hfma Eastern Michigan Chapter
healthcare financial management association

HealthCents

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Chapter Web site: www.hfmaemc.org

INSIDE THIS ISSUE

President's Message

making connections

By Steve Collard

I remember the lights were really bright. And I think we looked pretty spiffy in those red-white-and-blue straw hats. After 40+ years I still remember my co-stars were Julie Blue, Paul Hodge and Dee Ann Woods. It was my first public performance (and encounter with butterflies), singing, "This Land is Your Land" in front of all 500 students at the Waterford Village School. I was in first grade. And I think we almost nailed it :)

From first grade, I moved on to years of high school/college speech classes, Optimist Club speech contests, debate team competitions, church teaching assignments, and finally, finance presentations to various committees, boards and leadership groups. The words flow a little easier, the outlines seem a little crisper – but the butterflies are still there and I always have speaker's remorse, wishing I had said something differently. The development continues…

If you are like me, an educational event entitled "Present Like a Pro" sounds like a great opportunity to keep my communication skills heading in the right direction. A session that focuses on learning how to make presentations that connect with your audience is a great way to jump-start your professional development in 2009! So please make plans to come and join us on February 24, 2009 at the Troy Community Center for breakfast and an educational session with Cyndi Maxey, a Certified Speaking Professional, based in Chicago.

Cyndi taught an interactive and fun session on making presentations at the HFMA National Leadership Training conference in San Antonio in 2008. This session is another example of our chapter's sponsorship program making it possible for us to provide a "national" seminar to our members locally at a very affordable price. For the February 24 session, the price is even better – half of the participants will attend for free! Sign up on the Eastern Michigan Chapter website (www.hfmaemc.org) and you can bring a guest for free. Mark it on your calendar and I'll see you there!

Before I close this month's note, I want to commend the Financial Accounting & Reporting Committee for two excellent educational sessions the chapter held in October 2008. Check out speaker John Daly's article on "The Quick Close" on page 3 of the newsletter. I also want to thank the Revenue Cycle Committee for an excellent session in November on "The Future of the Front End." Watch for the next topical educational event – the Annual Insurance &

Please see **President's Message** on page 2

President's Message from page 1

Reimbursement Update - on March 19, 2009 in Novi. Remember that these committees offer opportunities to network with your peers at monthly meetings! The committee contacts are listed at the end of this newsletter. If there is a topic you would like to suggest for future member meetings, please send a quick email to our administrative assistant, Susan Stokes at susan-stokes@comcast.net.

And a final thank you goes out to the presenters from Dykema who provided yet another first-rate Compliance Update seminar on January 15, 2009 at Andiamo's in Bloomfield Hills. Our chapter secretary and Dykema attorney Maria Abrahamsen made an outstanding presentation, and I also need to thank her for facilitating the production and distribution of the Eastern Michigan Chapter Membership Directory to all of our members in November. If you haven't received your copy, please let Susan Stokes know at susan-stokes@comcast.net.

My year as the chapter's president is flying by and there is no better sign of this than the chapter elections for next year's officers and directors, which will be conducted in early February. Please take a moment to cast your vote! We value your participation!

Hoping to connect with you soon,
Steve

Up Front – Editor's Letter Another New Year's Resolution?

By: Jo Ann Roberts
William Beaumont Hospital
jroberts@beaumonthospitals.com

> A New Year's resolution is a commitment that an individual makes to a project or the reforming of a habit, often lifestyle change that is generally interpreted as advantageous. The name comes from the fact that these commitments normally go into effect on New Year's Day and remain until fulfilled or abandoned. (definition from Wikipedia, the free encyclopedia). http://en.wikipedia.org/wiki/Wikipedia:Citing_Wikipedia accessed 1/5/09

Besides a toast of champagne, most of us begin the new year with composing a list of New Year's resolutions. Composing a resolution is a form of goal setting. Many people consider the process of setting resolutions as a waste of time since most of us never achieve our well intended resolutions. I look at it as a process for self evaluation. Only through the process of self analysis can we expect to improve. This is the first step; actually meeting our goals is an added bonus!

As with every new year, I have set a few New Year's resolutions, and once again, I will struggle to achieve them. I still have all the same standbys: Lose weight, get fit, eat right, less shopping, volunteer…..but one new goal that I have set for 2009 is to "spend quality time with friends and family." My plan is to take the extra time to be in the moment when visiting with friends and family. So many times, we go through the motions but are not truly committed to the event. We spend time thinking of what we need to do next that we pass by the moment. Our multi-tasking skills get in the way of focusing in on the moment.

As part of our "Making Connections" theme, I invite you to share with our readers one of your 2009 New Year's resolutions. We will publish your feedback in our next newsletter in the "Tell Us" section of the newsletter. If possible, please include a photograph of yourself. The newsletter submission deadline is 3/13/2009. (hopefully you have not abandoned the resolution by this time).

HAPPY NEW YEAR

Please submit articles to Maryanne VanHaitsma mvanhait@dmc.org or Jo Ann Roberts JRoberts@beaumonthospitals.com .

Implementing the Quick Close

By: John L Daly, ***MBA, CPA, CMA, CPIM***
President, Executive Education
Daly@ExecutiveEducationInc.com
Web site: www.ExecutiveEducationInc.com

When I began my first controller job twenty-five years ago, my predecessor routinely distributed monthly financial statements 15 to 21 calendar days after month end. Ten years later, my department was able to distribute financial statements in only five business days. For that era, we considered five days to be very good performance. Today, according to two different articles in the ***Journal of Accountancy***, five days is merely average.

Today, some companies are able to prepare their financial statements in a single day. Others are able to do a virtual close where there are literally no month-end closing processes separate from recording the previous day's transactions.

There are many reasons why the ability to present financial information quickly is important. Fresh information tells what is happening now and is immediately actionable. However, when information is stale, managers are more skeptical and sometimes deny that the company still has the problems that the financial statements reflect. Time spent analyzing the past is time not available to work on creating the future. As a result, financial departments that can provide financial information quickly are able to make a greater contribution to the company's success.

Performing a quick close is not easy. Some accountants think they must sacrifice cost and accuracy to close quickly. Some companies "cheat" by cutting off some kinds of transactions five or six days before period end. Companies that do this are merely camouflaging their slow closing process rather than actually improving it. I advocate that companies do not sacrifice accuracy for speed. We should accept nothing less than processes that will enable us to perform our closings faster, better and cheaper.

Accountants who attempt to launch a single project to transform their closing process are likely to experience frustration and failure. The task of perfectly aligning the company's transaction collection processes can be overwhelming. It is better if we place the quick close in the context of continuous improvement. The steps required to execute a quick close are much more manageable if confronted one small part at a time.

Many accountants begin the process of moving to a quick close by documenting the existing month-end closing process. However, this starting point will only lead you down the path of seeking ways to create the same output faster. A better approach is to start by examining your preconceived ideas about the company's financial reporting processes. You can only challenge these perceptions by talking to the actual users of financial information.

Most accountants have never discussed the usability of the company's financial reports with their intended users. Users may include the bank, the board of directors, officers, managers and even hourly employees. Ask probing questions to determine what information is useful and not useful on each report. You will probably find your accounting department:

Please see **Quick Close** on page 4

Quick Close from page 3

- Creates reports that have far too much detail.
- Fails to integrate financial and non-financial information in a meaningful way.
- "Pushes" information to users when accounting is ready to distribute it rather than allow users to "pull" information when they need it.

Broad discussions with users will often lead to the realization that your department wastes substantial data collection effort and that you can save time by eliminating non-value-added work. Your ultimate objective should be to be able to provide accurate financial information at any time.

Quality control professionals believe that most organizations spend large portions of their costs, perhaps 30%, fixing things not done correctly the first time. Accounting departments often spend substantial time performing month-end reconciliations because they are not sure their financial statements are error free. For example, reconciliations of cash, accounts receivable and accounts payable are part of almost every organization's month-end procedures.

Are account reconciliations necessary? They are when financial processes are unreliable. However, ten to twenty percent of the participants in our accounting seminars report that the reconciliation of their accounts receivable and accounts payable aging to the general ledger balance is never, or almost never, off. They have an "air-tight" process that prevents the totals ever disagreeing. In such organizations, the amount of time to perform an accounts receivable or accounts payable reconciliation is trivial because the balances are never wrong. Such accounts are never a barrier to a quick close.

In order to accomplish a quick close, we accountants must think like process engineers, analyzing the products that our users need and then designing lean, reliable processes to satisfy their information needs.

Most accountants agree that closing quickly is an important goal. However, many accounting departments will never complete even a single small project to implement process improvements because other tasks always seem to be more pressing. Your first process improvement project provides the time to perform the second project. Each project will make your life easier, your department more efficient and the users of financial information more satisfied.

If I were to go back to my first CFO position today, 16 years later, I would not be satisfied with closing in 5 days. While the accounting profession considered a five-day close very good in 1992, it is a long way from excellent today. Today, our financial software knowledge of financial statement preparation techniques is much better than it was then. There is always room to improve.

Membership Committee News

By Christina Wong and Michael Berryman

New Members of the Eastern Michigan Chapter are an important part of the chapter's continued success. Please take a moment to contact our new members and share your experiences about our chapter. We value their membership and encourage them to become active on chapter committees.

Jennifer Heinrich, Financial Analyst
Henry Ford Wyandotte Hospital
Jheinri1@hfhs.org

Carrie Czajka, Principal Analyst
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John G. Saylor, Assistant Admin
Henry Ford Hospital

Lawrence E. Smithkey, Vice President
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dllarrys@securityfirstbenefits.com

Carol L. Trewartha, Health System Manager
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Doug Strong, Director & CEO
University of Michigan Hospital & Health Center
dougs@umich.edu

Gary Lawera,
Well Spring Partners
glawera@huronconsultinggroup.com

HERE'S HOW THE 2009 MEMBER-GET-A-MEMBER (MGAM) PROGRAM WORKS:

- Recruit one or two new members who begin their membership between June 1, 2008, and April 30, 2009, or former* HFMA members who reactivate their membership between August 1, 2008, and April 30, 2009, and you will win your choice of an HFMA apparel item (approximate retail value of $25) or a $25 Fuel Visa® Prepaid Card.** Fuel cards can be used at the gas station of your choice or anywhere Visa debit cards are accepted worldwide.
- Recruit three or four new and/or former* HFMA members and you will receive a $100 Visa prepaid card good anywhere Visa debit cards are accepted worldwide. You will also be entered into a drawing among all those recruiting three or four to receive a $1,000 cash prize.
- Recruit five or more new and/or former* members and you will receive a $150 Visa prepaid card. You will also be entered into a drawing among all those recruiting five or more to receive a $2,500 cash prize.

*Sponsors will receive credit in the Member-Get-A-Member campaign for former members who reinstate (reactivate) their memberships between August 1, 2008, and April 30, 2009. Sponsors will also continue to receive credit in the Member-Get-A-Member campaign for new members who join (or have joined) between June 1, 2008 and April 30, 2009.

** Cards are issued by Citibank, N.A. pursuant to a license from Visa U.S.A. Inc. and managed by Ecount, a Citi company.

Chapter Calendar

February			
2/2/2009	Ballots to be sent out		
2/4/2009	Managed Care Committee Meeting – Topic: Blue Cross PGIP Program	8:30 - 10:30AM	St John Corp Offices 27800 Dequindre Rd Room TBD
2/6/2009	Membership Committee Conference Call	1-2PM	
2/2/2009	Ballots to be sent out		
2/16/2009	Ballots are due and election ends		
2/17/2009	Financial Analysis Decision Support	8:30 - 10:30AM	St John Corp Offices 27800 Dequindre Rd Roon S-7
2/18/2009	Bowling Night	6PM Start	Langan Nor-West Lanes, 14Mile & Northwestern Hwy.
2/20/2009	Revenue Cycle Committee Meeting	9AM	Botsford Hospital
2/23/2009	Certification of Ballots		
2/24/2009	Present Like a Pro: Presentations that Connect	8:30AM – 11:30AM	Troy Community Center, 3179 Livernois, Troy, MI 48083
March			
3/6/2009	Membership Committee Conference Call	1-2PM	
3/14/2009	Newsletter		Submission Deadline for HealthCents
3/17/2009	Financial Analysis Decision Support	8:30 - 10:30AM	St John Corp Offices 27800 Dequindre Rd Roon S-7
3/20/2009	Financial Accounting & Reporting	8:30 - 10:30AM	500 Stepehnson Hwy., Troy, 1st Floor. Park @ 530 Bldg.
3/19/2009	I & R Committee Annual Update/Member Meeting	8:30 - 12:30AM	DoubleTree-42100 Crescent Blvd. Novi, MI 48375
3/19/2009	Board Meeting	Following meeting	DoubleTree-42100 Crescent Blvd. Novi, MI 48375

Save The Date…

The Annual HFMA/MACPA Healthcare Conference will be Thursday, April 30, 2009.

Location: TBD

CMS Restates Physician Supervision Requirements for Hospital Outpatient Services

By: Maria B. Abrahamsen
Dykema Gossett PLLC
mabrahamsen@dykema.com

In comments to the 2009 final hospital outpatient regulations, CMS "restated and clarified" its interpretation of the existing requirements regarding physician supervision of certain hospital outpatient therapeutic and diagnostic services. Here are CMS's key points:

- Outpatient diagnostic services furnished in an off-campus or an on-campus hospital outpatient department must be under the same level of physician supervision (general, direct or personal) as is required when the same service is paid under the Medicare physician fee schedule, such as when furnished in a physician's office. This means, as a practical matter, that all hospital diagnostic testing will be subject to the same physician supervision requirements as apply in a physician's office, except diagnostic testing provided to Medicare inpatients.

- Hospital outpatient therapeutic services that are covered as being "incident to" the services of a physician must be performed under "direct" physician supervision if furnished off the hospital's main campus. "Incident to" services include emergency department visits and outpatient surgery. Services that fall within a separate Medicare benefit category (such as outpatient physical therapy) are not "incident to" services. "Direct" supervision means the physician must be on the premises, although not necessarily in the same room, and immediately available to assist and direct the therapeutic service.

- When outpatient "incident to" services are furnished on the hospital's main campus, CMS "assumes" that the direct physician supervision requirement is satisfied. CMS clarified in these recent comments that "assume" does not mean on-campus facilities are exempt from the direct physician supervision requirement; rather, CMS focuses less on compliance with the physician supervision requirement in on-campus departments because physicians are typically nearby within the hospital.

- Non-physicians may not provide the physician supervision required for diagnostic or therapeutic services.

Chief Financial Officer Profile John Liston

Organization: **Port Huron Hospital for 2 years**
Title: **Vice President of Finance & Chief Financial Officer**
Years in current position: 2 **years**

Joined HFMA because: **For the Networking Opportunities**

Biggest issue facing health care financial managers today: **Margins are not sufficient enough to provide for replacement of Plant & Equipment.**

"Get to Know You" questions:

1. If I had time, I would like to travel to: **Australia**
2. You would be surprised to know: **I'm a bowler.**
3. Proudest moment**: Birth of my daughter**
4. Restaurant we might bump into you**: the local Coney Island**
5. Favorite saying**: "Sometimes you're the dog, and sometimes you're the tree"**
6. Person I would like to meet: **Tiger Woods, he's the most prolific athlete of our time**
7. Dream automobile: **Red Corvette (and I own one)**

Fall Conference Committee Chair Profile Shelley Lake

Organization: **Artus Medical Receivables Management**
Title: **President**
HFMA Member Since: 1976
Years in current position: 17 years
Joined HFMA because: **Encouraged by employer and found the educational opportunities to be exceptional and a great networking spot.**

"Get to Know You" questions:

1. Favorite soft drink: **Dr. Pepper**
2. If I had time, I would like to travel to: **St. Petersburg, Russia**
3. You would be surprised to know: **I'm a Master Gardener**
4. In case of fire, I would grab my**: Purse or if home, my cat**
5. Restaurant we might bump into you: **Boodles**
6. Favorite saying: **Do it right the first time**
7. Person I would like to meet: **Today – Barak Obama, A Week Ago – Stephen King**

Update on Medicare Payment for Hospital Outpatient Visits

By: Maria B. Abrahamsen
Dykema Gossett PLLC
mabrahamsen@dykema.com

CMS's recently published 2009 hospital outpatient regulations include new payment rate and policy clarifications relating to hospital outpatient visits.

Type B Emergency Department Visits

Since January 2007, CMS has distinguished between Type A and Type B emergency departments (EDs). Both Type A and Type B EDs must satisfy the EMTALA definition of a "dedicated emergency department." However, Type A facilities operate 24/7, while Type B operate less than 24/7.

Prior to January 1, 2009, Medicare paid for visits to a Type B ED at the same rate as paid for a clinic visit. Beginning January 1, 2009, Medicare will pay for 3 Type B ED visits at a rate higher than a clinic visit and less than a Type A ED visit (although Level 5 visits to a Type B ED are paid at the same rate as a Level 5 visit to a Type A ED). CMS decided to create this intermediate payment rate for Type B visits based on data regarding the costs incurred by hospitals to deliver care in Type B EDs.

CMS re-emphasized that a "fast track" emergency facility does not qualify as a Type A ED if it operates less than 24/7, despite the fact that it is on the hospital's main campus, is an area within the ED, and uses the same patient registration and process of care as the hospital's 24/7 ED.

"New" Vs. "Established" Patients

The Medicare program pays higher rates for "office or other outpatient visits for evaluation and management services" if the patient is a "new," rather than "established," patient of the hospital.

Effective January 1, 2009, CMS distinguishes between a new and an established hospital outpatient based on whether the individual has been registered as an inpatient or outpatient of the billing hospital within the past three years. Prior to 2009, CMS defined an established hospital outpatient as one who had a hospital medical record that was created within the past three years.

CMS refused to adopt a service-specific definition of established patient. In other words, an individual is an established patient if he was registered within the last three years to receive any services at the hospital, even if the services were totally unrelated to those that he is currently receiving at the hospital. CMS also declined to follow public suggestions that it eliminate the new/established distinction in paying for outpatient clinic visits; CMS continues the distinction because cost data shows that new patient visits are more costly to hospitals than equivalent visits by established patients.

Hospital Accreditation Shake Up

By: Maria B. Abrahamsen
Dykema Gossett PLLC
mabrahamsen@dykema.com

New Hospital Accreditation Alternative Approved by CMS

It has been more than 40 years since the Medicare program approved a new accreditation program for general acute care hospitals, but this Fall CMS announced that a hospital accredited by Det Norske Veritus Healthcare, Inc. ("DNV") will be "deemed" to satisfy the requirements for Medicare and Medicaid participation. DNV's accreditation program integrates ISO 9001 with the Medicare Conditions of Participation (CoP) and measures compliance with both of these sets of standards through annual surveys. A hospital contemplating a switch from Joint Commission and/or AOA accreditation to DNV should confirm that the hospital will continue to comply (1) with the accreditation requirements associated with any residency programs the hospital sponsors and (2) with the requirements of the third party payment plans in which it participates. Blue Cross Blue Shield of Michigan has not yet approved DNV accreditation as an alternative to Joint Commission or AOA, but is considering the matter.

Joint Commission Loses its Statutory "Lock" on Medicare Approval

Joint Commission (JC) is the only hospital accrediting organization guaranteed by statute to have Medicare "deeming authority" (i.e. hospitals accredited by JC are deemed by CMS to satisfy the CoP). JC's special statutory status was repealed by Congress in 2008, effective July 15, 2010. JC will have deeming authority after July 15, 2010 only if it applies and is accepted by CMS as a Medicare-approved hospital accrediting organization, in the same manner as other organizations are approved. JC has issued a public statement of its intent to apply to CMS to continue its hospital deeming authority. CMS advises that any hospital that is JC accredited as of July 15, 2010 will retain its Medicare deemed status until the normal expiration date of the hospital's accreditation, even if JC is not approved by CMS as an accrediting organization after July 15, 2010.

At present, a few of JC's hospital standards deviate from the CoP. Presumably CMS will require JC to eliminate these inconsistencies by 2010. An indication of the scrutiny that JC's hospital accreditation program will undergo came in late 2008 when CMS announced that JC's accreditation program for critical access hospitals (CAHs) was only conditionally approved by CMS. CMS stated that "significant gaps remain between the Joint Commission standards and the Medicare Hospital Conditions of Participation" and gave JC 180 days to close those gaps.

CMS Clarifications Regarding Deemed Status

Another accreditation development occurred recently when CMS issued a set of "Frequently Asked Questions" regarding the impact of accreditation on a provider's compliance with the applicable Medicare CoP. Highlights include:

- CMS has approved accrediting organizations for hospitals, ASCs, CAHs, home health agencies, and hospices.

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- Accreditation organizations often offer two types of accreditation – one that satisfies the CoP and one that does not. A provider that expects to use private accreditation as evidence that it meets Medicare standards must be accredited under the proper program.

- An accredited provider must still enroll in Medicare and satisfy all other Medicare requirements. The only difference that deemed status makes is that the provider is not required to be surveyed by the state agency (in Michigan, MDCH) which acts on behalf of CMS.

- Medicare enrollment will occur no earlier than the date on which the provider fully satisfies the accrediting organization's standards.

- Accrediting organizations do not have authority to determine whether a hospital unit (e.g. psychiatric or rehab) will be excluded from the Medicare inpatient prospective payment system; the CMS Regional Office makes these decisions.

- CMS clarified the ability of a provider that is denied accreditation, loses its accreditation from one organization, or fails the CMS survey, to establish its compliance with the CoP by another means.

- The FAQ discuss the procedures followed when an accredited participating hospital expands to a new off-campus location for which it seeks provider-based status.

- Finally, CMS reminds providers that even facilities that have deemed status through accreditation are subject to "validation surveys" conducted by the state agency on behalf of CMS. A validation survey that identifies condition-level non-compliance with the CoPs will result in removal of deemed status and placement of the provider on track for termination of its Medicare provider agreement.

Please see **Shake Up** on page 11

"When you have an hour of free time what do you like to do?"

If it is gardening season in Michigan, you will find me planting, pruning, watering or taking pictures in the many gardens I take care of. If it is winter, you will find me curled up under the afghan (the one my mother, Cathy Brunkey knit for me) reading a book.

Susan Stokes
Chapter Administrative Assistant,
HFMA-Eastern MI Chapter
susan-stokes@comcast.net

I spend my extra hours knitting. I find it very relaxing and it helps me to de-stress. I have to concentrate on the pattern so I am only thinking about what I am doing. Before I know it, I have accomplished an entire afghan. Then I give them to my family to enjoy.

Cathy Brunkey
Retired-Chapter Life Member
Cathyb923@hotmail.com

The Questions for "Tell Us What You Think?" for the next newsletter is, **"What is one of your 2009 New Year's resolutions?"** Submit your response to Jo Ann Roberts JRoberts@beaumonthospitals.com or Maryanne VanHaitsma MVanhait@dmc.org our newsletter editors. Next HealthCents deadline is March 13, 2009.

New ASC Performance Standards for 2009

By: Maria B. Abrahamsen
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mabrahamsen@dykema.com

Medicare's standards for ambulatory surgery centers (the "conditions for coverage" or "CfCs") have been almost unchanged since first issued in 1982. The status quo changed, however, on January 1, 2009, when major changes to the CfCs became effective. Some of the new CfCs impose requirements comparable to those that apply to outpatient surgery performed in a hospital.

An ASC must comply with the CfCs as a condition to receiving Medicare payment. ASCs that are accredited by a CMS-approved organization are "deemed" to satisfy the CfCs, but nevertheless may be surveyed under the CfCs in response to a complaint or if selected for a "validation survey." Highlights of the updated CfCs include:

- ***Definition***. CMS had proposed a definition of ambulatory surgery center that would have prohibited keeping a patient beyond 11:59 PM of the day of surgery. In response to negative industry comments, CMS instead has defined an ASC as providing surgical services to patients who do not require hospitalization and who are not expected to require treatment for more than 24 hours after admission.

- ***Governing Body***. The ASC's governing body is now responsible for the facility's "quality assessment and performance improvement" (QAPI) program and for maintaining a written disaster preparedness plan that addresses the needs of both patients and non-patients in the ASC during an emergency. The disaster plan must be coordinated with plans of state and local authorities and must include annual drills with written evaluations and follow-up on the drills.

- ***QAPI Program***. CMS now imposes on ASCs requirements similar to those imposed on other provider categories to operate a proactive and preemptive plan to identify and implement measurable quality improvement mechanisms on an ongoing basis.

- ***Radiology Services***. CMS abandoned its proposal to apply its portable x-ray standards to ASCs. Instead, ASCs continue to be subject to the hospital radiology service requirements.

- ***Patient Rights***. ASCs must post a visible written notice of their patient rights policy in the ASC and inform individual patients of their rights verbally and in writing. If a patient's physician has a financial interest or ownership in the ASC, the facility must disclose that fact to the patient before the date of the procedure. (CMS rejected provider comments that this disclosure obligation be shifted to the physician.) ASCs are also now required to provide information regarding their advance directive policies and to maintain and document a patient grievance procedure.

- ***Infection Control***. CMS imposed more rigorous infection control requirements on ASCs (as was also done recently with hospitals), including a requirement that a qualified professional be designated to direct the ASC's infection control program. CMS expects ASCs to use nationally

Please see **ASC Performance Standards** on page 14

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recognized and approved standards and guidelines in their infection control programs.

- ***Patient Admission, Assessment and Discharge***. The pre-surgical assessment (which must document any drug allergies) must be completed by a physician or other qualified practitioner authorized by ASC policy. ASCs may adopt policies that allow a registered nurse with post-op experience, as well as a physician or other qualified practitioner, to perform post-surgical assessments. Finally, each ASC patient must now be given written discharge instructions and overnight supplies.

Every ASC should review the revised CfCs and confirm that its policies and practices comply with these new Medicare standards.

February & March Member Meeting Information

SAVE THESE DATES !!

Date: Tuesday, February 24, 2009

Topic: "Present Like A Pro: Presentations that Connect"

Speaker: Cyndi Maxey

Location: Troy Community Center, 3179 Livernois, Troy, MI 48083

Time: 8:30AM – 11:30AM

Do you want to:

- **Drive results from every presentation?**
- **Master influence at every meeting?**
- **Ignite your team's talents?**

Then this seminar is for you.

Click link below for brochure with details.

Present Like a Pro brochure

Date: Thursday, March 19, 2009

Topic: Annual Insurance & Reimbursement Update 2009

Speakers: Various (Specifics coming soon!)

Location: DoubleTree Hotel Detroit/Novi, 42100 Crescent Blvd., Novi, MI 48375

Time: 8AM - Noon

Registration details coming soon!!

If there is a topic you would like to suggest for future member meetings please send a quick email to our administrative assistant, Susan Stokes at susan-stokes@comcast.net.

2008-2009 Board of Directors, Officers and Committee Chairs

Chapter website www.hfmaemc.org

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Click below for printable listing of officers, Board and Committee Chairs which includes phone numbers.
www.hfmaemc.org/BoardCommitteeList2008_2009.htm
If you are interested in any of the committees listed above and would like to attend one of their meetings or volunteer to help, feel free to contact a committee chair. All committee meeting dates are listed on the calendar and are open to everyone.