, CHFP – Committee Chair
Work Phone: 201-786-6000 x 6015
Email: jnoonan@md-x.com

Maria Facciponti, FHFMA – Committee Co-Chair
Work Phone: (973) 614-9100
Email: mfacciponti@armds.com

Michael Alwell, FHFMA
Work Phone: (973) 656-6949
Email: mike.alwell@atlantichealth.org

Announcement of Final Scheduled Test Date in 2008

We will be offering proctored exams in two locations on December 6th, 2008. The exams will be offered at the following locations. Testing will begin promptly at 9:00AM. Please reserve your spot in advance through the contact information listed below.

Atlantic Health
1000 The American Road, Atrium Level
Morris Plains, NJ 07950

ARMDS
261 Connecticut Dr. Suite 1
Burlington, NJ 08016
On a plane ride back from a ski vacation four years ago, I read an article in the airline magazine about two women in Michigan who had renovated the room of a young cancer patient who was recovering at home. I turned to my son and said, “Matt, you have to read this.” Matthew had been thinking about what he wanted to do as his bar mitzvah project, and by the time they got off the plane, he had decided. They called it Healing Spaces. A non-profit organization was born in Wayne, New Jersey by Linda Dumoff, our daughter Sarah, our son Matthew, and me. It became a mission to warm the hearts and bring joy to seriously ill children by creating a unique healing environment in their home that minimizes the stress of hospitalization and gives them their own space to recover.

Through an acquaintance, we were introduced to Dr. Michael Harris, Director of the Tomorrows Children’s Institute in Hackensack. It was Thanksgiving week of 2004, and Dr. Harris basically interviewed Matthew. “I want to bring healing to the home, and I’ve been trying to figure this out for 30 years. You’ve brought me the answer, Matthew,” said Dr. Harris.

“I view the home as a place where healing must take place,” the atmosphere within the home is very important. “The second thing is, there’s no doubt the families get tremendous comfort from knowing that people are watching out for their children – total strangers,” Harris said. “At a time when they are really down, it gives them faith in humanity.”

Healing Spaces provides a complete makeover for the patient’s room. Utilizing designers, artisans, painters, electricians, carpenters, and high school student volunteers, along with support from organizations like Sharp Electronics which donates Aquos flat panel HDTV’s, air purifiers and air conditioners; and Dell which donates laptop computers, we create one of a kind Healing Spaces bedrooms for these children.

“We had heard about this program. It pulls at the heartstrings,” said Andrew Kritzer, an associate vice president at Sharp who attended Healing Spaces’ first annual golf outing and dinner earlier this month. “I had tears in my eyes listening to these kids talking about how this made their recovery a much easier process.”

The charity’s clients are referred from Hackensack University Medical Center and Saint Barnabas Medical Center in Livingston. They are nominated first by social workers from the hospital, and then interviewed by a team from the charity before being approved.

“We ask the child what kinds of colors and themes they’d like, if they like sports, music or animals,” said Matthew Dumoff, now 16. Then the charity puts the family up for a weekend in one of several hotels that donate their services, and a team sets to work on the room – and often other parts of the home.

A recent client was Richard Mohan, a 23-year-old from West Orange who’s suffered from a brain tumor since he was 10.

“It’s amazing,” said his mother, Kamlawattie Mohan. “The bed he had before had sharp edges, which we always had to pad with pillows and sheets. Because of the way he gets off his bed, we always had to worry about him hurting himself. Now he has a brand new padded bed.”

Richard Mohan can’t walk, moving around his second floor bedroom by dragging himself along the floor. “They put in a good padded rug to make it easier on him. His closet used to have everything piled on the floor because he couldn’t reach the shelves. They moved the shelves around so he could reach them,” his mother said.
Richard appreciates those changes, as he does the new air conditioner and television. A lifelong Giants fan, he’s especially thankful for one other gift: “They gave me a jersey signed by Tiki Barber.”

But nothing compared with the most unexpected donation: a motorized wheelchair. “We live up on a hill, and with his tumor he shakes a lot,” his mother said. “Now he has independence.”

“For a kid to start something like this, he has to come from a good family. He has to have been taught good values. Healing Spaces is like a dream come true,” said Mrs. Mohan.

Since obtaining approval from the Internal Revenue Service for the charity’s tax-exempt status in 2006, Healing Spaces has redone seven children’s bedrooms. Neither the Dumoffs nor any of the Board Members or volunteers take a penny in salary from Healing Spaces. Aside from the $4,000 to $5,000 it spends to redo clients’ rooms, its only other expense has come from running fund-raising events.

The charity has created a working relationship with Sharp Electronics in Mahwah, which supplies new televisions, air conditioners, air purifiers and other equipment.

“We had heard about this program. It pulls at the heartstrings,” said Andrew Kritzer, an associate vice president at Sharp who attended Healing Spaces’ first annual golf outing and dinner earlier this month. “I had tears in my eyes listening to these kids talking about how this made their recovery a much easier process.”

Our next project will be for The Valerie Fund, and will take us to Morristown Memorial and Overlook Hospitals, where our hope continues to be able to improve the quality of life for more children and their families.

Healing Spaces’ goal for 2009 is to touch the hearts of ten children and their families by creating Dream Bedrooms in which they can recover. In order to expand Healing Spaces and serve the many children and families that are in need, we are building awareness by sponsoring world-class fund-raising events. This will attract like-minded supporters who share our passion for Bringing Healing to the Home.

Healing Spaces welcomes donations and volunteers always at www.healingspaces.org.

Please contact us at:
Healing Spaces
P.O. Box 2603
Wayne, NJ 07470

For over 20 years HFS has been serving the healthcare community with comprehensive programs that provide an effective and professional approach to the management and collection of uninsured and delinquent receivables-

We are proud of our excellent reputation, and we invite you to check with any of our valued client references.

If you would like to know more about our services please visit our website at www.hcfs.org, or contact Larry Friia at 973-429-8530 x7116 or at lfriia@hcfs.org, or Jerry Castoria at x7191 or at jcastoria@hcfs.org. We would welcome the opportunity to send you information on our company or schedule a meeting at your convenience.

Healthcare Financial Services Inc.
299 Glenwood Avenue
Bloomfield, New Jersey 07003
973-429-8530
HFMA-NJ’s Publications Committee strives to bring New Jersey Chapter members timely and useful information in a convenient, accessible manner. Thus, this Job Bank Summary listing provides just the key components of each recently-posted position in an easy-to-read format, helping employers reach the most qualified pool of potential candidates, and helping our readers find the best new job opportunities. For more detailed information on any position and the most complete, up-to-date listing, go to HFMA-NJ’s Job Bank Online at www.hfmanj.org.

[Note to employers: please allow five business days for ads to appear on the Web site.]

Job Position and Organization

FINANCE: STAFF ACCOUNTANT
St. Peter’s University Hospital

BUDGET & REIMBURSEMENT:
CHARGE DESCRIPTION MASTER COORDINATOR
St. Peter’s University Hospital

HEAD OF REIMBURSEMENT
Provident Health & Services

DIRECTOR, HEALTH INFORMATION SERVICES
A Northern NJ facility

PRESIDENT, INTERIM STAFFING FIRM
Interim Staffing Firm

CONTROLLER
Cape Regional Medical Center

CHIEF FINANCIAL OFFICER
Daughters of Israel

DATA ANALYST
QualCare, Inc.

ASSISTANT CONTROLLER
Trinitas Regional Medical Center

HOSPITAL CONTRACTING SPECIALIST –
NEWARK, NJ
Horizon Blue Cross Blue Shield of New Jersey

People Watching

Karen Lumpp, CPA, named Sr. VP and CFO of Trinitas Regional Medical Center

Karen Lumpp, CPA, newly named Senior Vice President and Chief Financial Officer, has 25 years experience in the field. Ms. Lumpp is former Director of Special Projects and Atlantic Health System and Director of Finance at Overlook Hospital in Summit, New Jersey. Ms. Lumpp holds a Bachelor of Science degree from Babson college in Wellesley, Massachusetts. Her professional affiliations include the American Institute of Certified Public Accountants, the New Jersey Chapter of the Healthcare Financial Management Association, and Executive Women of New Jersey. In her new role, Ms. Lumpp will apply her experience in budget preparation, project management, financial planning, capital financing, and financial statement preparations to the operations of the Finance Department.
New Jersey is in the process of crafting its Energy Master Plan (the “EMP”), which will be the blueprint for the state’s energy initiatives through 2020. A major focus of the EMP concerns energy conservation and efficiency initiatives, including prospective building and appliance regulations and codes. The EMP will have a major effect on hospitals and health systems throughout New Jersey. Despite the fact that the policies now being considered will have a tremendous impact on the health care community, hospitals and health systems have been virtually absent from the ongoing policy discussions. All New Jersey stakeholders, including hospitals and any business that owns or uses large buildings, should join the debate to assure that whatever policies are ultimately fashioned will be responsible, cost-justified and consistent with the interests of hospitals, the real estate community generally, and the State. At present, there is a real danger that this will not occur absent active participation by all affected parties.

The Board of Public Utilities (BPU) is responsible for most energy policy initiatives and is being assisted by an energy efficiency “think tank” of “experts” that will recommend the adoption of very aggressive, largely untested policies and standards. If adopted, these standards could inflict tremendous economic harm to large facility owners. A recent presentation by the experts indicated they will recommend to the BPU, among other things:

1. Implementation of mandatory, aggressive energy efficiency standards for existing and new buildings (30-50 percent greater efficiency is being debated);
2. Time of sale restrictions (targeted for implementation beginning in 2012) that would require compliance with certain energy standards as a condition precedent to the sale of residential, commercial and industrial properties; and
3. A goal that by 2030 all new buildings be “net zero energy” and “carbon neutral”

To put the enhanced energy efficiency standard in perspective, a major New Jersey commercial property owner has determined that for a 1980s vintage, 180,000 square foot office building to become 30 percent more energy efficient (the minimum standard being discussed), an investment of $2 million would be required, most of which could not be recovered from tenants. This cost would be equivalent to $11+ per square foot and have a 17+ year payback period. This would represent an approximate seven percent decrease in the company’s portfolio value, and would require it to borrow literally hundreds of millions of dollars to upgrade all of its New Jersey facilities. The costs to hospitals and health care systems would be equally as staggering if required to modify their buildings to meet this 30 percent energy efficiency threshold.

The EMP also contains a provision which requires that new and existing buildings will be “net zero energy” and/or “carbon-neutral” by 2030. “Net zero energy/carbon-neutral” buildings are self-sustaining, meaning that they are designed and constructed in a manner that would not require energy purchases for the building, and would not emit greenhouse gases. They are developed through the use of renewable (solar and thermal) energy, advanced building HVAC and operating systems, and aggressive building designs that eclipse LEED certification levels. There is currently one building in New Jersey that is considered net zero, a warehouse built at considerable cost with significant state rebates that are no longer available. There are only a handful of carbon neutral buildings in the world, many of which are deemed experimental in nature. It is questionable whether net zero energy buildings can be readily developed in the Northeast where there is only limited solar potential.

Despite the significant, adverse impact these programs will have, the New Jersey healthcare community has not been represented in these proceedings. A variety of such proposals will be considered over the coming year, but the BPU views these aggressive proposals favorably and appears ready to recommend their adoption. Absent input from all affected parties, these costly proposals could be adopted by ivory tower regulators who do not comprehend the economic impact these policies will have on large facility owners.

About the Authors
Steven Goldenberg and Andrew Kaplan are partners resident in the Princeton office of Fox Rothschild LLP. Steve serves as Co-Chair of the firm’s Energy and Public Utilities Practice Group, and is the founder of, and counsel to, the New Jersey Large Energy Users Coalition. Steve is a registered New Jersey lobbyist. Andrew is a corporate attorney whose practices focuses on mergers and acquisitions, contracts, loan transactions and real estate matters. For more information about this topic, please contact them via email at goldenberg@foxrothschild.com or akaplan@foxrothschild.com.
INDEPENDENT AUDITORS' REPORT

Board of Directors
Healthcare Financial Management Association
New Jersey Chapter

We have audited the accompanying statements of financial position of the Healthcare Financial Management Association, New Jersey Chapter as of May 31, 2008 and 2007, and the related statements of activities and changes in unrestricted net assets and statements of cash flows for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Healthcare Financial Management Association, New Jersey Chapter as of May 31, 2008 and 2007, and the results of its activities and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

September 30, 2008

Serluco & Co., L.L.C.

TEL (732) 946-2211 • 34 SOUTH HOLMDEL ROAD • HOLMDEL, NEW JERSEY 07733 • FAX (732) 946-3923
### HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
#### NEW JERSEY CHAPTER

#### STATEMENTS OF FINANCIAL POSITION

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>AS OF MAY 31</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT ASSETS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$240,575</td>
<td>$180,234</td>
<td></td>
</tr>
<tr>
<td>Receivables for program and other activities</td>
<td>5,872</td>
<td>48,645</td>
<td></td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>11,378</td>
<td>21,282</td>
<td></td>
</tr>
<tr>
<td>TOTAL CURRENT ASSETS</td>
<td>257,825</td>
<td>250,141</td>
<td></td>
</tr>
<tr>
<td>EQUIPMENT, NET</td>
<td>190</td>
<td>1,074</td>
<td></td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>$258,015</td>
<td>$251,215</td>
<td></td>
</tr>
</tbody>
</table>

#### LIABILITIES AND UNRESTRICTED NET ASSETS

| LIABILITIES: | | |
| Accounts payable and accrued liabilities | $76,206 | $95,303 |
| Accrued payroll and payroll taxes | 3,731 | 3,475 |
| Deferred revenue | 48,600 | -- |
| TOTAL LIABILITIES | 128,537 | 98,778 |
| UNRESTRICTED NET ASSETS | 129,478 | 152,437 |
| TOTAL LIABILITIES AND UNRESTRICTED NET ASSETS | $258,015 | $251,215 |

*SEE ACCOMPANYING NOTES TO FINANCIAL STATEMENTS*

### HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
#### NEW JERSEY CHAPTER

#### STATEMENTS OF ACTIVITIES AND CHANGES IN UNRESTRICTED NET ASSETS

<table>
<thead>
<tr>
<th>YEARS ENDED MAY 31</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVENUE AND GAINS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings and continuing education programs</td>
<td>$101,227</td>
<td>$126,798</td>
</tr>
<tr>
<td>Annual Institute</td>
<td>259,260</td>
<td>241,950</td>
</tr>
<tr>
<td>Social outings and events</td>
<td>87,874</td>
<td>115,580</td>
</tr>
<tr>
<td>National rebate</td>
<td>24,369</td>
<td>23,192</td>
</tr>
<tr>
<td>Advertising</td>
<td>65,913</td>
<td>67,050</td>
</tr>
<tr>
<td>Interest income</td>
<td>4,945</td>
<td>6,061</td>
</tr>
<tr>
<td>Other income</td>
<td>1,618</td>
<td>1,192</td>
</tr>
<tr>
<td>TOTAL REVENUE AND GAINS</td>
<td>545,105</td>
<td>581,753</td>
</tr>
</tbody>
</table>

#### EXPENSES

| Program services and scholarships | 439,405 | 465,640 |
| Membership services | 51,723 | 51,607 |
| Management and general | 78,936 | 73,718 |
| TOTAL EXPENSES | 568,064 | 590,965 |

#### CHANGES IN UNRESTRICTED NET ASSETS

| (22,959) | (9,212) |

#### NET ASSETS, BEGINNING OF YEAR | 152,437 | 161,649 |

#### NET ASSETS, END OF YEAR | $129,478 | $152,437 |

*SEE ACCOMPANYING NOTES TO FINANCIAL STATEMENTS*
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
NEW JERSEY CHAPTER

STATEMENTS OF CASH FLOWS

<table>
<thead>
<tr>
<th>YEARS ENDED MAY 31</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASH FLOWS FROM OPERATING ACTIVITIES:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in unrestricted net assets</td>
<td>$ (22,959)</td>
<td>$ (9,212)</td>
</tr>
<tr>
<td>Adjustments to reconcile changes in net assets to net cash flows from (used by) operating activities</td>
<td>884</td>
<td>1,299</td>
</tr>
<tr>
<td>(Increase) decrease in operating assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables for program and other activities</td>
<td>42,773</td>
<td>(43,842)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>9,884</td>
<td>(3,172)</td>
</tr>
<tr>
<td>Increase (decrease) in operating liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>(19,097)</td>
<td>11,213</td>
</tr>
<tr>
<td>Accrued payroll and payroll taxes</td>
<td>256</td>
<td>359</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>48,600</td>
<td>--</td>
</tr>
<tr>
<td>Net cash flows from (used by) operating activities</td>
<td>60,341</td>
<td>(43,455)</td>
</tr>
</tbody>
</table>

| CASH FLOWS FROM INVESTING ACTIVITIES: | -- | 263 |

| NET INCREASE (DECREASE) IN CASH | 60,341 | (43,192) |

| CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR | 180,234 | 223,426 |

| CASH AND CASH EQUIVALENTS, END OF YEAR | $240,575 | $180,234 |

"SEE ACCOMPANYING NOTES TO FINANCIAL STATEMENTS"
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION
NEW JERSEY CHAPTER
NOTES TO FINANCIAL STATEMENTS
YEARS ENDED MAY 31, 2008 AND 2007
(Continued)

NOTE 1. ORGANIZATION AND SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES - (Continued)

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

i. New Accounting Pronouncement
In June 2006, the Financial Accounting Standards Board (FASB) issued Interpretation No. 48 (FIN 48), Accounting for Uncertainty in Income Taxes, an Interpretation of FASB Statement No. 109 which the Chapter has adopted. FIN 48 clarifies the accounting for uncertainties in income taxes recognized in a company’s financial statements and prescribes a recognition threshold and measurement approach for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. There was no significant effect on the Chapter’s financial statements as a result of the adoption of FIN 48.

j. Reclassifications
Certain reclassifications have been made to the 2007 financial statements in order to conform with the 2008 presentation.

NOTE 2. EQUIPMENT
Equipment at May 31, 2008 and 2007 consists of the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video equipment</td>
<td>$4,160</td>
<td>$4,160</td>
</tr>
<tr>
<td>Computer equipment</td>
<td>$3,347</td>
<td>$3,347</td>
</tr>
<tr>
<td>Less: Accumulated Depreciation</td>
<td>$(7,317)</td>
<td>$(6,433)</td>
</tr>
<tr>
<td></td>
<td>$100</td>
<td>$1,074</td>
</tr>
</tbody>
</table>

NOTE 3. NATIONAL REBATE
The National Healthcare Financial Management Association administers the annual membership dues renewal and collection process. Each local Chapter is rebilled a percentage of the membership dues relating to its Chapter. Such rebate amounts were $24,388 and $23,152 for the years ended May 31, 2008 and 2007, respectively, and are reflected as part of Revenue and Gains on the accompanying Statements of Activities and Changes in Unrestricted Net Assets.
mark your calendar • • •

December 10, 2008
Medicaid and Uncompensated Care Education Session

January 13, 2009
Joint Quarterly Meeting with NJ AAHAM

January 22, 2009
990 Tax Forms & Implications for Community Benefit Reporting Requirements

all day
Atlantic Health Training Center

all day
Woodbridge Hilton

February 17, 2009
Medicaid and Uncompensated Care Education Session

March 10, 2009
Quarterly Meeting

June 9, 2009
Quarterly Meeting

all day
Virtua Health Education Center

all day
Woodbridge Hilton

all day
Woodbridge Hilton
advanced technology. The company is ISO 9001: 2000 certified and management systems operate at international standards. Quality is a primary aspect of the companies operations and the ISO certification has resulted in efficient productivity and reduced patient and employee complaints, volume increases through better service, increased income, a strengthened market position grounded in quality, and heightened brand recognition and acceptance.

The organization accepts corporate clients with voluntary private medical insurance, which represents 10% of revenues. Patient payments provide 90% of revenues. No funding is received from the CHIF. Patients who pay in full prior to service receive discounted rates. Installment payments are accepted for orthodontics, and a bank loan option also is available.

The MEDI clinics employ 1,300 staff (including 120 dentists) who receive specialty training from leading experts using the most current technologies. The company supports employees improving their skills and training, with the stress on immediate applicability. There are opportunities for employees to participate in international exchanges and to contribute to scientific research. All of the clinics are profitable and profit-sharing provides incentives for physicians and management staff. Profitability is determined by product line, and managers responsible for those products share in the profits. Physician compensation includes a base salary that is tied to qualifications plus a profit-sharing percentage.

Professional development and career opportunities are critical components of the enterprise. Full time employees are entitled to benefits that include: four weeks paid vacation (taken in two-week allotments), paid meals, medical insurance and a family assistance program that provides financial resources for births, weddings and death. These benefits are also tied to the years of service with MEDI. Employees also receive discounts on clinic services.

Conclusion

At the farewell dinner that marked the end of the trip, delegates consistently expressed highly positive opinions of the professional exchange and the opportunity to witness first hand the challenges facing healthcare professionals in a different culture. All came away with a better appreciation of America’s healthcare delivery system which, despite its high costs, delivers quality care in a timely manner. The HFMA partnership with People to People produced a trip that gave attendees an appreciation of contemporary Russian culture and the challenges faced by our professional colleagues in the post-Soviet era. The dissolution of the Union of Soviet Socialist Republics resulted in economic stress during the mid-1990s, but now has brought rapid economic growth in a mixed economy. It will be interesting to see whether the major investments now being directed to health care will bring about the needed increases in health quality indicators. Only time will tell.

About the Authors

Cheryl Cohen, FHFMA, is Vice President, Pantheon Capital and Immediate Past President of the New Jersey Chapter of HFMA. She currently serves on the National Advisory Council. John Dalton, FHFMA, is Senior Advisor to Besler Consulting and a Past President of the New Jersey Chapter. He served on the National Board of Directors and was the 2001 recipient of the Frederick C. Morgan award for lifetime achievement in healthcare financial management. Janet Turso is Vice President, Finance and Chief Financial Officer at Bacharach Rehabilitation Institute in Pomona and an Advanced Member of the New Jersey Chapter.
More Than 545 Get in the Spirit at the 2008 Annual Institute

by Tracy Davison-DiCanto, MBA

The 2008 Annual Institute at the Borgata Hotel, Spa and Casino in Atlantic City, New Jersey drew more than 545 registrants who felt the “Spirit of Collaboration”, setting a new event attendance record for the fifth consecutive year. In keeping with the theme, this was the first year that the event was a collaborative effort of both the New Jersey and the Metropolitan Philadelphia chapters. The 2008 Institute Committee worked on planning throughout the year to produce an event filled with thought provoking education sessions and fun filled networking events.

Workshop Wednesday

The Workshop Wednesday concept which began in 2007 was expanded this year to include four courses. The varied course offerings included: CFO Bootcamp, PPS Bootcamp, No Limits Leadership and the Certification Preparation Course. CFO Bootcamp prepared attendees for working through the potential challenges a new CFO might face, what key survival skills exist, how to develop personal relationships with your C-suite and how to utilize key benchmarks and outcomes, plus essential operating tactics, for top-line and bottom-line revenue, cost reduction and quality. PPS Bootcamp looked to provide attendees with an overview of the history of Medicare and all the various payment methodologies associated with it. Topics covered included: DRGs, APCs, Pass-Throughs, Outliers, Cost Report Settlements, Pay for Performance, Never Events, Recovery Audit Contractors (RAC), and J12 transitions (MAC reform). For those looking for a little excitement, the No Limits Leadership course brought just that. The course covered skills and mechanisms for creating high performance teams in an forum where laughter and discussion were encouraged and fun was had by all that participated. The Certification Preparation Course assisted those looking to take the HFMA Core Exam on how to be successful in studying and the best practices for ensuring that you pass. For additional information on HFMA certification visit: www.hfmanj.org/Certification.html.

The Zachary Foundation

Wednesday night’s festivities included the Vendor Fair and Networking Reception for our 2008 charity. This year’s selected charity was the Zachary Foundation. The Zachary Foundation was founded by the parents and friends...
of Zachary Friedberg of Morganville, New Jersey. Zachary suffers from a rare form of mitochondrial disease which prevents Zachary’s body from converting sugar to energy. The disease affects both his motor and cognitive abilities. Despite his disability Zachary is a fun and loving child who touches everyone he meets. Through the generous donations of this year’s attendees in conjunction with the Steiner Sports silent auction, Dueling Pianos song requests and the 50/50 raffle drawings which were held, we were able to raise $1,000 for the foundation. For further information regarding the charity, please visit www.thezacharyfoundation.org.

Speed Networking
It’s like speed dating, only better. In addition to the Vendor Fair and Networking Reception, our first ever Speed Networking event took place Wednesday evening. Participating vendors had the opportunity to present a 90 second overview to each of the providers that they met with on the services that their firm provides and how they might be able to help providers bolster their bottom line and gain efficiencies. With the help of referee, Fred Landrum, participants enjoyed a fast-paced, informative networking session.

Making Connections, Meeting Challenges
Brian Sherin, HFMA NJ Chapter President-Elect, served as Master of Ceremonies for the general sessions. He opened the Institute on Thursday morning by presenting Catherine Jacobson, HFMA National Chairman Elect and Senior Vice President of Strategic Planning & Finance, CFO and Treasurer, Rush University Medical Center. She addressed the current issues and actions affecting key drivers of business success, the long-term goal of national healthcare payment reform and how HFMA can assist and play a role in that development. Emphasis was placed on connections and the benefit that connections within the industry, government, and other organizations can have when seeking to meet challenges and achieve success.

Medical Myths That Can Kill You: And the 101 Truths That Will Save, Extend, and Improve Your Life
Dr. Nancy Snyderman, Chief Medical Editor for NBC presented the Institute’s first keynote address. Her reports appear on “Today,” “NBC Nightly News with Brian Williams,” “Dateline NBC,” MSNBC and MSNBC.com. Dr. Snyderman has reported on wide-ranging medical topics affecting both men and women and has traveled the world extensively, reporting from many of the world’s most troubled areas. Her address to the conference attendees was honest and open, ranging from personal stories from her own life and experiences to topics from her book. The audience was captivated and actively participated in a question and answer session relating to health issues and the current environment of healthcare in the United States. A special bonus from Dr. Snyderman was a copy of her book, “Medical Myths that Can Kill You: And the 101 Truths that Will Save, Extend and Improve Your Life”, that was given to all attendees and led to a book-signing opportunity at the end of her presentation.

The Future of Healthcare
Witty, intriguing, and Scottish are just a few words to describe the second Keynote Speaker, Ian Morrison. Mr. Morrison is an internationally known author, consultant, and futurist specializing in long-term forecasting and planning with particular emphasis on healthcare and the changing business environment. The discussion focused around the future of the healthcare marketplace and included a comparison of where the United States rates when reviewing similar statistics in other countries across the globe. A brilliant comparison using the popular MTV reality show, Pimp My Ride, made participants laugh and see the reality of what the industry looks like. Attendees gained some insight into why marker-based reforms struggle to work and why healthcare leaders need new visions of what is possible in the future.

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Chapter Awards Presentation

We took a moment out to celebrate the accomplishments of both the New Jersey chapter and individual members from the 2007 chapter year. The awards were presented by Past President Cheryl Cohen and current President Joseph Dobosh. For the 2007 chapter year, the New Jersey Chapter won the C. Henry Hotrum Award for Educational Improvement and the Bronze Award of Excellence for Membership. In addition, the chapter won four Helen M. Yerger awards for achievements in the areas of Publications, Future Leaders, 2007 Institute, and the Junior Board Member concept. The President’s Award was presented to Deborah Shapiro and Rosemary Nuzzo, co-chairs of the Membership Committee for achieving 2.6% membership growth in 2007. The Non-Leadership Recognition Award was presented to John Brault for going above and beyond the call of duty. Founders Merit Awards were also presented to chapter members who had attained Folmer Bronze, Reeves Silver, Muncie Gold, or Medal of Honor award levels. Those that achieved certification were acknowledged for their achievement as well.

Endless Education

The possibilities were endless when it came to all of the educational tracks offered during Thursday afternoon. With a total of twenty-five education sessions broken out into five subject oriented tracks, there was something for every attendee.

On Friday Everyone is Sleepless

Friday’s general sessions included Hospitals and Healthcare in the New Administration, Sleepless in the Northeast: The Topics Keeping CFOs Awake at Night and Six Sigma for the Revenue Cycle. Russ Rudish touched upon some of the factors that might be seen in healthcare dependent on the new administration that would win election in November 2008. The CFO panel is always a session that Hospitals and Healthcare in the New Administration attendees look forward to and this year’s panel was no exception. Former Chapter President John Dalton served as the moderator to the panel of four CFOs - Robert M. Segin, CPA, Vice President and Chief Financial Officer, Virtua Health; Karen Lumpp, Senior Vice President and Chief Financial Officer, Trinitas Hospital; Thomas J. Todorow, Executive Vice President for Corporate Services and Chief Financial Officer, The Children’s Hospital of Philadelphia; and Jack D. Robinson, CPA, Chief Financial Officer, St. Joseph’s Healthcare System. The session probed the burning issues that keep our CFOs awake at night including: the current state of the economy, the impact to the bond and capital markets, the election and potential healthcare reform, and the Horizon conversion. Each CFO was candid in expressing their concerns and potential challenges in the coming months given the constant change that is ever present in the healthcare industry.
The last session of the conference was an overview of Six Sigma, how it is applicable to the revenue cycle and the potential results that can be gained from using the Six Sigma approach in identifying and eliminating sources of variation.

Thank You

I would be remiss if I did not take an opportunity in this forum to thank some very important people who made the 2008 Institute a success. First and foremost, thank you to John Brault, the 2008 Institute Committee Co-Chair, who went above and beyond in every aspect of putting on this event. His creativity and perseverance were apparent in the varied and innovative educational topics and in the record setting vendor sponsorship efforts. Thank you to the 2008 Institute Committee who worked tirelessly at ensuring that every detail of the event was considered and volunteered long hours on-site at the event to ensure success, to Joseph Dobosh, New Jersey Chapter President and the Board of Directors of the New Jersey chapter who supported our efforts, and to the attendees who we hope found the experience as valuable as we did. Last but not least, thank you to all of the speakers and vendors who supported the event, without your commitment to the organization and the Institute, we could not have made this event such a success.

2009 Institute

Save the Date! The 2009 Institute will be held again at the Borgata Hotel, Spa and Casino in Atlantic City, New Jersey from October 14-16, 2009. The 2009 Institute Committee is now forming and if you are interested in participating in the planning, please reach out to Anthony.F.Consoli@marsh.com, the 2009 Institute Committee Chair for additional information.

About the Author

Tracy Davison-DiCanto is the 2008 Institute Committee Co-Chair. She is currently the Director of Managed Care at Princeton HealthCare System. She can be reached at tdavison-dicanto@princetonhcs.org.

Once again, our volunteer photographer, Steve Aaron of ARC Group Associates, did a fabulous job of capturing our event in photos. Thanks so much, Steve, your talents are much appreciated by all!
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