

MISSISSIPPI

Headlines

HFMA President's Message



Mitch Beard

Hello, everyone! It's hard to believe that it is already the middle of January 2006. As our chapter gets ready for this new and exciting year of new educational events, we look forward to all our chapter members attending as many meetings as they can. We have five months left in this chapter year to improve on our educational hours. Please try to attend each and every meeting.

Our next meeting will be the Tri-State Winter Institute in Tunica, which will be held with Arkansas and Tennessee chapters. The dates for this meeting are February 1st - 3rd. Let's have a great attendance. We have a lot

of outstanding speakers for this three-day event.

We will have a meeting in Jackson in March at the Hilton. Our annual meeting will be held at the Imperial Palace in Biloxi, as we try to help the Mississippi Coast Line recover from Hurricane Katrina. Our thoughts and prayers continue to go out to everyone affected by hurricanes in 2005.

Earlier this year, members of our chapter were emailed an invitation to participate in the annual Chapter Survey. The first email with link to the survey was sent on November 1, 2005. Follow-up emails were sent on November 10 and November 15. Members were invited to participate through a link to the survey site. I wanted to make you aware of some of the results for our chapter:

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UPCOMING HFMA MEETINGS

[HFMA Tri-State Winter Institute](#)
February 1 - 3, 2006
Gold Strike Casino
Tunica, MS

[MS Chapter HFMA 2006 Spring Workshop](#)
March 22-24, 2006
Hilton Hotel
Jackson, MS

[MS Chapter HFMA 2006 Annual Institute](#)
May 24-26, 2006
Imperial Palace Hotel & Casino Resort
Biloxi, MS

[MS Chapter HFMA Summer Workshop](#)
August 16-18, 2006
Golden Moon Hotel & Casino
Philadelphia, MS



Please visit our Chapter's Web site often, as information changes frequently

www.mshfma.org

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When was the last time that you attended an educational event?	ALL	Mississippi Chapter
Within the last 6 months	44.7%	42.7%
Within the past year	22.2%	29.2%
Within the past two years	12.0%	14.6%
More than 2 years ago	10.3%	7.9%
Never	10.5%	5.6%

Education Hours per Member by Year	
Year	Mississippi
2004-05	27.22
2003-04	26.91
2002-03	16.13
2001-02	17.33

As we prepare for the new year, Athena Adams is nominated to be your president. She will be looking for many volunteers to help with the upcoming events. If you would like to serve on one of our many committees, please let Athena or a volunteer know.

Louisiana Credentialing Case Affects Content of Hospital Disclosures

By: Jeffrey S. Moore, Partner, Phelps Dunbar LLP

Background

Hospitals are often caught in a “Catch 22” situation when responding to credentialing inquiries from other hospitals about former staff physicians. If a physician leaves a hospital’s medical staff under questionable or suspicious circumstances, the hospital is often leery about sending a candid assessment of the physician’s circumstances to the inquiring hospital. The hospital may be worried that if it makes a full disclosure regarding the physician’s medical staff history, the physician will sue the disclosing hospital for defamation, liable, slander or some other similar tort. On the other hand, hospitals and their boards of directors are concerned that failing to make a full and candid disclosure to an inquiring hospital about a former medical staff member could result in harm to patients at the new hospital.

Dr. Robert Lee Berry practiced anesthesiology at Lakeview Regional Medical Center (LRMC) in Covington, Louisiana from January 1997 to March 2001. During that time, Dr. Berry was an employee of Lakeview Anesthesia Associates, LLC (LAA). Kadlec alleges that at some point during the year 2000, LRMC conducted an audit of Dr. Berry’s narcotic medication records and discovered that he failed to document withdrawals of the drug Demerol. On March 13, 2001, Dr. Berry failed to respond to hospital pages during a 24-hour shift at LRMC. Hospital staff found Dr. Berry sleeping in a chair and determined that he “appeared to be sedated.” Based on this incident and LAA’s suspicions that Dr. Berry was diverting Demerol, LAA terminated Dr. Berry’s employment effective that same day. Dr. Berry’s medical staff privileges at LRMC subsequently expired and do not appear to have been adversely affected by any formal peer review action.

The issue of whether “to disclose or not to disclose” has just gotten more complicated. In *Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs.*, the Federal District Court for the Eastern District of Louisiana held that a Louisiana hospital has a duty to disclose to an inquiring hospital “relevant and material information” about the physician’s tenure at the hospital. The court ruled that Kadlec Medical Center (the inquiring hospital) submitted evidence that raised genuine issues of material fact in the case and denied Lakeview Regional Medical Center’s (the disclosing hospital) motion for summary judgment on the claims of intentional misrepresentation, negligent misrepresentation and negligence. The case is currently under appeal to the United States Court of Appeals for the Fifth Circuit which could affirm, modify or reverse the Federal District Court’s holding.

After his termination, Dr. Berry sought employment through Staff Care, Inc. which placed him at Kadlec Medical Center in Richland, Washington. Before Dr. Berry started practicing medicine in Washington, Kadlec sent a letter to LRMC requesting, among other things:

- “evidence of current confidence to perform the privileges requested” and
- “a candid evaluation of [Dr. Berry’s] training, continuing clinical performance, skill, and judgment, interpersonal skills and ability to perform the privileges requested.”

Kadlec included an “Appointment Reference

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Questionnaire” with the request for information.

On October 26, 2001, in response to Kadlec's inquiry, LRMC send Kadlec a brief letter stating that Dr. Berry was on the active medical staff in the field of anesthesiology at LRMC from March 4, 1997 to September 4, 2001. The letter represented that such limited information was provided “due to the large volume of inquiries received in the office.” LRMC did not answer any of the questions on the enclosed questionnaire.

Based on the information contained in the letter from LRMC and two letters of recommendation from physicians at LAA, Kadlec retained Dr. Berry's services through Staff Care, Inc. in late 2001. Approximately one year later, Dr. Berry was the anesthesiologist for a simple tubal ligation procedure performed at Kadlec. The patient, Kim Jones, suffered extensive brain damage and has remained in a non-responsive state since the surgery, allegedly due to Dr. Berry's gross negligence and the fact that he was impaired by drugs during the procedure. Kim Jones' family argued that Dr. Berry removed Ms. Jones' breathing tube too soon during the tubal ligation, leaving her without oxygen causing a heart attack and massive brain damage.

Kadlec and Dr. Berry settled a medical malpractice action with the Jones family in the amount of \$7.5 million. Dr. Berry's Washington medical license was suspended on charges of substandard care and has since been permanently surrendered. Dr. Berry faces felony drug charges in Washington while Louisiana and Arizona are investigating his medical licenses.

Kadlec's Claims

Kadlec and its insurance company asserted claims against LRMC for intentional misrepresentation, negligent misrepresentation, strict responsibility misrepresentation and negligence based on LRMC's alleged omission of material facts in a letter representing Dr. Berry's term of service at LRMC. Before the court could determine that LRMC had a duty to disclose information to Kadlec, Louisiana law required that both a pecuniary interest in the transaction and a special relationship existed between the parties. LRMC argued that because it did not have a legal obligation to respond to Kadlec's inquiry for information about Dr. Berry, and because it “received no compensation, either direct or indirect from sending the letter”, whatever response LRMC did give was “entirely gratuitous.”

Pecuniary Interest

The court reasoned that “far from being a purely gratuitous act, . . . , LRMC had a vested, pecuniary interest both in

omitting the type of information at issue and answering inquiries of the type made by Kadlec.” LRMC openly admitted that it omitted the information at issue because of a fear of liability to Dr. Berry for defamation or other causes of action based on disclosure. The court reasoned that LRMC had a general pecuniary interest in responding to the credentialing inquiries for the following reasons:

- If LRMC chose not to respond, it could have difficulty recruiting and retaining physicians;
- Doctors may avoid working at a medical facility that is unresponsive to requests for employment information, potentially foreclosing the possibility that those doctors could gain future employment elsewhere; and
- Other health care providers could become unwilling to supply references to LRMC while their own inquiries go unanswered.

Special Relationship and Duty to Disclose

Under Louisiana law, a duty to disclose material information arises only in the context of a “contractual or fiduciary relationship.” Kadlec argued that Louisiana courts have also imposed a duty to disclose in certain “confidential relationships.” The Federal District Court agreed that Louisiana law would recognize Kadlec's relationship with LRMC as a “special relationship” that gives rise to a duty of disclosure. The court reasoned:

Kadlec and LRMC have a unique ‘special relationship’ which existed in part to further communication to health care providers so that future patients could be protected. Notwithstanding LRMC's contention that ‘public policy militates against creating a boundless duty to disclose,’ this court finds that if and when a hospital chooses to respond to an employment referral questionnaire, public policy should encourage a hospital to disclose the sort of information at issue.

In determining that LRMC owed a duty to disclose to Kadlec, the court states,

Any additional expense that LRMC would incur as a result of its communication of the reasons behind Dr. Berry's termination is clearly outweighed by the benefits of a hospital not knowingly passing on an impaired doctor to another unsuspecting health care provider. If LRMC omitted such information negligently or intentionally, LRMC may have breached its duty of care to Kadlec, which is a question of fact for the jury.

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Material Omission

The court noted that, “in order to maintain a successful claim for misrepresentation, intentional or negligent, a plaintiff must show that the defendant misrepresented, or omitted, a material fact.” Kadlec offered evidence that it actually relied on the letters supplied by LRMC as part of its credentialing of Dr. Berry. LRMC ignored Kadlec's attached credentialing questionnaire, opting to respond with a prefatory phrase which indicated that LRMC was inundated with such credentialing requests and that it could only provide the physician's dates of service. However, Kadlec introduced evidence that in contrast to the generic response it received, LRMC responded to other inquiries about doctors who had no adverse employment information with responses such as “there is no information of a derogatory nature contained in Dr. [X]'s file.” The court ultimately ruled against LRMC's Motion for Summary Judgment finding that there was a genuine issue of material fact with respect to the materiality of the omitted information as well as LRMC's intent to deceive Kadlec.

Immunity from Liability, but Not Suit

The Health Care Quality Improvement Act (“HCQIA”) of 1986 and most state's peer review laws provide immunity to health care providers and individuals who participate in peer review activities. The HCQIA provides immunity to a hospital that provides information to another hospital for peer review purposes. The HCQIA reads in relevant part: Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any state (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false. State peer review laws generally provide similar immunity from damages, provided that the health care provider acts in good faith and without malice in the peer review process. However, although HCQIA and state peer review laws generally provide immunity to providers from damages, these laws do not prohibit a party from filing a lawsuit resulting in legal fees and expenses to the provider that must defend the lawsuit. As set forth in the options below, the best way for a provider to avoid a lawsuit is to obtain a detailed and specific release from the physician undergoing peer review by the inquiring hospital.

Options for Hospitals

What options are left for hospitals who fear legal action from a former medical staff member leaving the staff under

less than perfect circumstances?

- One option is for the hospital to refuse to respond to the inquiry. The court did not rule in Kadlec that a hospital has an absolute duty to respond to a credentialing inquiry but rather that a hospital owes a duty to an inquiring hospital not to misrepresent information, or omit material information, regarding a physician's medical staff status at the hospital. However, ignoring all credentialing inquiries is not a recommended option as this would result in the breakdown of the entire credentialing process. As you are aware, your hospital relies on other hospital's providing meaningful responses to your credentialing questionnaires and inquiries in order to protect your hospital's patients.
- Your hospital may demand a detailed release from the physician in question. A hospital responding to an inquiry that involves a problem physician should not rely solely on the generic release forms included in the requesting hospital's medical staff application and bylaws. Physicians making application for medical staff privileges sign a statement in the medical staff application granting immunity to health care providers who release information to inquiring health care providers regarding the physician's credentials. Physicians also sign a statement in the medical staff application to the effect that they have read and agree to be bound by the hospital's medical staff bylaws that include similar immunity provisions.
- The hospital responding to the credentialing inquiry should demand from the physician a detailed release granting immunity to the hospital for disclosures to the requesting hospital. If the physician refuses to execute the detailed release agreement, the responding hospital may send a letter to the inquiring hospital advising the inquiring hospital that the physician has refused to execute a release agreement. This letter will put the inquiring hospital on notice that the applicant physician may not have a clean medical staff history, without subjecting the responding hospital to a defamation or other similar claim.
- The responding hospital may want to consider negotiating a mutually agreed upon response with the departing physician regarding his medical staff history and status with the hospital. Often, when a problem physician resigns from a hospital's medical staff in a situation that does not give rise to a National Practitioner Data Bank report, the physician will request that the hospital enter into an agreement with him not to make disparaging remarks about him to third parties. Obviously, the

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10 Strategic Planning Resolutions You Can't Afford to Break

By: Aaron DeBoer, Mitretek Healthcare

The New Year may have come and gone, but it's not too late to make a few more resolutions. Here are 10 resolutions that your management team can make to ensure a smooth, successful, strategic planning process.

1) **Establish a strong analytical foundation for your strategic plan**

A strategic plan is only as good as the foundation upon which it was built. A good strategic plan can propel your organization forward once your leadership team has a common understanding of your current position, future trends, and key uncertainties. On the other hand, a strategic plan based on an insufficient understanding of the internal and external environment can, at minimum, lead to poor acceptance of the plan and, at worse, subpar decisions.

2) **Focus the environmental assessment**

When developing an environmental assessment as part of your analytical foundation, it is important to select only those elements that will address the organization's future challenges and resulting array of strategic opportunities. An efficient way to focus your environmental assessment is to develop and test a set of planning hypotheses centered on major market forces. With hypotheses formed, the organization can focus its analysis efforts on building a common understanding of the environment.

However, performing a focused environmental assessment is not an end in itself. If the data does not convey a message and support the decision making process, it is simply data, not "information."

To mitigate this risk:

- Identify what information is most important to make decisions.
- Effectively transform the data into actionable

information.

- Understand that there will never be perfect information.

3) **Explicitly consider key uncertainties**

Addressing key uncertainties can help build a sense of charting your own course, albeit in turbulent waters. Tools like scenario planning, game theory, and decision tree analysis can all aid in understanding the risks associated with pursuing a particular approach/direction. Strategies that reduce the identified risks can then be incorporated into the strategic plan.

4) **Keep your strategic plan focused on strategy, not operations**

All organizations have extensive opportunities to improve their efficiency and effectiveness in the areas of customer service, cost, and quality. An internally-focused strategic plan often seems successful because of the substantial operational improvements that can be made. However, it does not take long for organizations that are too operationally focused to grow out of touch with their markets. True strategic initiatives on the other hand, frequently have higher risk, are more disruptive to the organization, and may have longer implementation times and payoff returns. While operational initiatives are necessary to keep you in the game, strategic initiatives address competitive advantage. Too many operational initiatives in your strategic plan will weaken it and detract from its value, so keep your strategic plan strategic.

5) **Avoid the use of "me too" strategies**

Many organizations take comfort in adopting the same strategies that other organizations have deployed. Once a strategy has been proven successful by one organization, it is often ubiquitously adopted by competitors, diluting the impact of the strategy. Strategic success begins with articulating what differentiates the organization from its key competitors. That is, how will we choose to compete

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physician is bargaining to make it easier to relocate and to obtain future employment or staff privileges at another facility. The agreement between the hospital and physician not to make disparaging remarks to future inquirers must, of course, be accurate and truthful.

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(e.g., on price, quality, service)? In what ways will we create value for consumers? How will we respond to other organizations' strategies?

6) Minimize least common denominator strategies

Decision making in health care organizations is often compromised when leaders wait for unanimous stakeholder agreement. Not only will this stall the process, but it will weaken the boldness of the strategy. After all, you will only be able to progress as fast and as far as the least ready person will allow. Remember, broad based input is desired, but effective leadership is ultimately about making tough decisions.

7) Align strategies with financial capabilities

Even the most brilliant strategy is reduced to mere speculation if the health care organization does not have the financial means to implement it. Every organization must ensure that its strategic plan is congruent with its financial capability.

A strategic-financial plan should:

- Include a full financial capability assessment
- Address the allocation of scarce resources
- Maximize the financial viability of the organization

8) Communicate early, often, and clearly when bringing

your strategic plan to life

A plan must be well known by key physicians and employees to be successful. The strategic intent for the organization should be communicated frequently, clearly, and concisely to ensure that the momentum created during the planning process is carried forward in the implementation. Make a resolution to communicate the strategic plan consistently throughout the year.

9) Add metrics to your strategic plan

In stable environments, one has the luxury of making a few mistakes and course corrections. In an unstable environment, those course corrections must come sooner. Metrics are one tool that can be used to monitor the organization's progress towards achievement of goals, strategies, and/or tactics. Metrics are the combination of a measure and a target. Measures are what we want to achieve, while the target is the quantified value of the measure. Figure 1 outlines some of the different metrics an organization can adopt.

The value of this resolution can be summed up by the old adage "what you measure is what you get." If you want results, identify what you want to achieve, assign responsibility, and create appropriate timetables.

10) Have fun and inspire your team!

	Strategic Metrics		Management Metrics
	Vision Level	Goal Level	Strategy/Tactic Level
<i>Definition</i>	Metrics that indicate broad success, usually across multiple goals.	Metrics that indicate progress along a specific goal.	Metrics that indicate progress along a strategy or action.
<i>Characteristics</i>	<ul style="list-style-type: none"> • 3± Participants • Board/Senior Leadership • Annually • Vision/Desired Future State • Entity 	<ul style="list-style-type: none"> • 15± Participants • Senior Leadership • Semi-Annually /Annually • Core Goals • Entity 	<ul style="list-style-type: none"> • 100± Participants • Middle Management • Weekly/Monthly/Quarterly • Strategy/Tactic • Entity/Programs/Units
<i>Example (Financial)</i>	<ul style="list-style-type: none"> ✓ Desired bond rating 	<ul style="list-style-type: none"> ✓ Operating margin ✓ Days cash on hand ✓ Cash-to-debt 	<ul style="list-style-type: none"> ✓ Personnel costs as a percent of net patient service revenue ✓ Supply cost per adjusted discharge

The New Frontier of Automated Charity Processing

*By: Bruce Nelson, Vice President, Search America
Man Rashilla, Eastern Region Manager, Search America*

In some ways, Revenue Cycle Management has not changed substantially in the last five years. But, when you are talking discounts for the uninsured, charity processing and collection practices, everything has changed.

In fact, virtually every hospital in the nation has changed its credit and collection policy related to charity within the last 18 months to provide better guidelines for charity qualification. These revisions have allowed hospitals to confidently answer “yes” when asked “Does your institution have a clear policy related to provision of charity care?” But, the real question that needs to be asked is this: “Is the organization's published policy applied in a non-discriminatory way and will it hold up to outside scrutiny?”

Unfortunately for many of the nation's hospitals, the answer has to be “no.” After all, if you think about it, you will realize that it is impossible to manually process charity accounts and maintain this process as non-discriminatory. This is true for two reasons. First, hospitals attempting to process uninsured/underinsured discounts cannot do this without up-to-date patient financial information. Second, the time it takes to get up-to-date financial information on patients via manual processing is time-prohibitive.

As a result, many hospitals have changed their credit and collection policies, but are unable to properly adhere to the policy because of these related operational challenges:

- Financial counselors are unable to verify information;
- Strict adherence to the policy is a time-consuming effort;
- Some patients are reluctant to participate in the qualification process;
- Extensive charity follow-up delays financial clearance of accounts;
- It is difficult to apply charity policies objectively;
- Recent lawsuits and media reports have put hospitals on the defensive; and
- Many hospitals already have patients saying they do not have a social security number just so they can qualify for federal coverage under section 1011. It will be good to screen for these patients.

Automating the charity screening process addresses each of these operational challenges using data and tools that map a patient's actual financial profile against the defined financial criteria in the organization's charity policy to determine charity eligibility.

This automation provides additional benefit for marginal accounts that don't quite meet the charity rules by reducing collection expenses for accounts with little or no ability to pay.

Example:

- Retrospective analysis of charity write-offs for a health care system. Review consisted of accounts written off to charity over the past year.
- Results showed that the hospital was not very successful

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MS Chapter HFMA Election Ballot: Officers and Board 2006-2007

If you have not already voted, please indicate your approval for the following Officers and Board Members for the upcoming year. Your approval is important, please check below.

OFFICERS 2006/2007

- _____ Athena Adams - President
 _____ David Butler - President Elect
 _____ Cheryl Cotten - Treasurer
 _____ Suzette Duhe' - Secretary/Founders

BOARD MEMBERS 2006/2007

- _____ Annie Lott

- _____ Jerry Knighton
 _____ Lexie Fuller

The following Board members will automatically move into 2nd year term:

- Brandon Slocum
 Sandy Riley

You must email or fax your completed form back to me before February 4, 2006:

Email: NEWMAND@phelps.com
 FAX: (662) 842-3873
 Dinetia Newman, Past-President & Nominating Chairman

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in manually classifying accounts for charity.

- 41% of patients accounts (76% of the total charges) had a "High" likelihood of paying (>\$8.4M).
- 28% of accounts had a "Medium" likelihood of paying.
- 31% of accounts had a "Low" likelihood of paying.
- 59% of the accounts had a credit line which would cover the balance owed (>\$6.5M).

So what is the solution for the nation's hospitals when tackling this difficult issue?

1. Hospitals need a system that screens for charity, uninsured and underinsured discounts.
2. This automated system must evaluate patient financial need.
3. The new technology should ensure non-discriminatory

compliance.

4. The system must have the ability to calculate discounts automatically.
5. The system should estimate household size, income and assets.
6. The system should have the ability to support individual charity rules, customized applications/forms.
7. Online reconciliation reports that will help hospitals understand the volume of charity processing completed should be provided.
8. The system should do all of this using the most accurate financial data and information available to minimize errors.

MS HFMA Welcomes New Members

<u>NAME</u>	<u>COMPANY</u>	<u>TITLE</u>	<u>ADDRESS</u>
Robie D. Frizzell	MS Physicians Care Network	Chief Operating Officer	P.O. Box 1530, Ridgeland, MS 39158-1530
Robin J. Douglas	Holmes Community College	Medical Office Instructor	1583 Teasdale Road, Enid, MS 38925-2474
Cynthia H. White	Rankin Medical Center	Health Information Mgt Director	350 Crossgates Blvd., Bradon, MS 39042-2601

CORPORATE SPONSORS Mississippi Chapter HFMA

PLATINUM SPONSORS

(\$3,000 Contribution)

- Franklin Collection Services, Inc.
- KPMG LLP
- Horne LLP
- PricewaterhouseCoopers, LLP

SILVER SPONSORS

(\$1,500 Contribution)

- WAUSAU Signature Agency/Wausau Insurance
- The SSI Group
- Receivables Management Bureau, Inc.
- Custom Software Systems, Inc.

GOLD SPONSORS

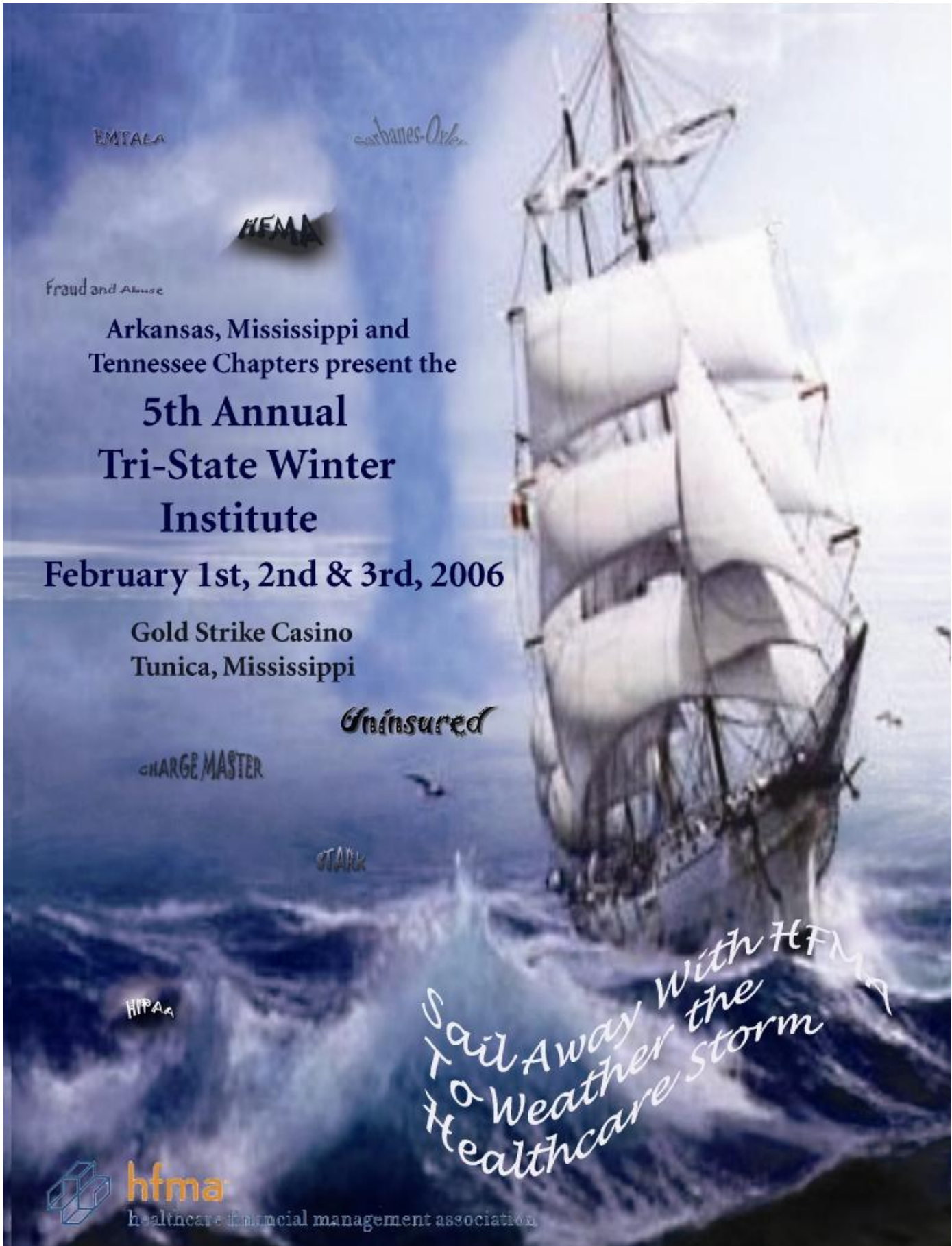
(\$2,000 Contribution)

- Phelps Dunbar LLP
- Smith, Rouchon & Associates, Inc.
- The Mash Program

BRONZE SPONSORS

(\$1,000 Contribution)

- Smith, Turner & Reeves, PA
- Advanced Practice, Inc.
- Passport Health Communications, Inc.
- MedAssist, Inc.
- Shared Services Healthcare, Inc.



EMTALA

Carbanes Act

HFMA

Fraud and Abuse

Arkansas, Mississippi and
Tennessee Chapters present the

5th Annual Tri-State Winter Institute

February 1st, 2nd & 3rd, 2006

Gold Strike Casino
Tunica, Mississippi

Uninsured

CHARGE MASTER

STARK

HIPAA

Sail Away With HFMA
To Weather the
Healthcare Storm

Agenda – HFMA Tri-State Meeting

Wednesday, February 1, 2006

11:00 – 2:30 pm	Registration - Foyer	
1:00 – 4:30pm	HFMA Certification Coaching Course – Joe Wewers	
1:00 – 4:00 p.m.	VENDOR SET-UP – BALLROOM A & FOYER	
1:30 – 2:30 p.m.	General Session – Panel Discussion (Gulf Coast Hospitals) - Ballroom C “Emergency Preparedness Following Katrina - What Worked and Lessons Learned”	
2:30 – 3:00 p.m.	Break – Foyer	
3:00 – 4:30 p.m.	Session 1 – Ballroom E “Managing Fraud & Abuse and Sarbanes/Oxley” Laura Laemmle	Session 2 – Ballroom F “Improving Cash Collections in the ER” Jeanne McGrayne
4:30 – 5:30 p.m.	Chapter Board Meetings – Ballrooms E, F & D	
5:30 – 7:00 p.m.	Opening Reception with Vendors– Ballroom A & B and Foyer	

Thursday, February 2, 2006

8:15 – 8:30 a.m.	Opening Remarks and Announcements		
8:30 – 9:00 a.m.	General Session – “HFMA National Update” – Richard Rodriguez – Millennium Theater		
9:00 – 10:15 a.m.	“Results That Last” – Quint Studer – Millennium Theater		
10:15 – 10:45 a.m.	Break with Vendors		
10:45 – 12:00 p.m.	“Results That Last” Continued – Quint Studer – Millennium Theater		
12:00 – 1:00 p.m.	Lunch – Ballrooms B & C		
1:00 – 2:30 p.m.	Session 1 – Training Room “Critical Access: Recent Regulations and Reimbursement Updates” – Robert Hughes	Session 2 – Ballroom E “Patient Friendly Billing – Uninsured & Underinsured” Terry Allison Rappuhn	Session 3 – Ballroom F CFO Session “Managing the Modern Medical System with Metrics” – Steven Berger
2:30 – 3:00 p.m.	Break with Vendors		
3:00 – 4:30 p.m.	Session 1 – Training Room “Critical Access: Recent Regulations and Reimbursement Updates” continued	Session 2 – Ballroom E “Transition to Consumer Driven Healthcare” David Burchfield, Ph.D.	Session 3 – Ballroom F CFO Session continued – “Managing with Metrics” continued
6:00 – 7:30 p.m.	Hospitality and Dinner – Ballrooms B & C		
7:30 – 11:30 p.m.	Band and Dancing with “The Alley Cats” – Ballrooms B & C		

Friday, February 3, 2006

8:30 – 10:00 a.m.	Session 1 – Ballrooms B “Determining and Monitoring Revenue Cycle Key Performance Metrics” – Steven Berger	Session 2 – Ballroom C “UBO4 Transition Updates” Suzanne Lestina
10:00 – 10:30 a.m.	Break with Vendors	
10:30 a.m.	VENDOR TEAR-DOWN	
10:30 – 12:00	General Session – “Habits of the Heart” – Jeff Conley - Ballrooms B & C	

2005-2006 MISSISSIPPI CHAPTER HFMA ADMINISTRATION

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