Words From Your President

Diane Maheux, FHFMA

Happy 2017!

Calendar Year 2016 was filled with many surprises, and 2017 probably has a few more in store. We had a busy fall lining up many educational offerings for you. I would like to thank all the volunteers who contributed to the success of these education events! We have some exiting winter events coming. Please mark your calendars for our annual meeting March 16 through 17 at Church Landing in Meredith, NH. We also have the Women in Leadership Conference April 18 at the Manchester Country Club and several webinar offerings that the Education Committee has set up. The Region 1 conference will be held May 23 through 25 at the Mohegan Sun Resort in Uncasville, CT. For those of you who have never attended, Region 1 brings the four New England Chapters of HFMA together. The agenda is packed with some great topics. I highly recommend you check it out on hfmaregion1.org! See page 12 of this newsletter for a complete listing of upcoming education events.

I want to thank those of you who participated in the HFMA evaluation of our chapter. We are here to meet your needs and as we await the results — we hope that we have met them! If we haven’t, please contact any of our officers — myself, Eric Walker, Wendy Dumais, or Erica McNamara. See page 15 of this newsletter for our contact information.

Our HFMA fiscal year, which ends on May 31, is half over. It’s been a busy year for all of us and I have appreciated all the work put in by our board of directors, committee chairs, members, and officers for all their hard work. Thank you all for your efforts.

I hope that your 2017 is a wonderful one!

Diane
Achieving CDI Potential

Glenn Krauss, Director of Enterprise Solutions, ZirMed

Clinical Documentation Improvement programs in the hospital setting have the potential to more closely align and integrate with the revenue cycle—but doing so requires taking the appropriate steps and updating legacy processes to reinvigorate current initiatives.

CDI programs have evolved to some extent over the past decade, yet their fundamental structures and processes have not changed since the inception of the programs back in 1982, when the programs emerged as something of a knee-jerk reaction to the introduction of DRG and the prospective payment system. The goal of traditional CDI initiatives—then and now—is enhancing reimbursement through the CDI specialist’s query process, seeking improved clinical specificity of diagnoses and capture of additional diagnoses that directly impact reimbursement.

While this goal is valid, the reality is that legacy CDI programs don’t truly support it. Nor do they mirror or align with ongoing revenue cycle operations, especially for high-performance organizations. In fact, traditional CDI programs sometimes detract from the overall effectiveness and efficiencies of revenue cycle operations because they lead to unnecessary, self-inflicted, and wholly avoidable clinical validation and medical necessity denials. They can also lead to DRG downcodes, which I will address later in this article.

How CDI, done wrong, can detract from revenue cycle

There are several potential operational deficiencies in current CDI programs that would significantly detract from the revenue cycle. Some are extremely expensive and contribute to a higher cost to collect—others have a subtler but nonetheless detrimental impact on revenue cycle management.

Let’s start with the most basic deficiency in the majority of CDI programs: a lack of measurable, meaningful, and enduring documentation process-improvement initiatives. That’s the only way to drive positive changes in general physician documentation patterns and behaviors. Witness the fact that the most common CDI query consists of congestive heart failure, specifying the type of heart failure to include systolic, diastolic, combination and acute, chronic or acute-on-chronic. This ICD-9 (now ICD-10) code has existed in the classification system for over 5 years, yet we are still querying for this common diagnosis day in and day out. Other common diagnoses that are quite prevalent in the hospital setting—and that also requiring clinical specificity not found in traditional documentation without prompting include chronic renal failure, acute respiratory failure, chronic respiratory failure, pneumonia, acute/chronic renal insufficiency, pneumonia, etc. A quick check with your CDI program leadership to inquire about the most...
common types of clinical queries will drive home the point that affecting and driving positive change in documentation patterns is not a strong point in most CDI programs. In reality, and practically speaking, the sheer volume of queries generated by CDI specialists should eventually trend down as physicians become increasingly familiar with documentation requirements necessary to accurately capture and reflect complexity of care and establishment of medical necessity for hospitalization regardless of level of care from both a hospital and physician perspective.

Clearly, something isn’t working—and it’s incumbent upon us as CDI professionals to work with our colleagues to figure out why, and then fix it.

I would propose that the missing component in the majority of CDI programs is knowledge-sharing between CDI professionals and their physician colleagues. These conversations should center on best practices of clinical documentation, and deep dives into what true clinical documentation “looks like.” Namely, a narrative and details that adequately and fully outline and report the clinical information, clinical facts of the case, clinical content and context supportive of physicians’ clinical judgment, medical decision making, thoughts processes and demonstration of medical necessity. All patient services including physician evaluation and management encounters—regardless of patient setting—must be reasonable and necessary, and the documentation must reflect and support that.

For example, a basic Medicare requirement is that any billed service must be adequately supported in the record—and the information submitted by the supplier or provider on the claim must corroborate the documentation in the beneficiary’s medical documentation and confirm that Medicare coverage criteria have been met. (More detail on that here: Medicare Program Integrity Manual Chapter 3 - Verifying Potential Errors and Taking Corrective Actions).

As CDI professionals, when we focus purely on the procurement of diagnostic documentation specificity absent the surrounding explicitly documentation, we’re not assisting physicians
and doing justice to further the establishment of medical necessity for hospitalization. Just as important, Medicare and other payers are transitioning away from Fee-for-Service healthcare delivery models that promote volume, and moving toward value-based delivery models that promote high-quality, cost-effective care through inclusion of financial incentives and quality of care measures. Without an enhanced focus on improving clinical documentation, a hospital not only risks elevated medical necessity denials, clinical validation denials and DRG downcodes—it also undercuts its ability to succeed under fee-for-value, because all payers’ risk models and capitation will be driven in part by what is contained within the clinical documentation.

Securing diagnostic specificity and additional secondary diagnoses with proper specificity, while essential and important, is low-hanging fruit. It can sometimes be a lesson in futility given the fact that third-party payers as well as the litany of Medicare contractors (MACs, CERT contractor, Recovery Auditors and BFCC QIOs) are on a tear utilizing data analytics to identify potentially suspect claims. These claims are then reviewed with a focus on medical necessity (or lack thereof) and high-weighed DRGs—which include the very diagnoses I outlined above as well as DRGs with one CC or MCC. High-weighed DRGs and DRGs with just one major CC/MCC are consistently identified as high-risk target areas in the OIG’s ongoing Hospital Compliance Reviews program.

Speaking of high-risk areas and significance and relevance of data analytics and data mining, of note is the following quote from the Testimony Before the United States House of Representatives Committee on Ways and Means Subcommittee on Oversight on healthcare fraud investigations:

“To accomplish our mission, OIG employs data analytics and real-time field intelligence to detect and investigate program fraud and to target our resources for maximum impact. OIG is a leader in the use of data analytics, employing a dedicated data analytics unit. Gathering claims data and other electronic information from multiple sources and efficiently and effectively merging that information into a manageable and usable format is a highly specialized skill. Our special agents have direct access to Medicare claims data and use innovative methods to analyze billions of data points to identify trends that may indicate fraud, geographical hot spots, emerging schemes, and individual providers of concern.”

Current KPIs—Are They Valid and Reliable?

One area to consider in the revenue cycle is current KPIs for measuring CDI success. These often include CC/MCC capture rate, query response rate, specific DRG frequencies and case-mix increase (translating into reimbursement). This focus on outcomes-based measures fails to align and integrate with the revenue cycle given the undisputable fact that all of these measures do not necessarily equate to net patient revenue. The old adage of “just because you billed for it it doesn’t mean you get paid for it” and “just because you got paid does not mean you get to keep what you were paid” definitely applies in this particular instance. Case-mix increase is merely a number that can be manipulated in many different ways; in essence this number equates to “gross patient revenue” versus more important (and real) “net patient revenue.”

A relatively simple exercise can drive this point home. Gather the volume of inpatient cases caught up in the denials and appeals process, calculate the dollar amount and case-mix represented in these cases, and subtract the results from the case-mix and anticipated gross and net patient revenue in the month in which the denial, DRG downcode and clinical validation denial occurred.

You will quickly observe the magnitude and economic impact of these cases and recognize the opportunity for your CDI program to enhance alignment and integration with the revenue cycle.

Realizing CDI’s True Potential

The time is ripe to take a hard look at your current hospital wide CDI initiatives and embrace the concept of 5 R’s in the interest of achieving optimal net patient revenue integrity—both to circumvent the real possibility of being targeted by outside parties for review of claims considered high risk areas and to address documentation insufficiencies associated with medical necessity denials, clinical validation denials and DRG downcodes.

Continued, next page
The 5 R’s consist of revisiting, revising, revamping, reengineering and rebranding CDI. The granular goal is facilitating clear, concise, and consistent clinical documentation that best communicates the patient care to the mutual benefit of all healthcare stakeholders including the patient. The broader goal is promoting and achieving solid documentation process improvement that stands the test of time and supports the revenue cycle in a multitude of ways. This entails a full commitment on the part of hospital administration and revenue cycle professionals. CDI professionals must take a leading role in helping the organizations they serve understand that clinical reimbursement improvement as the sole objective of CDI is not truly aligned with optimizing the revenue cycle—and can actually undercut efforts to do so.

Yes, reimbursement improvement should be a by product of documentation improvement. But rather than resulting from simply querying, it should instead result from focused efforts to drive lasting improvement in how documentation tells the true patient story. By positioning the medical record as a communication tool for all stakeholders, CDI specialists can engage in more targeted and sophisticated conversations around the need for documentation improvement. And as they challenge themselves to elevate their own perspective, they can incorporate new best practices into their daily chart reviews and responsibilities.

What constitutes best practice standards of documentation?

- **Medical Record Documentation and Content:** The medical record must identify the patient, **support the diagnosis, justify the treatment, and document the course and results of treatment and facilitate continuity of care.** The medical record must be sufficiently detailed and organized to enable:
  - The responsible practitioner to provide continuing care, determine later what the patient’s condition was at a specified time, and review diagnostic/therapeutic procedures performed and the patient’s response to treatment.
  - Other physicians should be able to review physician author note and assume care where the previous physician left off. This means the documentation must include:
    - Past and current diagnoses
    - Current patient problem(s)
    - Current treatments and plan of care
    - Planned workup
    - Clinical rationale, judgment, medical decision making, thought processes, and problem solving/analytical skills
    - Follow-up care
    - Justification for diagnostic work-up & therapeutic treatments

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**YOUR PEERS, YOUR STAFF, YOUR MOVE**

**MEMBER-GET-A-MEMBER PROGRAM**

You know – more than anyone – the value of belonging to HFMA.

Spread the word. Invite your peers, your staff, and your colleagues to join you – and join HFMA.

You can win prizes when each new member you recruit joins HFMA.

[HFMA.ORG/MGAM](http://HFMA.ORG/MGAM)
Goal setting is everywhere in our world. We set goals for our careers, our health, and our lives in general. It seems modern society is always encouraging us to think about the next milestone.

What we don’t think about enough is the science and strategy of how to accomplish your goals. An author, Mark Manson has realized that having a goal is the easy part. Wouldn’t you want to write a best-selling book, or lose weight or earn more money? Everybody wants to achieve these goals!

The real challenge is not determining if you want the results but if you are willing to accept the sacrifices required to achieve your goal. You may agree, everybody wants a gold medal but few people want to train like an Olympian. The first key insight is: Goal setting is not only about choosing the rewards you want to enjoy, but also the cost you are willing to pay.

Experts define goal setting as the act of selecting a target or objective you want to achieve. In very specific terms, what do you want to achieve? Goals are useful for setting the direction. Systems are great for actually making progress with your goal.

This is a helpful way to bridge the gap between goal and systems. We think about the minimum threshold we want to hit. If you can do more than the minimum, go for it. Your goal might be 60 minutes of daily reading and reviewing the CHFP material. You have the freedom to make a wide range of choices with the environment we find ourselves in. Study time is what works best for you!

Setting and striving to achieve goals is one of the more important things we can do in our lives, as we strive to grow, learn and improve. No matter what, don’t give up...are you setting smart goals for 2017?

Start by setting smarter goals right now for “Certification”. The basic breakdown for your goal is Specific, Measurable, Attainable, Realistic and Timely. You can become certified, but you need to set it as your personal goal for 2017!

Lastly, effective documentation must meet the following standards and qualifiers:

- Concise—no “fluff”
- Accurate reporting of acuity
  - Nature of presenting problem
  - Chief complaint
  - History of “Present Illness” vs. “Past Illness”
  - Physical exam reflective of nature of presenting problem & clinical judgment
- Assessment
  - Clinical specificity
  - Diagnosis relevant to the patient encounter
  - Trace-back of diagnosis
  - Plan of care that is congruent with assessment

**Final Note**

Most hospitals have developed and implemented CDI programs as a core part of the revenue cycle—they’ve made the investment, but aren’t yet reaping the full and true benefits. That’s why the time is now to examine the operations and outcomes of these programs. We must recognize and understand the current limitations of CDI as it exists today, and initiate continuous quality improvement efforts to facilitate achievement of optimal CDI potential.

Doing so requires wholesale changes to better align and integrate with the revenue cycle and more fully support overall fiscal health and integrity. Addressing low-hanging fruit of diagnoses securement provides immediate but fleeting revenue gains; instead, what is needed is a focus on enhanced physician behavioral patterns of documentation over time. Long-term gains in the stock market as opposed to short term gains ultimately provide for a better return on investment when you factor in income tax implications. The very same concept holds true and applies to clinical documentation improvement initiatives.
Health care is changing – and so is the Certified Healthcare Financial Professional (CHFP) designation.

The new CHFP from HFMA prepares finance professionals, clinical and nonclinical leaders, and payers to address the continually evolving healthcare business environment. Multidisciplinary courses focus on providing today’s essential skills: business acumen, strategy, collaboration, and leadership.

Course modules include:

**The Business of Healthcare**
Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources

**Operational Excellence**
Exercises and case studies on the application of business acumen in health care

Take the next step in your professional development – check out the new CHFP at [hfma.org/chfp](http://hfma.org/chfp).
HFMA Certified Healthcare Financial Professional (CHFP) Certification

Jane Piotrowski, FHFMA

In December, the NH/VT Chapter HFMA Certification Committee traveled to Burlington, VT to host the third CHFP workshop entitled “HFMA CHFP Certification: The New Format and What to Expect”. Like the previous two, this workshop was designed to provide insight into the new certification format. There was a presentation on Module I – The Business of healthcare and Module II – Operational Excellence and their components as well as a viewing of the YouTube videos that were developed by the Chapter (along with the Arizona, Connecticut and Wisconsin Chapters) as a learning tool for this exam.

A big thank you goes out to Amy Vaughan for her help in organizing this workshop. Through her efforts we were able to host the workshop at The University of Vermont Medical Center (UVMMC) and have the most attended workshop thus far. In addition to candidates from UVMMC, there were also candidates from Central Vermont Medical Center, led by Amy Gibbs and Erica McNamara.

Prior to the presentation, everyone had the opportunity to talk about HFMA and what it has meant to them and their careers. Everyone agreed, HFMA is definitely an indispensable resource for healthcare finance and Certification via CHFP designation is a valuable component of HFMA as well as the financial professional’s skillset. The CHFP designation is recognized by employers and peers alike and, as the healthcare landscape becomes more competitive, it is important for the financial professional to gain every advantage.

If you are interested in CHFP Certification or any other Certification programs offered by HFMA, please feel free to contact any one of the Certification Committee members, they would be more than happy to assist you in your goal to become certified.
Harder than It Looks: Appropriate Use of the CMS Advanced Beneficiary Notice (ABN)

Emily Anne Nolte and Catherine Hood, PwC

Of all the acronyms that Medicare patients become familiar with, the “ABN” is certainly not one of the favorites. An ABN, or “Advance Beneficiary Notice” is a waiver form that alerts a patient that a test or procedure will likely not be covered by Medicare, usually due to CMS medical necessity requirements regarding required diagnoses for coverage or the frequency with which a procedure can occur. By checking one of three boxes and signing the form, a patient can inform his provider that he would like to go forward with the non-covered procedure (accepting potential financial responsibility) or opt not to have the service. However, the process to complete this relatively short form can take many wrong turns and may put providers at risk for patient dissatisfaction, compliance errors, and lost reimbursement.

The first wrong turn in the process begins when the hospital representative must decide if an ABN form should be used at all. Providers must issue ABN forms for specific procedures which CMS has deemed “not medically necessary” based on the combination of the procedure and associated diagnosis, Medicare’s frequency requirements, or the procedure being experimental; issuing ABNs outside of these conditions is referred to as using a “blanket ABN”. If an organization issues blanket ABNs, patients are accepting financial responsibility for services Medicare may cover, which is against CMS regulations. For example, some practices have patients sign ABNs prior to even seeing a provider just in case a procedure is ordered during the visit that violates Medicare’s medical necessity requirements. Other providers require an ABN for every occurrence of a specific procedure without regard to the individual patient’s situation. The frequency of a test or procedure as well as the patient’s individual diagnoses affect whether Medicare determines if a service is medically necessary. Failing to take these factors into account can lead to unnecessary paperwork and patient dissatisfaction. It is important to note that for items that are never covered by Medicare regardless of the patient’s situation (“non-covered services”), you may show a patient the ABN form as courtesy.

When determining whether or not to issue an ABN, it is also important to know which type of patients need ABNs. ABN waivers are applicable to Medicare patients in both inpatient and outpatient setting. However, organizations may be incorrectly using ABN forms when providing services for Medicare Advantage patients or patients on other health plans. This is not compliant with CMS guidelines and payor rules. ABN forms are only applicable to traditional Medicare patients. Medicare Advantage plans and other payors have alternative rules and processes for informing a patient that a service may not be covered.

A second potential misstep for providers may occur when discussing the ABN form with the patient. ABN forms combine the clinical considerations about a patient’s care along with the financial realities of a patient’s life. For providers and patients alike, this is a sensitive junction. EMR systems may flag an account for medical necessity and even provide information about potential financial patient liability. These are excellent tools to make the conversation easier, especially if they offer the provider an opportunity to review and potentially avoid the need for the ABN through an appropriate addition or modification of a diagnosis code; but effective policies and training are essential to supporting staff’s comfort with the process and their likelihood to use the ABN form properly. A staff member lacking confidence or uncomfortable with the ABN conversation may not ask for the patient to sign an ABN form, resulting in services being provided that neither Medicare nor the patient are required to pay. Conversations regarding the ABN must occur prior to services being performed and should occur in a private setting where the patient and the clinician are able to review the form and discuss the impact of not receiving treatment. Attempting to have this conversation without proper training, outside of a suitable environment, or at the wrong time may hurt patient provider relationships and even risk patient privacy.

Continued, next page

1 Medicare makes the list of statutorily excluded services available here.
A third area for confusion related to ABNs involves accurately completing the form. Many healthcare providers fail to list the provider’s name, address, and phone number at the top of the form. Additionally, the form must document the specific procedure (i.e. description and CPT), as well as, an estimate of the full price for the procedure. Missing any of these critical data elements or not completing the form on the approved, authorized notice format has the potential to invalidate the ABN form, rendering it useless.

After an ABN has been properly issued, discussed, and completed, the process can still veer off track. With many organizations streamlining check out operations, it is important to have a process in place to guide completed forms into the right hands. Two copies of the ABN form are necessary: one for the patient, and one for the provider to store in practice records. Patients who complete the form with their provider team may walk out with the ABN form in their pockets or purses, leaving the practice with no record that the patient accepted financial liability for their services. Alternatively, collecting the ABN form without providing a copy to the patient is a compliance violation. Especially for lab services, it’s important to have processes and controls in place to validate all necessary parties have adequate ABN documentation prior to services being rendered.

With compliant policies and procedures, adequate training, and thoughtful controls to guide an ABN from patient discussion and execution to the permanent patient record, providers can minimize their risks of potential financial loss due to services not covered by Medicare. For a simple form with three boxes and a space for a signature, there’s a lot at stake. But with these considerations, organizations can protect reimbursement, mitigate compliance risk, and turn a delicate conversation into an opportunity to build trust with, rather than damage, patient relationships. For official CMS guidance regarding the ABN form as well as the current update of the ABN, please refer to the CMS website.

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Clarifications for Restricted Cash in Statement of Cash Flows

In November 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2016-18 – Restricted Cash. FASB issued the ASU to clarify the presentation and classification of restricted cash in the statement of cash flows to reduce diversity in practice related to transfers among unrestricted and restricted and other cash flows.

The primary change is that all cash, whether restricted or not, will be included in the beginning and ending period total amounts of cash and cash equivalents, in order to reconcile period activity in the statement of cash flows.

An entity should then present in the notes to the financial statements a summary of cash and cash equivalents, along with restricted cash and restricted cash equivalents, reconciled to the amounts presented on the statement of cash flows, as illustrated below, from the ASU:

<table>
<thead>
<tr>
<th>Cash and cash equivalents</th>
<th>12/31/19X1</th>
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<tbody>
<tr>
<td>Cash</td>
<td>$ 1,465</td>
</tr>
<tr>
<td>Restricted cash</td>
<td>125</td>
</tr>
<tr>
<td>Restricted cash included in other long-term assets</td>
<td>75</td>
</tr>
<tr>
<td>Total cash, cash equivalents, and restricted cash shown in the statement of cash flows</td>
<td>$ 1,665</td>
</tr>
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</table>

Additionally, an entity should disclose the nature of the restrictions, if material on restricted cash and restricted cash equivalents. The example offered in the ASU is as follows:

“Amounts included in restricted cash represent those required to be set aside by a contractual agreement with an insurer for the payment of specific workers’ compensation claims. Restricted cash included in other long-term assets on the statement of financial position represents amounts pledged as collateral for long-term financing arrangements as contractually required by a lender. The restriction will lapse when the related long-term debt is paid off.”

The effective date of this ASU is for fiscal years beginning after December 15, 2017 for public business entities. All other entities must adopt the ASU for fiscal years beginning after December 15, 2018. Early adoption is permitted.

Contact me with questions about these or any other accounting matters you may have.

W. Karl Baker, CPA, is a principal in the New England health care practice at CliftonLarsonAllen LLP. He can be reached at Karl.Baker@CLAconnect.com or 617-984-8162.
# Upcoming Education and Events

We hope you will join us for one or more of these upcoming events. For more information, click the links below, or visit [nhthfma.org/events](http://nhthfma.org/events).

<table>
<thead>
<tr>
<th>EVENT</th>
<th>DATE/TIME</th>
<th>LOCATION</th>
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<tbody>
<tr>
<td><strong>REGISTER TODAY</strong> Webinar – Preparing Your Occupational Mix Survey</td>
<td>1/19/17 12:00 – 1:00</td>
<td>Webinar</td>
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<tr>
<td><strong>REGISTER TODAY</strong> A Status Report – Innovative Payment Models in NH and VT – Lessons Learned and How We Move Forward</td>
<td>1/26/17 8:00 – 4:30</td>
<td>Fireside Inn &amp; Suites West Lebanon, NH</td>
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<tr>
<td><strong>REGISTER TODAY</strong> Medicare Cost Report Training – Intermediate for Prospective Payment Hospitals and Critical Access Hospitals – Form CMS-2552-10</td>
<td>1/31/17 8:00 – 4:30</td>
<td>New Hampshire Hospital Association Concord, NH</td>
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<tr>
<td><strong>SAVE THE DATE</strong> Webinar - Strengthen Your Appeal Process Survey</td>
<td>2/2/17 12:00 – 1:00</td>
<td>Webinar</td>
</tr>
<tr>
<td><strong>SAVE THE DATE</strong> Annual Meeting</td>
<td>3/16 – 3/17/17 8:00 – 4:00</td>
<td>Inn at Mill Falls Meredith, NH</td>
</tr>
<tr>
<td><strong>SAVE THE DATE</strong> Women in Leadership</td>
<td>4/18/17 8:00 – 5:00</td>
<td>Manchester Country Club</td>
</tr>
<tr>
<td><strong>SAVE THE DATE</strong> Legislative Update Webinar</td>
<td>4/12/17 12:00 – 1:00</td>
<td>Webinar</td>
</tr>
<tr>
<td><strong>SAVE THE DATE</strong> HFMA Region 1 – 16th Annual Healthcare Conference</td>
<td>5/23 – 5/25/17</td>
<td>Mohegan Sun Resort Uncasville, CT</td>
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Come to ANI and plug into the network that is generating real-world solutions to the challenges of today—and tomorrow. Collaborate with your colleagues who together are leading to better outcomes for patients, shareholders, and stakeholders. Prepare yourself to shape the future of health care.

Register now at hfma.org/ani.
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The New Hampshire/Vermont Chapter of the Healthcare Financial Management Association (HFMA) is a professional membership organization for individuals in financial management of healthcare institutions and related patient organizations.