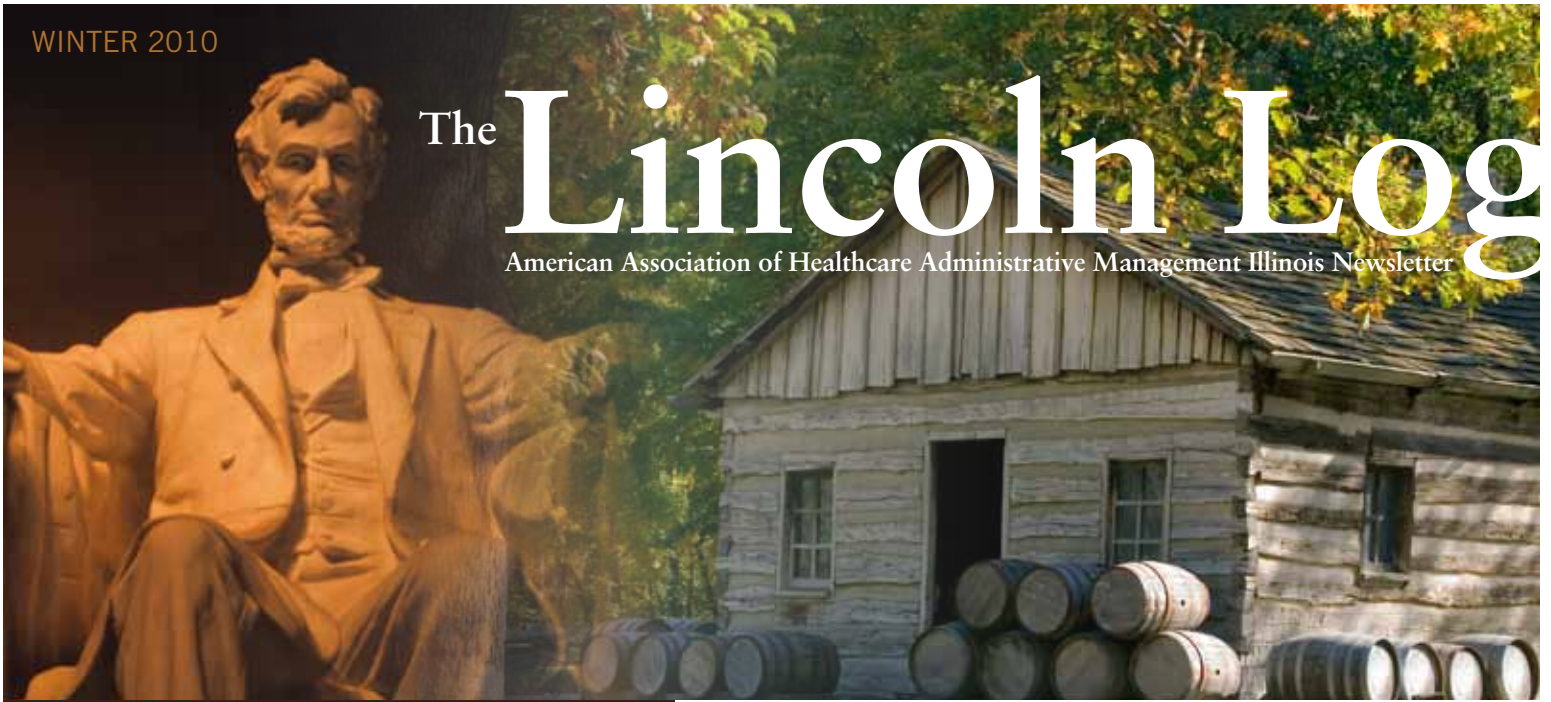


The Lincoln Log

American Association of Healthcare Administrative Management Illinois Newsletter



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AWARD WINNING EZINE

for the Illinois Chapter

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2002 - 2010



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President's *Message*

2010 has been another great year for Illinois AAHAM. I was honored and proud to represent Illinois AAHAM at this year's ANI in Fort Lauderdale and despite soaking my BlackBerry in the surf, enjoyed a great trip. Must be an omen, two BlackBerry's lost or destroyed in two consecutive ANI trips!

That being said, the ANI was great! The National office always does a terrific job in selecting the venue and providing top notch education. I always look forward to the networking and renewing friendships with AAHAM members from across the country.

Illinois AAHAM was honored again this year as we received the 1st Place National Journal Award, 3rd Place Chapter Excellence Award and two awards for membership. Thanks to Steve Dennis, Julie Van Pelt and Tim Turczyn for their work on "The Lincoln Log." Kudos as well to Doris Dickey and Cheri Lockhart for their countless hours and dedication to our Chapter Excellence application. We're #1 as far as I'm concerned. John McGlasson and his committee have done a great job with membership as we exceeded 200 National members for the first time. We are now one of the three largest chapters in the country. Congratulations!

The mid-term elections are over, thankfully, and now the speculation begins regarding changes in health care reform at the state and national levels. With the change in House majority and a number of newly elected senators and representatives headed to Washington, I expect to see a strong push to address health care, insurance and reimbursement issues.

Our Annual State Institute, December 1-3, provided some insight on these topics at the local level.

2011 will be a special year for Illinois AAHAM – we will be celebrating our 30th Anniversary. Wow! Lot's of great things happening for our chapter. Renew your AAHAM membership and plan to be a part of it all.

Best regards –

Bill Carlson

President – Illinois AAHAM

EDITOR'S CORNER



One of the more challenging aspects of health care receivable management is finding work/life balance. The “to do” list is infinite. I truly believe that if you could physically and mentally work around the clock, seven days a week, you would not complete the list. In fact, there are times I am convinced that there is some cosmic force that senses when you are accomplishing tasks and so as to not let you feel caught up can exponentially cause things to occur in a way that the list grows more rapidly.

I actually have had performance evaluations – yes, that’s plural -- where the number one objective is for me to find life balance. Yes, I understand that at some point the mind and body both require rest to function at what feels like warp speed. Yes, I know that it is good for the individuals to report to you to grow a little in your absence. Yes, I know that fiscal controls and GAAP embrace the idea of vacations for key management staff to validate that no improprieties are occurring. And yes, I understand that those who work hard should enjoy the fruits of their labor having fun. It is just so hard to take my hands off the keyboard and go.

This year I had an opportunity to vacation with all four of my children in a sunny location. Before you question my sanity and how four kids and vacation can co-exist in the same sentence, let alone a 500 square foot hotel room, let me preface this by saying two of my children are adults, so I wasn’t outnumbered. With the support of my COO (one of many authors of an evaluation that said to find life-work balance), I took a full week off. Did I peek at emails, answer work calls and occasionally write myself a reminder of something that popped in my head? Naturally. I did not, however, sign on to my laptop or bore my kids with stories from the front line. We laughed, splashed, ate, got sandy, tired and had a blast.

Did I come back to work re-charged and balanced? Absolutely. Am I a better manager as a result of my time away? Hard to say. Am I able to handle the fires, the stress, the silliness with more aplomb and dignity? Maybe. But, here’s what I think I accomplished: Four people who are either starting or preparing for their life work strengthened their bond that will serve them well as life’s challenges and events unfold. Four people experienced the fun that is a reward of hard work. Four people who I brought in to the world with the intention of becoming pretty great contributors to life are a little better prepared to do so. That is my life-work balance. Give yourself that gift this holiday season!

Julie VanPelt, co-editor

2010 ANI in Ft. Lauderdale

PHOTO ALBUM



2010 AAHAM
ANNUAL NATIONAL INSTITUTE
FT. LAUDERDALE, FLORIDA

Congratulations *ILLINOIS AAHAM!*



*Awarded at the 2010 AAHAM Annual National Institute
Fort Lauderdale, Florida*

- National Journal Award – In Recognition of Excellence in Journalism & Graphic Design – 121+ Member Category **1ST PLACE**
- Chapter Excellence Award – For Excellence in pursuing the goals of the American Association of Healthcare Administrative Management **3RD PLACE**
- National Member Award - Recognition of 200+ National Members
- Carolyn Gostomski Membership Achievement Award: In recognition of efforts to increase National membership – 121+ member category.
- Our congratulations as well to **Liz Baptist, CPAM of Perry Memorial Hospital**. Liz was selected by National President Laurie Shoaf to receive the **National President's Award** in recognition of her exceptional contributions made at the National level toward furthering the profession of healthcare administrative management.



AUTOMATION IS THE KEY TO EFFICIENT HEALTH CARE REFORM

*Written By: Christopher Thunder and Ryan Brebner,
R&B Solutions, Waukegan, Illinois*

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law, expanding Medicaid and forming health insurance exchanges. The goal of the bill is for all Americans to have access to some form of medical coverage. Medicaid is expected to play a major role in covering more uninsured people and providing eligibility to nearly all people under age 65 with income up to 133 percent of the federal poverty level (FPL). Medicaid, along with its smaller companion program, the Children's Health Insurance Program (CHIP), is expected to cover an additional 16 million people by 2019. Health insurance exchanges are to be formed by 2014 to help insurers comply with consumer protections, compete in cost-efficient ways, and to facilitate the expansion of insurance coverage to more people. However, both government programs, Medicaid and the Government-Sponsored Enterprises (GSE), will have to coordinate in some way with each other.

A great deal of the burden in the coordination and enrollment of these programs will fall on the states. According to the Kaiser Commission on Medicaid and the Uninsured, it is commonly understood that "given the expected new demands on Medicaid eligibility and enrollment systems, and continuing fiscal strains on states, the impetus to streamline and automate Medicaid systems has never been greater." Many believe this task will be difficult for states to execute. U.S. hospitals expect a \$155 billion reduction in Medicare and Medicaid funding over the next decade as a result of the ACA's cost for health care reform. Disproportionate Share Hospitals will be affected more so than most since they receive a significant portion at a higher rate of reimbursement for services that treat more uninsured than insured. The Center of Budget and Policy Priorities found that 48 states had budget shortfalls in 2009 and 2010, and estimates that 46 states will continue to have budget shortfalls in the following year, which places the States' ability to provide matching funds in question. With budgets decreasing, unemployment and Medicaid eligible patients increasing, and health insurance exchanges forming, how do hospitals continue to assist their patients and ensure the fiscal health of the hospital?

Douglas Elmendorf, head of the Congressional Budget Office (CBO), recently remarked in a letter to Senator Max Baucus, Chairman of the Senate Finance Committee, that one of the greatest difficulties in enrolling people who are eligible for government programs is the application process itself. One solution he saw was to create a more "efficient enrollment process." Elmendorf indicated that an additional 14 million people would become eligible for Medicaid and CHIP under the new ACA guidelines. Even if states accomplish the goal of streamlining and automating Medicaid systems, it does not mean that patients will actively seek out and enroll themselves. Since there will be more Medicaid-eligible patients than ever before, hospitals will require a process that will quickly screen and fill out all the extensive paper work in order to expedite and secure approval for Medicaid and other programs.

Individuals won't be registered for these programs and taking advantage of their benefits until they find themselves in need of it, sick in the hospital. The car insurance industry has shown us that just because the state mandates auto insurance does not mean every driver has it. Often times, an accident will have to occur before an uninsured motorist looks to find insurance. In order for the hospital to gain reimbursement, it will have to educate patients on their options, and assist them with their enrollment in Medicaid, insurance exchanges, or other available programs. The verification of information will also have greater importance as the ACA established the new IRS Code Section 501(r), which requires hospitals to take action and confirm if a patient is eligible for financial assistance, and states look to implement investigations similar to (Recovery Audit Contractor) RAC audits on Medicare. The Washington Post recently published an article on North Carolina's hiring of IBM to review the past six years of Medicaid data for questionable payments. Now more than ever, the

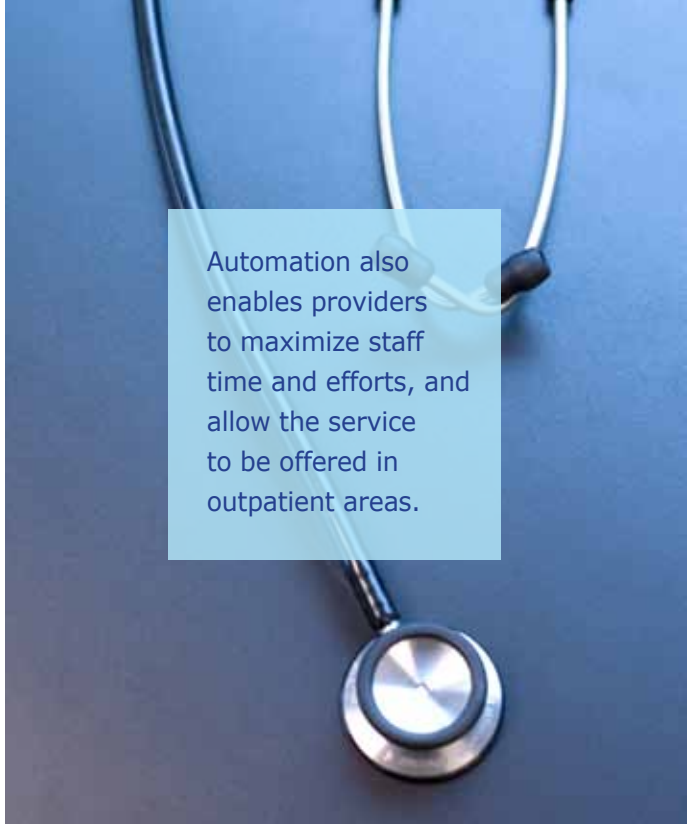
(Continued on next page)

burden of proof is being placed at the feet of the hospital, not the patient.

In their executive summary titled “Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid’s Reach under Health Care Reform,” Julia Paradise of the Kaiser Commission on Medicaid and the Uninsured and Michael Perry of Lake Research Partners, found and suggested “it is appropriate for CMS to spearhead automation efforts by developing model enrollment systems for states and providing technical assistance and incentives to promote their adoption.” Whether or not the states will be able to accomplish this remains to be seen, whereas hospitals are afforded a better chance of success on the front lines of patient interaction and care and have a major incentive to assist patients in enrollment than the state. The only way hospitals can handle the volume of necessary enrollment while driving down costs is through automation.

In doing this, hospitals keep with best practices, and all patients are screened for multiple programs at once with the same questions, which eliminates the possibility of repetition and other forms of human error. Automation also enables providers to maximize staff time and efforts, and allow the service to be offered in outpatient areas. Programs with integrated calculators can compute spend-down requirements, as well as insurance exchanges enrollment fees by the 2014 ACA deadline. All of this information is kept on file for report generation and the IRS 990, which will also eliminate duplicate applications in multi-system hospitals. At the end of the interview, the tool will bring forth the completed application for the best program the patient is eligible for, any necessary attachments, an electronic signature, and the documents required by the state for eligibility determination, such as electronic pay stubs and tax return information. By being electronic, the application is then capable of being submitted online, or by facsimile, with tracking information returned to the hospital.

If the goal of Healthcare Reform is for all Americans to have access to some form of medical coverage, then hospitals will need to play the largest role in assisting people towards the proper access channel and the appropriate form of eligibility. Hospitals are in the unique position of seeing patients when they will need coverage the most: at the time of care. The ACA does offer some direction in terms of an approach to handle the millions of newly eligible patients, but the guidance does not provide the means to properly assist the millions more currently now eligible or eligible-but-not enrolled. Unfortunately, the current state of the economy means hospitals will have to do more with less, and assist a greater number of uninsured patients. Automation will be the key component at the state level (as laid out in the ACA), and also for hospitals to handle the Medicaid increase and maximize their reimbursement across a variety of repayment options.



Automation also enables providers to maximize staff time and efforts, and allow the service to be offered in outpatient areas.

Christopher Thunder is a freelance writer for R&B Solutions, a Medicaid Advocacy company headquartered in Waukegan, Illinois.

Ryan Brebner is Manager of Business Development for R&B Solutions, and is responsible for leading the company’s sales and marketing. Ryan is an active member of HFMA, AAHAM, and NAHAM. Ryan graduated from Saint Norbert College in DePere, Wisconsin with a Bachelor of Arts in Politics and Philosophy. For further information, Ryan Brebner can be reached at 847-887-8514.

About R&B Solutions: (www.randbsolutions.net)

R&B Solutions is a leading Medicaid Advocacy corporation that both uninsured patients and medical providers alike have come to trust to solve many of the problems facing uninsured patients and the medical facilities from which they seek help. R&B Solutions offers a wide variety of solutions for medical providers to assist their patients. The company uses highly-trained patient advocates efficient in State Human Services processes, internally developed software, and years of legal experience to identify and assist the uninsured. R&B Solutions offers expertise in the field of Medicaid Advocacy (inpatient solution), Solutions for Uninsured Patients (SUP), outpatient solutions, and RAMP (Rapid Application for Medical Programs), proprietary software that screens for Medicaid and charity eligibility. Founded in 1986, R&B assists health care providers and their uninsured patients across the United States.

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100 NE Route 44
Anytown, IL 10101-0001

Patient Name: HOSPITAL PATIENT
Billing Account Number: XXXXXXXXXX-XXXX
Statement Date: 12/04/07
Discharge/Service Date: 11/08/07

Description	Amount
CLINICAL LABORATORY	48.00
DX X-RAY	172.00
DX X-RAY/CHEST	202.00

Account Summary

Previous Account Balance	\$432.00
New Charges	.00
Less Payments/Adjustments	.00
Current Account Balance	\$432.00
Current Amount Due:	\$432.00

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To help us process your payment, please return the lower portion of this statement with your payment. Do not send currency.

Billing Address	Billing Account Number	Date Due	Amount Due	Amount Enclosed
HOSPITAL PATIENT	XXXXXXXXXX-XXXX	12/18/07	432.00	

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State: _____ Zip: _____ Phone: _____

Fax: _____ E-mail Address: _____

Website: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Local Chapter (see page 6, left, for name and fees) _____

Membership Type: (See back for details & dues) National Member Student Member

How did you hear about AAHAM? Colleague Publication Website

Other (Please list) _____

If referred by AAHAM Member, Give Name: _____

Please allow 2 weeks for processing once your application is received at the AAHAM National office.

Dues are not tax-deductible as a charitable contribution, but may be deductible as a business expense.

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Account Number: _____ Name: *as it appears on card* _____

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AAHAM Membership
11240 Waples Mill Road, Suite 200
Fairfax, VA 22030
AAHAM Tax ID# 23-1899873

Your Payment Total:

National Dues:	
\$Local Dues:	
\$Total Enclosed:	\$

National Membership - The fee to become a National member is \$175. If you join anytime between July 1st and August 31st, the dues are \$140 for the rest of the current year. If you join between September 1st and December 31st, the fee is \$210 for the rest of the current year and all of the following year.

Please note, membership is on an individual, not institutional basis, and is non-transferable.

Student Membership - The student membership fee is \$50. If you join between July 1st and August 31st, the pro-rated dues are \$35, and if you join between September 1st and December 31st, dues are \$65 (for 15 months of membership). To qualify for student membership you must currently be taking 6 credit hours per semester. Student members receive all the benefits of membership with the exception of voting, eligibility for professional certification, and cannot be a proxy for a chapter president at any national board meetings.

Please Check the Appropriate Codes in Each Category Below.

Years in Healthcare:	<input type="radio"/> Outsourcing	Responsibility:
<input type="radio"/> 0-5	<input type="radio"/> Software/IT	<input type="radio"/> Accounting
<input type="radio"/> 6-10	<input type="radio"/> Provider	<input type="radio"/> Administration/Operations
<input type="radio"/> 11-20	<input type="radio"/> Law Firm	<input type="radio"/> Admitting/Access
<input type="radio"/> 21-25	<input type="radio"/> Other (please list)	<input type="radio"/> Audit
<input type="radio"/> 25+	_____	<input type="radio"/> Benefits
	_____	<input type="radio"/> Budget
Certification:	Position:	<input type="radio"/> Business Development, Sales, Marketing
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Employer Type:		
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<input type="radio"/> Collection Agency		
<input type="radio"/> Consulting		



METHODIST MEDICAL CENTER OF ILLINOIS: *Self-Service Kiosks*

Written By: Steve Marshall, CHFP, FHFMA

At the spring meetings of AHAAM and HFMA we presented our point of service collection experience for both our physician group and our hospital. As a part of that presentation we talked about our self-service kiosk initiative as a next step. We introduced self-service kiosks at one hospital location and two physician offices in April 2010. Our initial introduction of the technology was to ‘coach or direct’ our patients to utilize the kiosk in order to process 80% of our registrations via the kiosk.

This article is intended to provide an update on the goals we set out to achieve, a review of the results, the changes we made, and the lessons learned.

Goals:

- to make check-in more convenient for patients
- to speed patient check-in processes and improve data accuracy by eliminating the need for staff to re-enter demographic and insurance information into hospital information systems
- to decrease patient wait times
- to increase patient satisfaction
- to create a better overall experience
- to automate registration processes
- to minimize data re-entry
- to improve accuracy
- to capture more revenue by reducing denied claims
- to increase collections at the time of service
- to reduce costs by providing patients with electronic consent forms

(Continued on next page)

Results:

- Waiting time in the registration areas was virtually reduced to none or one to two minutes.
 - Overall registration time decreased from an average of ten minutes to five minutes for the first time user and to two minutes for patients utilizing the kiosk on the subsequent visits.
 - We witnessed six patients arriving simultaneously and all six completing the check in a total of 17 minutes.
 - Staff had a high commitment to the success of the project and made several process changes ‘on the fly’ as we “finetuned” the kiosk usage.
 - Physician office point of service collections increased by approximately \$20,000 per month.
 - Hospital point-of-service collections declined to about \$50,000 a month. Part of this is due to the economy/and a decrease in elective self pay surgeries. This is a decrease of approximately \$20,000 per month.
 - Technologically we were able to maintain the synchronization of two separate computer systems and the shared MPI without any data corruption errors.
 - There has been virtually limited downtime of the system during operating hours. Any downtime have been for short durations of time.
 - Registration forms are downloaded via a cold feed to the EMR which eliminated document scanning.
- In addition, 90% of patients were not requesting a copy of the admission forms. The estimated savings is \$50,000 per year.
- The most number of patients presented in the morning hours for walk-in labs and scheduled procedures. The kiosk process assisted with the patients presenting simultaneously.
 - Initial introduction of the kiosk did require that we provide patients with one on one assistance for registration on the kiosk.
 - Elderly patients and walk-in patients consistently rated the experience as difficult with the reasoning that they were not comfortable with computers. This difficult rating was for 6% of respondents. An additional 29% rated the experience as average and 65% rated the experience as easy. These particular results were over the initial four weeks of the go live.
 - The most frequent reasons for patient concerns about the kiosk were; ‘do not like self service/too many screens.’
 - Our Press Ganey registration results declined by over 20 points.
 - The registration ‘errors’ are predominately related to insurance plan selection rather than demographics. Data capture for demographics is improved.
 - There has been a negligible impact on denials.



Changes in process and patient flow from initial ‘go live’:

- Registrars scripting changed to ‘Check-In’ versus Registration as patient’s perceived that they were doing their own registration.
- Registrars would offer to complete the ‘check-in’ for the patient based upon the patient’s answers to the questions presented on the kiosk.
- Staff was educated to refer to the patient by Mr., Ms. or Mrs. rather than by first name as had been the practice.
- We moved two kiosks to private registration booths to address patient concerns over privacy.
- Walk-in patients and inpatients were automatically registered in a booth due to the length of time for the kiosk check-in and the patient dissatisfaction experienced.
- Staff was stationed by the kiosk area to automatically greet the patient.
- Volunteers accompanied the patient to the test area.
- We resumed printing of the patient test schedule to avoid the patient leaving before completing all tests. This schedule was provided to the volunteer wayfinder and so that department personnel would know where to direct the patient if necessary.
- White noise was installed in the new registration area that is now part of the hospital entrance to decrease overall noise.
- Patients are given the choice of registering in a booth or registering via kiosk. This reduced the kiosk usage to 50%.
- We revised the software work flow based on patient feedback and redesigned screens to make the check-in easier.
- Stool height chairs were installed in the kiosk check-in area at the standing kiosk stations to allow the patient to sit for comfort purposes.

Lessons Learned:

- The patient acceptance cycle may be up to one year as it may take this length of time before a patient experiences the new registration area and kiosk process more than one time.
- Consider completing focus groups with patients to gauge acceptance of the technology prior to committing to the project.
- Go live with this technology as a separate initiative rather than include it with the opening of a new entrance, new wayfinding, new paperless initiative, new parking deck and new process flows for all of the areas.
- Design the registration space to allow for less noise and more privacy and keep it separate from the main entrance.
- Include in the technology backload to load a more complete patient history into the kiosk to decrease the amount of information that needed to be ‘built’ (entered) with the patients first use of the kiosk.
- Begin with only scheduled patients for utilization in the kiosk and add the ‘walk-in’ patient scenario after the patients have completed the initial ‘acceptance’ phase of the technology.
- Redesign the registration check-in counter to be a hotel design with greeters in a standing position rather than a sitting station with patients standing.
- Identify those pockets of organization resistance and do additional proactive education and seek endorsement for the project to avoid active resistance.
- Allow additional time before deploying the technology to adequately test and train staff on the system.
- Build in a software redesign process (change management process) after the initial go live to correct initial system weaknesses in the first 30 days.
- Patients can bypass the co-pay collection scenario on the kiosk as it is not a ‘hard’ stop.
- Streamline the information that is presented to the patient to limit the check-in screens to five or less.



Congratulations

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*The group serves the Peoria and St. Louis
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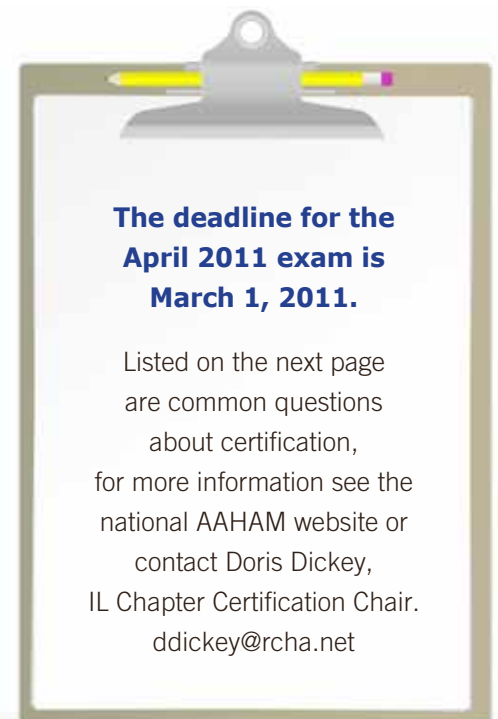
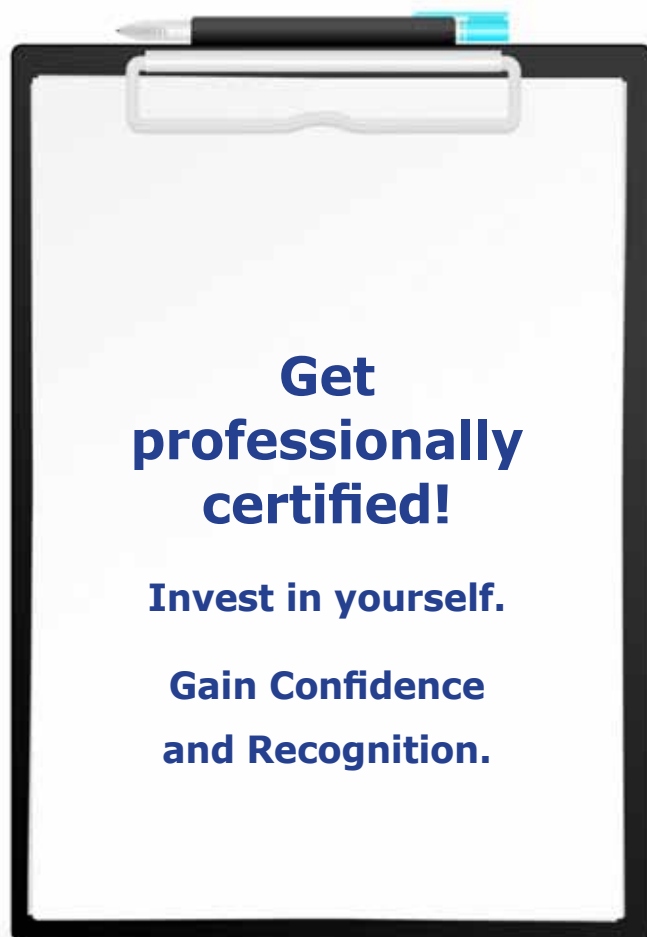
employers with 250 employees or more.

Sample Questions for the Patient Access Section of the Professional Exam:

- 1) In the hospital setting, how often is a MSP Questionnaire required/What does MSP stand for?
- 2) What type of services do not require a signed Medicare ABN/What does ABN stand for?
- 3) How would the patient access team be alerted to possible identity theft?

Answers:

- 1) Upon registration and again every 90 days/Medicare Secondary Payor
- 2) Screen diagnostic exams, such as PSA lab tests and Mammograms; routine physicals, self administered drugs, non medically necessary ambulance/Advanced Beneficiary Notice
- 3) No identification available from patient, information on ID not consistent with verbal info given, photo presented does not match patient, social security number given already in system as a different patient, patient info does not match info already in system from previous visits.



CPAM/CCAM Frequently Asked Questions

Q: What are the benefits of obtaining AAHAM certification?

A: Certification helps keep you in pace with the industry. You gain recognition by the industry, personal challenge and satisfaction, national recognition, professional development, individual enrichment, employer awareness, and advancement opportunity. In many instances certification can get you the job or promotion you really want.

Q: What is Professional certification?

A: Certification is an extensive written exam covering all aspects of patient account management. AAHAM offers two types of Professional certification; the CPAM (Certified Patients Account Manager) and CCAM (Certified Clinic Account Manager).

Q: Who is eligible?

A: AAHAM CPAM/CCAM certification is available only to National AAHAM members who are in good standing and have a minimum of four years health care experience, or two years health care experience and a two-year college or university associates degree.

Q: What is the difference between the CPAM and the CCAM?

A: The CPAM is designed for those who work on the hospital side of administrative management while the CCAM is for those who work on the physician or clinic side.

Q: What does the exam cover and how much time do I have?

A: Each examination is four sections. Sections for the CPAM Examination are Patient Access, Billing, Credit & Collections, and Revenue Cycle Management. Sections for the CCAM Examination are Front Desk, Billing, Credit & Collections, and Revenue Cycle Management. An examinee has eight hours to complete a full exam, six hours to complete a dual exam, four hours for two section retakes, and two hours for one section retake.

Q: When is the exam given?

A: The exam is offered twice a year one week in the Spring (usually the last week of April) and one week in the Fall (usually the last week of September.) These are the only times the exam is offered.

Q: How much does it cost?

A: The cost of taking a full exam is \$200. If you need to re-take a section the cost is \$50 for each section retake. A Dual certification exam is available to current CPAM's or CCAM's for \$125. Please make all checks/money orders out to "AAHAM" and send them to AAHAM's National Office Attn: Certification Dept. 11240 Waples Mill Rd., Suite 200, Fairfax, VA 22030. You can also pay by AMEX, VISA, or MC (no debit cards), through the mail, or fax 703-359-7562.

Q: What study materials are available?

A: National AAHAM offers The NEW AAHAM CPAM/CCAM Exam Study Manual available for purchase by [Clicking here](#). The NEW CPAM/CCAM Exam Study Manual is the only study manual written by AAHAM for AAHAM exams, specifically to assist you in studying for AAHAM's certification programs. The manual has a wealth of helpful information for those studying for the professional exams and for those who do coaching. The manual contains sections that match each section of the CPAM and CCAM exams with material targeted and geared toward exam questions. It features knowledge checks (practice questions) along the way to help you gauge your progress. AAHAM also produces a CPAM or CCAM Study Outline that is included in the price of your exam registration.

Q: By what method do you take the exam?

A: The examination is proctored and given online. It is an eight hour exam (two hours per section).

Q: What if I don't pass all of the sections?

A: If you do not pass at least two of the four sections of the exam you will have to retake the entire exam. You must then pass the final section(s) within 18 months of your original test date. Otherwise you will have to retake the entire exam.

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ILLINOIS CHAPTER

2009 - 2010 Corporate Partners

The Illinois AAHAM Chapter would like to thank our Corporate Partners for their continued support and dedication to the Chapter. Their partnership and generous financial support enable us to provide quality educational and networking opportunities throughout the year.

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Elena Butkus



Chris Stottlemyer



CPAM Attendees



First Time Attendees



Dr. Allen Goben



Education Session



National Chapter Excellence Award



ASI 2010 National Officers

2010 ASI Event Pictures



B. Carlson and J. McGlasson



B. Carlson, C. Lockhart and D. Dickey



B. Carlson, J. VanPelt, T. Turczyn



D. Wilson, R. Duncan, K. Senesac, J. Lines and M. Orwig



CPAT-CCAT Attendees



Kathy Uphoff and Toys for Tots Rep



*Our State Quarterback
Bill Carlson*



Bernadette Lopez



Sandy Kraiss



Steve Markesich

2010 ASI Event Pictures



ASI 2010 National Membership Awards



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ASI 2010 National Newsletter Award



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OUR Couple



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