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Health Care in Crises: Perspectives of Rural Hospital CEOs

By David Peel
Publisher and Editor
Washington Healthcare News

Rural hospitals face difficult times. Patient health status and mix, access to capital, staffing constraints, coordination of care with urban hospitals and other providers, and the percentage of uninsured relative to insured are serious challenges testing some of our most seasoned hospital executives.

What is "rural"?

While there is no single, universally accepted definition for what constitutes a rural hospital, commonly acknowledged ones include:

(1) those counties with a population density under 100 persons per square mile;

(2) all territory located outside of urbanized areas and urban clusters, or

(3) all counties outside of metropolitan and micropolitan statistical areas.

We'll confine our focus to issues facing executives at rural hospitals holding the Critical Access Hospital (CAH) designation.

A result of the 1997 federal Balanced Budget Act, the CAH program was intended to be a safety net that assures Medicare beneficiaries access to health care services in rural areas. It was intended to simplify billing methods, allow more flexible staffing options relative to community need, and provide incentives for local development of integrated health delivery systems including acute, primary, emergency and long-term care. Because reimbursement is cost-based, it can be proportionally higher than those amounts that urban hospitals receive for treating patients with similar conditions. Of the 39 CAH hospitals in Washington State, all fall into at least one of the three common definitions for rural hospitals.

Interviewing the leaders

How difficult has it become for our state's rural hospitals? In late January, I spoke with **Rodger McCollum**, Chief Executive Officer of Snoqualmie Valley Hospital in Snoqualmie, **Vic Dirksen**, Chief Executive Officer of Jefferson Healthcare in Port Townsend, and **Tom Martin**, Administrator of Lincoln Hospital in Davenport – all of whom lead CAH hospitals – to find out. Statistics and other information from the Washington State Department of Health, Office of Community and Rural Health reinforced their assessment.

Patient health status and mix

Peel: The Office of Community

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Washington Healthcare News
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LETTERS TO THE EDITOR

If you have questions or suggestions regarding the Washington Healthcare News and its contents, please reply to dpeel@wahcnews.com.

Letter from the Publisher and Editor

Dear Reader,

From 1996 to 2006 I held Chief Financial Officer positions at three separate Washington State health insurance companies. I didn't always do the best job of passing on information that may have benefited others. I thought my employees, peers and superiors were either too busy or not interested in reading some of the material that came across my desk. When I received something that was "passed on", I was often the last to get it and wasn't always sure whether to return it to the sender or throw it away!

Is the Washington Healthcare News one of those publications you read and then distribute to others? To help you decide, I've listed some of the reasons to consider passing the Washington Healthcare News on to others at your organization.

- The Healthcare Law, Healthcare Administration, Healthcare Agency, Healthcare Performance Improvement and Healthcare Marketing section articles are written by well-known experts in their field and contain valuable information to help protect, manage, insure, improve and grow your business.
- New or recently promoted health care leaders are announced each month.
- The most current hospital and plan financial information is presented to help you better understand your business partners, vendors and competitors.
- Healthcare Opinion articles are published that provide insight into the issues most relevant to our health care system.

If you decide to pass it on, just make sure you indicate whether they should return it to you or throw it away!

Until next month.

David Peel, Publisher and Editor

Washington Healthcare News 2008 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2008	Healthcare Public Policy	December 3, 2007	December 21, 2007
February 2008	Urban Medical Clinics	January 7, 2008	January 25, 2008
March 2008	Rural Hospitals	February 4, 2008	February 22, 2008
April 2008	Insurance Carriers	March 3, 2008	March 21, 2008
May 2008	Healthcare IT	April 7, 2008	April 25, 2008
June 2008	Rural Medical Clinics	May 5, 2008	May 23, 2008
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August 2008	Healthcare Human Resources	July 7, 2008	July 25, 2008
September 2008	Community Health Centers	August 4, 2008	August 22, 2008
October 2008	Third Party Administrators	September 8, 2008	September 26, 2008
November 2008	Insurance Brokers and Agents	October 6, 2008	October 24, 2008
December 2008	Urban Hospitals	November 3, 2008	November 21, 2008

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and Rural Health shows that Washington State's rural populations are at a higher risk for health problems than both the urban core areas and the state average. For example, from 2002 to 2004 the rate of children hospitalized due to unintentional injuries was 245 per 100,000 in rural areas while the state average was only 199. Rural areas have higher teenage birth rates per 1,000, as well as a lower percentage of pregnant women receiving first trimester prenatal care and a higher percentage of adults who smoke than the state average. In almost every key indicator of public health, rural areas ranked worse than the state average. Do you believe patients receiving care at rural hospitals have worse health status levels than patients receiving care at urban hospitals? If so, why is that?

Martin: Our hospital is thirty five miles outside of the Spokane area. We have an older population with many related to the farming community and they have lived in this area for some time. This creates challenges because older folks have co-morbidities with their illnesses. So as a patient presents to our hospital they usually are a little more complex as a result of that characteristic. We also have a high percentage of uninsured. Unfortunately, this is growing. We have a lower cost of living which tends to attract lower income folks to our communities. They generally aren't insured and generally don't participate in primary care because of the cost. When they get sick they usually end up in our emergency room. Many of our uninsured patients receive primary care services at our emergency room.

Dirksen: *We will need major healthcare system redesign. Rural communities are the ideal environment to carry that out.*

McCollum: When we look at the definition of rural, Snoqualmie Valley Hospital would be considered the least rural of the three hospitals. We have close access to tertiary care.

Dirksen: In our community we have a high Medicare aged population. I'm not sure our Medicare population has a different health status than other Medicare populations. We also have a high population of Medicaid patients and they don't use primary care like commercial populations.

Access to capital

Peel: Rural hospitals operate on narrow margins and private banks consider them risky lending candidates. Most are public district hospitals with the authority to assess taxes, yet there are limits and restrictions on that authority. Is access to capital a problem at your hospital?

Dirksen: If we weren't a district hospital we would not have access to capital. Basically, our margins are very narrow or they are a loss. One of the nice benefits of being a community hospital is we can go to the community, make the case for the need and the community can make the choice on whether they want to approve it or not approve it.

Martin: As we look at our margins over the last few years, it was not until 2007 where we essentially broke even which we thought was a major success. We offer services to the community that are not profitable but are essential. Like our nursing home. We've maintained our nursing home with 65 beds and it's usually occupied with 60 or 61 patients. It's one of only two nursing homes in the whole county. The other facility in our county reduced the number of nursing home beds because of low reimbursement by Medicaid. We believe the service is essential and subsidize it through the tax base or through our other operations. From a capital perspective, we don't attract a lot of banks because

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we're not generating much of a margin.

The other limitation is the statutory limit on debt capacity. There are limitations on how much you can indebt the public. As CAH hospitals review options on whether to go for a loan or bond they have to consider whether they can pay it back and generally over a long period of time…twenty or thirty years. With everything going on with the aging of the baby boom population and the challenges associated with getting government reimbursement there are real questions communities are asking themselves on whether they can indenture themselves for such a long period of time and that's putting a veil over the question of whether to rebuild or not.

One of the areas of concern around capital has to do with the EMS system, especially here in Lincoln County. We're seeing a real need to provide financial support to many of our voluntary programs. We're getting challenged more and more everyday finding volunteers who want to commit a significant amount of personal time and even out of pocket expenses to maintain their EMS licensure. There's not a source of revenue to support this.

McCollum: From our standpoint, our physical building is only 25,000 square feet and last year we did over 4,000 ER visits, 2,000 inpatient days with 30,000 clinic visits and that has just tapped us in capacity for delivering health care. At the same time, we're in one of the fastest growing regions of Washington.

This creates an obligation when people are moving into the district and expect health care here.

Martin: *If the staffing situation continues to worsen, it will prevent our hospital from meeting basic quality standards.*

We're in the position of having to come up with the capital to build a new hospital and try to determine what this community is going to need for its health care infrastructure for the next ten to twenty years. Fortunately we have a 50 acre piece of property here in East King County that has appreciated in value tremendously. I don't think we've ever broken even and if we didn't have that land asset we wouldn't have access to capital to even consider this even with being a CAH. This is a tough problem because we kind of lurch around trying to find capital to make long term plans with sometimes short term capabilities.

Staffing constraints

Peel: Most Washington State hospitals have staff shortages in both numbers and types in many areas. Is the problem more severe in rural hospitals?

Martin: If the staffing situation continues to worsen, it will prevent our hospital from meeting basic quality standards in the future. We're in competition with all the larger facilities that have the scale to offer significant compensation packages.

One of the primary issues my nurses have is they're feeling overloaded by the paperwork and they're asking me why they need to complete all of these insurance documents and all of this admission paperwork that is burdensome. A lot of it has to do with registration for the different kinds of insurance and that type of thing. They're drowning in it. We need to see how we can take the nurse away from that and move them towards the clinical applications that they're trained to provide. We need to look at how we can develop more nurse extenders.

Dirksen: I think this is the most frightening issue in healthcare. We're going to have to redesign the delivery system. Rural hospitals are more impacted by this issue in a variety of ways. The people that are receiving rural care

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are through primary care people and there are fewer and fewer people going into primary care.

The numbers are staggering. We've doubled the number of nursing graduates the last couple of years and the gap has remained about the same. We're going to have to graduate 4,000 more nurses next year to keep the gap the same. The 4,000 becomes 8,000 the following year and it goes up by 4,000 each subsequent year. So this means a gap of 4,000, 8,000, 12,000, 16,000 to 20,000 five years from now. So no matter what you do with the education system the care will need to be redesigned.

McCollum: As the general population ages so does our nursing staff. Consequently they'll work one or two days or just per diem. There's a whole industry building around traveling nurses where nurses can quit their regular job and get a huge increase in pay by going to the temp agency. Sometimes we lose a nurse and then hire them back through the temp agency at double what we were paying them.

The nursing schools I talk to have three year waits. It's not a lack of young people that want to get into health care professions. There just aren't slots for them. This needs legislative action to open up training positions so that we can have more nurses.

Coordination of care

Peel: Informally coordinated care for patient transfers from a rural to urban facility has been the norm, rather than use of formal, written agreements that address standardized protocol. Has this practice changed?

Martin: We worked very closely with Sacred Heart Medical Center in Spokane to develop a protocol for cardiac patients where we actually become an extension of their cardiac program. They allow us the ability to activate their resources, their call teams, their cath (catheter) lab, their helicopter service. It reduces the time delay for the patient to get into the cath lab to open the vein or artery and resolve the blockage. This has a significant, positive outcome for the patient. This has become a national standard we

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are able to bring to Lincoln County hospital as a result of our relationship with Sacred Heart.

More of these types of structured referral relationships need to be developed.

Dirksen: We just finished a "Lean" process improvement event with Swedish where we will mimic the model of care they have with the Ballard and Issaquah facilities and that will be available within our community. Our next "Lean" event will be working with Harrison hospital for our heart patients. We have to move from informal relationships to formalized partnerships and coordination.

McCollum: We have an informal relationship with Overlake through our physicians that work at both Overlake and Snoqualmie Valley. We really need those formal processes that Tom has been so successful in establishing as a model for the entire state.

Percentage of uninsured to insured

Peel: According to the Office of Community and Rural Health, 73% of adults in rural areas have health insurance as opposed to the 83% overall state average. Not only does this clearly impact your bottom line, but it also creates many other problems. Is there anything you can do about it?

Martin: Back in the late eighties there were about 13 rural hospitals together with Empire Health Services that formed Inland Healthcare Business / Health Alliance which was an insurance model. We ran it for about a year and a half and it didn't work. Hospitals getting into insurance programs and running insurance programs is difficult to carry out. Our experience is that hospitals need to focus on the provision of healthcare and the prevention of disease and the guidelines for the money handling needs to come from our legislature and congress.

McCollum: *We kind of lurch around trying to find capital to make long-term plans with sometimes short-term capabilities.*

Dirksen: We wanted to partner with an insurer rather than be an insurer. We were willing to absorb part of the deductable for people that would commit to our system to help make insurance affordable to our individuals and small businesses. We realize that's a losing proposition in the short term, but the option of having more people without insurance as it becomes unaffordable to individuals and small businesses would result in even greater losses to us. We have not been able to put a program together with an insurer to date. The time will come when the businesses are not going to be able to afford the insurance.

Final thoughts

Peel: As we conclude, what other thoughts would you like to share with our readers?

Dirksen: We will need major healthcare system redesign. We are currently looking at some pilot projects to redesign parts of our system. Rural communities are the ideal environment to carry that out.

Martin: Vic Dirksen's comment is very true. Rural communities are set-up as incubators and we've always been sensitive to major changes. We are in a very good place to look at care coordination for our population because we have the primary care focus.

Having structured relationships with hospitals and providers in urban areas will allow us to coordinate care for our patients even if we aren't the provider of the service. We want to assure there is a full continuum of care provided that patient rather than have the patient drive around the city and try to navigate the large multi-specialty complex.

McCollum: Tom Martin's statement was truly visionary. If that's going to work it's going to be the rural health care communities that make it happen. It will involve technology on a very large scale.

The Importance of Medical Staff Credentialing

By Robert Walerius
Partner & Health Care Practice Lead
Miller Nash LLP

Your hospital may currently have Dr. A.T. Pruf on staff. You know Dr. Pruf—he may have recently transferred from out of state to your hospital, or perhaps he is a longtime member of your medical staff. He's had a recent DUI and lately some behavioral and quality-of-care issues.

Every hospital has an independent duty to patients to exercise reasonable care in selecting, retaining, and supervising the performance of the medical staff.

Careful credentialing and privileging are mandated by numerous requirements, including the hospital's corporate bylaws and medical staff bylaws, CMS conditions of participation, state laws, and federal immunity laws.

The public looks to modern hospitals as comprehensive health care centers responsible for coordination of total health care. The hospital's role is not just to furnish facilities and equipment for physicians to practice in isolation. The hospital is in a superior position to monitor and control physician performance. An organized medical staff allows the benefits of professional medical judgment to assess quality of care. The medical staff's acceptance of this role is critically important, as evidenced by the recently published survey of 1,662 physicians by the Institute of Medicine, which appeared in the December 4, 2007, issue of *Annals of Internal Medicine*. Nearly half of physicians will not report impaired or incompetent colleagues, according to the survey. This reluctance to report poor practice may be overcome by the medical staff through education on the important role of peer review, use of progressive performance improvement steps, and personal immunity for those willing to respond. There are also financial incentives, given that avoiding negligent credentialing is a major way to reduce claims and insurance costs.

> ***"(According to a) survey of 1,662 physicians by the Institute of Medicine...Nearly half of physicians will not report impaired or incompetent colleagues..."***
>
> Robert Walerius, Partner & Health Care Practice Lead
> Miller Nash LLP

In determining whether a hospital has breached its duty to its patients, courts will look to the medical staff bylaws, state and federal law, and accreditation standards such as JCAHO. At one time, Washington State used the "locality rule" as a means to determine standard of care. The locality rule recognized that a physician in a small, often rural community does not have the same resources to stay current as a physician in a large city. But the locality rule was rejected by Washington courts in 1967. The courts recognize that plenty of opportunities exist to stay current with advances in travel, medical journals, television, radio networks for physicians, taped seminars, and today the Internet.

The degree of care expected of Washington hospitals when credentialing and privileging a physician is to hold the physician to that degree of skill, care, and learning possessed at that time by other persons in the same profession and specialty acting in the same or similar circumstances, in other words, the clinical standard of the average competent physician acting in the same or similar circumstances.

Local practice is only one factor that a hospital and its medical staff must consider. Other factors

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include available referral centers and specialists appropriate for the medical condition in question.

Dr. A.T. Pruf has sent up a number of red flags:

- He has had two DUIs in the last four years, with the most recent five months ago;
- He is noticeably slow in surgery;
- He is combative to nurses to the extent that nurses are reluctant to call him, particularly after hours; and
- You now learn that the hospital from which he relocated is very happy that he left its community.

Options available to the medical staff and the hospital in reviewing Dr. Pruf include a conditional appointment to the staff. In addition to a focused review of patient charts, the physician can be encouraged to cooperate with the Washington Physician Health Program (WPHP). WPHP is a nonprofit corporation founded by the Washington State Medical Association in 1986. The program is confidential and physician-directed.

WPHP will perform initial assessment of physicians and certain other licensed professionals with substance-abuse, physical, and mental disorders, refer them for evaluation and treatment, and monitor their recovery . In addition, WPHP contracts with the Medical Quality Assurance Commission to implement a statewide impaired-practitioner program.

As public scrutiny of patient safety increases, hospitals must protect patients from incompetent and impaired physicians. It is essential for patient protection and public confidence in the health care system that hospitals and their medical staffs actively monitor quality of care and competence. It is equally important that they intervene when problems are detected.

Robert Walerius is a Partner and Head of the Health Care Practice at Miller Nash LLP. Miller Nash LLP has over 100 attorneys with offices in Washington and Oregon. Mr. Walerius can be reached at robert.walerius@millernash.com.

Workplace Wellness: Why Promote Wellness?

By Joan Flood, RHU
Account Executive
Parker, Smith & Feek, Inc.

What is Workplace Wellness?

Workplace wellness refers to the education and activities that a worksite may do to promote healthy lifestyles to employees and their families. Examples of wellness programming include such things as health education classes, subsidized use of fitness facilities, internal policies that promote healthy behavior, including incentives or changing the cafeteria or vending choices, health risk assessments, and any other activities, policies or environmental changes that affect the health of employees. Wellness programs can be simple or complex. Many programs require a minimal investment of time and money. More substantial programs often use more resources, but the many benefits to supporting and encouraging employee health and safety outweigh the costs.

Why Workplace Wellness?

It affects your company's bottom line in many ways.

Here are three key factors:

- Decreased healthcare costs
- Increased productivity
- Better morale

Rising healthcare benefit costs are a significant concern and poor health habits and unnecessary medical care costs consume portions of our corporate resources as well as the employee paycheck.

The worksite is an ideal setting for health promotion and disease prevention programs. Employees spend many of their waking hours at work, nearing 50 hours per week. That's why the workplace is an ideal setting to address health/wellness issues.

> ***"An employee wellness program can raise awareness so employees with fewer risk factors remain in a lower-cost group. A program can also encourage employees with health risk factors to make lifestyle changes to improve their quality of life and lower costs"***
>
> Joan Flood, RHU, Account Executive
> Parker, Smith & Feek, Inc.

Why Start a Company Wellness Program?

Wellness programs help control costs

An investment in your employees' health may lower healthcare costs or slow the increase in providing that important benefit. In fact, employees with more risk factors, including being overweight, smoking and having diabetes, cost more to insure and pay more for health care than people with fewer risk factors.

An employee wellness program can raise awareness so employees with fewer risk factors remain in a lower-cost group. A program can also encourage employees with health risk factors to make lifestyle changes to improve their quality of life and lower costs. The payoff in dollars as well as in quality of life can have a big impact on your company's bottom line.

Increase productivity

Healthier employees are more productive. This has been demonstrated in factory settings and in office environments in which workers with workplace wellness initiatives miss less work. The risk of ill people coming to work and exposing their co-workers is reduced with a healthier workforce. Presenteeism, in which employees are physically present on the job but are not at their most productive or effective, is reduced in workplaces that have wellness programs.

Reduce absenteeism

Healthier employees miss less work. Companies that support wellness and healthy decisions have a greater percentage of employees at work every day. Because health frequently carries over into better family choices,

Please see> Workplace, P24

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Healthcare Consulting Firm Celebrates Five Successful Years of Serving Pacific Northwest Medical Clients

Neither an unsettled economy nor a declaration of war could hold back Barbara Derry and Crystal Nolan as they set out to follow their passion in March 2003. Caring for the health of healthcare organizations was paramount. The two owners, both Fellows in the American College of Medical Practice Executives, forged ahead in their mission to bring financial and operational improvement strategies to medical organizations struggling with rising costs.

Though much has changed since that spring day, much remains the same. The war continues, the economy slugs along, physicians (still) face rising overhead and technologically savvy patients, and the need for Derry Nolan's professional team is as great as ever. Primary services remain focused on:

- Waste reduction – labor, inventory and inefficient workflow
- Organizational improvement – operational and financial assessments and recommendations
- Cash flow management – increasing profitability
- Interim management and executive recruitment

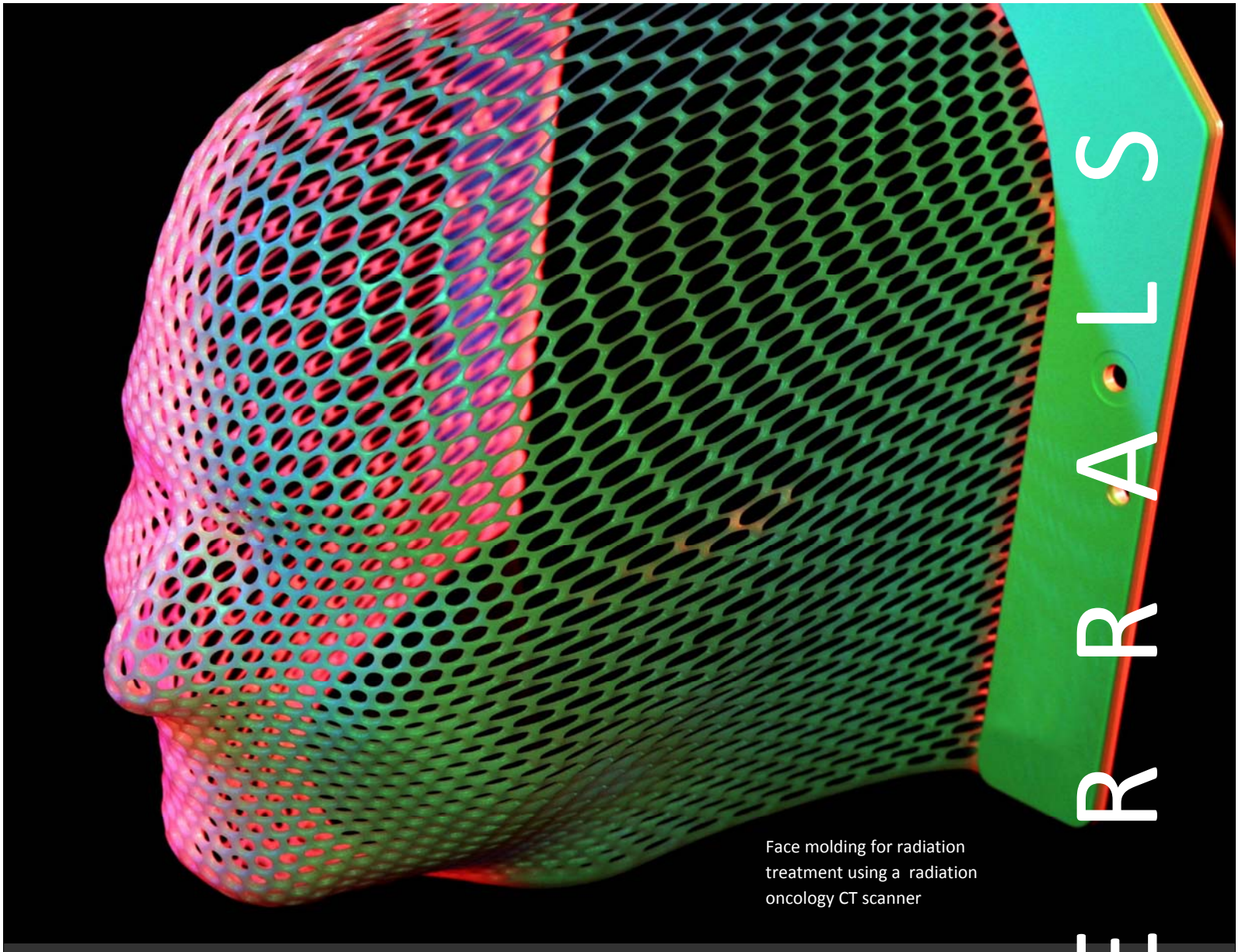
When clients talk to Derry Nolan, they're heard. Consultancy expansion has helped up the ante. Enhanced compliance support services include medical chart/billing auditing, provider education through their Certified Coders, and revenue cycle analysis for both hospital and outpatient settings. For situations where clients request a physician-to-physician approach, William Fallon, M.D. provides counsel on governance, grievance or compensation issues. But they haven't stopped there.

New Ambulatory Surgical Centers (ASC) development is the latest undertaking for the group – working with physicians on feasibility, facility design, staffing models, operations and certification. Existing ASCs also benefit through financial, operational improvement and recertification services.

Electronic medical records (EMRs), once the wave of the future, are now firmly entrenched. Multiple clients have already benefited from the company's proactive deep dive into EMRs with the *Epic* systems and other EMR technology. Providers and support staff in a number of specialty clinics enjoy improved information workflow within *Epic* functionalities. Derry Nolan works closely with *Epic* analysts to facilitate optimal design and use of the *Epic* EMR capabilities. The collaboration results in greater patient satisfaction and higher physician and staff efficiency. Improvements in the areas of provider and nursing clinical documentation templates, billing compliance and revenue enhancements and patient workflow design also reap rewards for the organizations.

Doing it right the first time is "business as usual" for Derry Nolan. Whether reducing inefficiencies in business processes or optimizing an industry tool, the firm repeatedly proves its value. It helps that the two principals, Barbara and Crystal, believe strongly in making a personal connection with their clients. That's why they've kept one particular service a constant from day one – the one hour complimentary evaluation meeting. Their approach and methodology, the resolution to be a different type of consultant – one who cares, has ensured their success. It's not about writing a report, citing a few industry standards and moving on. A Derry Nolan consultant sees their client through the implementation of key recommendations and supports the organization through the changes. And their clients appreciate it – just read the testimonials on their website. *"Caring for your practice, so you can care for your patients."* It's their passion.

To learn more about Derry Nolan visit www.derrynolan.com.



Face molding for radiation treatment using a radiation oncology CT scanner

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Time is of the Essence: Reducing AMI Door to Dilation Time

By Lynette Jones and Cassie Undlin
Principals
Strategic Opportunity Solutions

Timely access to health care treatments is a critical aspect of high quality health care. A plethora of research indicates that if heart attack victims receive angioplasty within 90 minutes of entering a hospital emergency room (ER), their outcomes will be significantly better, mortality will be lower and hospital stays will be shorter. The government and many private third party payers, track and benchmark numerous measures of performance quality across hospitals. One of these measures is the timeliness of treating patients for acute myocardial infarctions (AMIs).

In Olympia, Providence St. Peter Hospital wanted to improve their timeliness for treating AMIs. Specifically, the goal was to have the time from arrival in the ER to the time the patient started treatment in the cardiac cath lab span no longer than 90 minutes. Reaching this goal meant that treatment for AMIs would have to involve finely tuned coordination of at least four separate functional units in the hospital, as well as with community emergency medical services (EMS) personnel in the field.

To achieve this coordination, the hospital formed a project team involving several cardiologists from the community, an emergency room physician, two nurses, a unit coordinator, cath lab management and an advanced life support coordinator from Thurston County EMS. The team leader was an in-house process improvement expert with a background in industrial engineering.

> ***"Prior to the project, approximately 65% of AMI patients were being treated within 90 minutes. In the third quarter of 2007, on average, 89% of AMI patients were treated within 90 minutes"***
>
> Lynette Jones and
> Cassie Undlin, Principals
> Strategic Opportunity Solutions

To start the project, the team used several sources of information to benchmark its current performance against the standard, including external data from CMS and data from internal sources. The team also examined best practices at other Providence Hospitals in Portland and Everett.

The team leader utilized a combination of the Six Sigma DMAIC (Define, Measure, Analyze, Improve and Control) process and Lean principles. The team leader also conducted one on one interviews and examined inputs and outputs across each step of the process. During the analyze stage of DMAIC, a tool called a "Swim lane Diagram" was used to map out the process. This diagram illustrated how each of the tasks in the process moved through different areas of responsibility and highlighted the criticality of coordination between the EMS personnel in the field and the hospital. Tasks performed in the process had formerly been sequential, but the "Swim lane Diagram" illustrated the benefits of performing tasks simultaneously.

New policies and procedures were developed. The team agreed to increase reliance on field assessments made by EMS personnel, allowing patient, cardiologist and cardiac cath lab transportation to occur simultaneously during off-hours. Hospital communications staff were given prompts with standardized terminology for querying clinical staff to determine whether cardiac cath lab staff should be called to the hospital. In addition, once potential AMI patients arrived in the emergency room, St. Peter's staff prioritized, tracked and timed each task to assure the patient left the ER and was transferred to the cardiac cath lab within 45 minutes.

St. Peter experienced immediate gains in meeting their 90 minute goal. The project formally started in April 2007 with sustainable

Please See> Time, P24

What do your patients do **while waiting for you?**

- ☐ A. *Complain about waiting*
- ☐ B. *Talk loudly on their cell phones*
- ☐ C. *Become irritable and restless*
- ☐ D. *Disturb other patients*

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It's Time for Healthcare Marketers to Wake Up and Smell the Digital Revolution!

By Don Morgan
Director of Marketing
Palazzo Intercreative

In his best-selling book, *The New Rules of Marketing and PR*, David Meerman Scott sums up today's marketing environment with this statement "*The Internet has profoundly changed the way people communicate and interact with each other. It has also changed the way businesses communicate with current and potential customers. In the old days, marketers could only communicate through the filter of expensive advertising or media ink placed by a PR firm. Today, the rules have changed entirely.*"

For some time now, we have been encouraging our clients to look for new ways to reach their customers in today's digital age. In a recent article, I pointed out that while hospital marketers increasingly say they recognize the value that web marketing can play in their brand building efforts, many are moving much too slowly. A Forrester study reported that only 39% of visitors to hospital web sites report that they are satisfied with their experience. That same Forrester study found that consumers who visit hospital web sites are accustomed to using the Internet for help with their healthcare. Ninety percent of hospital site visitors have sought information on medical conditions, 88% have researched general health or fitness topics, and 80% have researched medications online.

> ***"It's time for healthcare marketers to take advantage of the power the Internet affords to build brand loyalty and preference, not just awareness"***
>
> Don Morgan,
> Director of Marketing
> Palazzo Intercreative

The web site is only one element of the new digital marketing mix that is available to healthcare marketers. It is important to recognize that the Internet is not so much about technology as it is about people. The history of marketing communications has been about pushing messages to prospects. With the power and influence of the Web, marketing is now about engaging the customer in a conversation and persuading them to take action.

When people visit your web site, they aren't there to hear your sales pitch, your slogan or to see a flash animation of your logo. They want information, interaction and choices. They want a conversation, not a lecture. It's time for healthcare marketers to take advantage of the power the Internet affords to build brand loyalty and preference, not just awareness. With the right messages to the right people, you can lead consumers into a preference for your brand.

2008 will be a year when internet marketing becomes mainstream. We are already seeing the emergence of online advertising as an integral part of many consumer products' marketing programs. I am particularly intrigued by the integration of offline media and online media as a new way to use the power of the Internet.

A great example of this is the current Burger King Whopper Freakout campaign. Thirty second TV commercials direct consumers to a special web site, *whopperfreakout.com*, where an eight-minute, documentary-style video tells the story of how real customers reacted to a staged situation of a Burger King that no

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RECRUITING

Over 3,300 health care leaders in Washington State and the Northwest receive the Washington Healthcare News each month. As a health care organization, doesn't it make sense to target recruiting to the people qualified to fill your jobs?

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Raising the Profile of Dental Benefits

By Karen Brown
Communications Manager
Dental Health Services

Business owners and decision makers usually understand how important it is to have health insurance benefits to attract and retain quality employees. On the other hand, some employers see dental care as a secondary coverage that is optional. This is true with limited budgets. However, employees consistently cite dental coverage as one of the most sought after benefits.

Employers may not realize that failing to offer this coverage can cost them significantly each year. Dental disease or discomfort is often overlooked as a cause of employee absence and poor job performance. A Surgeon General report reveals that dental ailments and periodontal disease result in 164 million work hours lost each year, 12.7 million days workers placed on restricted activity, and 6.1 million days of disability.

According to the American Academy of Periodontology, 25 percent of Americans over 35 and 50 percent of Americans 55 or older have periodontal disease, more commonly known as "gum disease" or "gingivitis." The chronic nature of periodontal disease requires consistent, ongoing care.

You can boost your business and provide a valuable service by helping clients understand the link between oral health and overall health. Periodontal disease is often an indicator or contributing factor in other serious medical conditions that result in increased medical plan costs. The American Dental Hygienists Association breaks it down like this: Every dollar spent on preventive dental procedures saves $8 to $50 in future dental treatments.

> ***"About 85 percent of people who have experienced a heart attack have periodontal disease, according to the American Academy of Periodontology"***
>
> Karen Brown
> Communications Manager
> Dental Health Services

As far back as the late 1800s, oral infections were thought to have an important relationship to many systemic diseases. The mouth is the greatest incubator of bacteria. In fact, the Academy of General Dentistry reports that 90 percent of medical illnesses first manifest themselves in the mouth. Oral health is a factor in many medical conditions including the following:

Respiratory Ailments – The bacteria that grow in the oral cavity can travel to the lungs, causing respiratory diseases such as pneumonia, especially in people with gum disease. Researchers are also examining links between periodontal disease and osteoporosis, kidney disease and Alzheimer's disease.

Diabetes – Diabetes is twice as prevalent among people with periodontal disease, according to the American Academy of Periodontology. Periodontal diseases are often more frequent and more severe among diabetics because of lowered resistance and longer healing process, as stated by American Dental Association. In addition, diabetics are more likely to acquire gum disease, which can make it harder to control their blood sugar.

Heart Disease – People with gum disease may run twice the risk of having a fatal heart attack. About 85 percent of people who have experienced a heart attack have periodontal disease, according to the American Academy of Periodontology. Bacterial byproducts from gum tissue can enter the bloodstream, causing small blood clots, which may contribute to clogging the arteries. The inflammation caused by gum disease may also lead to fatty deposits inside heart arteries.

Cancer – More than 30,000 people in the U.S. are diagnosed with oral and throat cancer each year and more than 8,000 of them will die, according to a study by Dental, Oral, and Craniofacial Data Resource Center. With a five-year survival rate of only 52 percent, oral cancer is one of the

Continued on next page

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deadliest types of cancer. Since cancer survival is directly related to the stage at diagnosis, it is even more important to have a dental exam.

In addition, men with a history of periodontal disease have a 63 percent higher risk of developing pancreatic cancer than men without periodontal disease, according to a 10-year study conducted for the Harvard School of Public Health.

Premature Birth – Pregnant women with untreated periodontal disease are seven times more likely to have a baby born prematurely, according to American Academy of Periodontology. Gum disease can trigger increased levels of biological fluids that induce labor. Pregnancy costs through delivery can be up to 15 times higher with the birth of a pre-term or low birth weight baby. The good news is that periodontal treatment during pregnancy reduces premature births by 84%.

Dental insurance has always been consumer-driven since it typically offers first-dollar preventive care including regular check-ups and teeth cleaning. Cost sharing on basic and major care encourages members to become better informed consumers. As the medical insurance industry moves toward consumer-driven healthcare, this is likely to be a stronger connection between oral and overall health.

Educating consumers (employers, employees, individuals) about new benefit designs is the key to showing them that they can afford dental benefits. The dental insurance industry is developing more options to ease the financial strain while driving consumer responsibility. Our role is to provide continuous education so that consumers understand how dental benefits can improve their overall health and their personal and/or companies' bottom line—they will thank us for it.

Karen Brown is the Communications Manager for Dental Health Services, an employee-owned dental benefit plan company serving 100,000 people throughout WA and CA. Karen can be reached at kbrown@dentalhealthservices.com.

First Change the Rules of Health Care

By Robert Mecklenburg, MD
Medical Director
Center for Health Care Solutions
Virginia Mason Medical Center

The cost of U.S. health care continues to rise with double-digit increases every year and there's no relief in sight. Millions of individuals and families can no longer afford health care. Businesses of every size are struggling to provide subsidized medical coverage for their staff. Medicare costs are spiraling out of control for both seniors and the federal government. The crisis is here. If we're going to solve the problem, we must first change the rules.

Less is more

At the center of the problem is America's misaligned reimbursement system. Doctors and hospitals are rewarded and reimbursed at higher levels for the volume of services and expensive tests provided to patients, rather than the results or value-added care given. Focusing on outcomes and eliminating unnecessary steps will drive down the costs in health care.

Virginia Mason Medical Center has interwoven waste reduction into its system-wide management methodology, called the Virginia Mason Production System. By focusing on removing waste from processes in order to eliminate defects, the medical center operates more efficiently and provides better quality care for patients.

But the medical center is not working on this effort alone. Together with Aetna, Regence BlueShield, Premera Blue Cross, and several major Northwest employers, Virginia Mason has looked at ways to reduce costs and waste in several of the most expensive work-related care issues, such as back pain and migraines.

> ***"Statistically, Virginia Mason providers refer patients to expensive emergency department treatment for migraines only 25 percent as often as other doctors in Washington state"***
>
> Robert Mecklenburg, MD
> Center for Health Care Solutions
> Virginia Mason Medical Center

The patient-centered efficiency team analyzed the process a patient went through to get his or her back pain treated and back to work. Several layers of waste such as initial doctor visits and unnecessary MRI diagnostics were identified. The solution for back pain became clear. The most value-added results for patients came from physical therapy. So physical therapy was placed first rather than last in the care delivery system.

By streamlining the process, the wait time for appointments was reduced from about a month to less than a day, and the average cost of back-pain care dropped dramatically from $2,100 to $900. This was a significant savings for both employer and insurer. And as a health care system, Virginia Mason was able to see five times as many back-pain patients as before through the optimized workflow and process efficiency. Ultimately, it meant patients got faster, better care for their back pain and were able to return to work sooner.

Another expensive workplace health issue in both lost employee time and health care cost is migraine headaches. The team again looked at the process for patients and identified the need to provide an effective drug treatment at the onset of the migraine rather than an emergency department visit or MRI test. Consequently, the cost for treating migraines dropped dramatically as well. Statistically, Virginia Mason providers refer patients to expensive emergency department treatment for migraines only 25 percent as often as other doctors in Washington state.

While the cost savings for back pain, migraine and other streamlined treatments is good for health plans and employers, it proved to be a challenge for Virginia Mason. By reducing the number of expensive steps involved in treatment, reimbursement rates were no longer profitable for the health system. Improvements were saving employers and health plans

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Workplace Wellness: Why Promote Wellness?

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your employees may miss less work caring for ill family members as well. The cost savings of providing a wellness program can be measured against reduced overtime to cover absent employees and other aspects of absenteeism.

Improve morale and enhanced image for the organization

A company that cares about its employees' health is often seen as a better place to work. Those companies save money by retaining workers who appreciate the benefit of a wellness program and they can attract new employees in a competitive market.

Joan Flood, RHU, is an employee benefits consultant at Parker, Smith & Feek, Inc., a full service brokerage and consulting firm in Bellevue, WA. She can be reached at 425-709-3645 or by email at jiflood@psfinc.com

Time is of the Essence: Reducing AMI Door to Dilation Time

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improvements achieved by July 2007. Prior to the project, approximately 65% of AMI patients were being treated within 90 minutes. In the third quarter of 2007, on average, 89% of AMI patients were treated within 90 minutes.

At St. Peter, AMI patients are already experiencing better care. However, St. Peter should also begin to realize other benefits. In addition to improving their performance against other hospitals in the country, the change should lower St. Peter's adjusted mortality rate. Since some third party payers are either already paying hospitals for superior quality performance or are planning to do so, improvement in the AMI process may also have a direct impact on the bottom line.

For more information about this project, contact Kurt Miller, Heart Program Director, at Kurt.Miller@providence.org or Alan Messegee, Project Leader, at Alan.Messegee@providence.org.

Lynette Jones and Cassie Undlin are Principals in the consulting firm Strategic Opportunity Solutions. The firm specializes in engagements that improve performance of health care organizations. Lynette can be reached at lynettedjones@gmail.com. Cassie can be reached at cassieundlin@gmail.com.

It's Time for Healthcare Marketers to Wake Up and Smell the Digital Revolution!

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longer offered the Whopper on its menu. It is a very creative way to engage customers in their story of a taste preference for the Whopper versus the Big Mac and other alternatives. According to a Burger King spokesman, the site has received over 1.5 million views in its first month, about five times what they would have considered successful.

Isn't it time for you to wake up and join the revolution?

Don Morgan is Director of Marketing for Palazzo Intercreative, a full-service Seattle advertising agency that specializes in healthcare. *For more information, contact Don via e-mail at don@palazzo.com*

First Change the Rules of Health Care

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money and lost employee time, but the medical center was now in the red on specific procedures.

Doing things the old way was better for the bottom line but not better for patients, employers or health plans. Several health plans recognized this disincentive and agreed to pay more for value-added care that was cost effective and better for patients.

Introducing the Center for Health Care Solutions

Based on the success of streamlining back pain and migraine care, Virginia Mason launched the Center for Health Care Solutions in the fall of 2007. This new program is focused on forging partnerships with regional employers and health plans to reduce health care costs while providing better, timelier care. Virginia Mason will continue to align its work with results and values perceived by patients and employers, rather than the number of services rendered.

Robert Mecklenburg, MD, is the Medical Director of the Center for Health Care Solutions at Virginia Mason in Seattle.

New or Recently Promoted Health Care Leaders

First Name	Middle Initial/ Name	Last Name	Title	Effective Month/ Year	Organization	New or Promoted Leader
Alvin		Calderon MD PhD	Program Director	Jan '08	Virginia Mason Internal Medicine Residency	Promoted
Sandy		Dillman	Executive Vice President	Jun '07	Aon Risk Services	New
Dave		Forsell	Vice President	Aug '07	Aon Consulting	New
Janet		Hirsch	Senior Vice President, Healthcare Practice	Oct '07	Aon Risk Services	New
Meg		Kerrigan	Executive Director	Feb '08	University of Washington Physicians Network	New
Keith		Mock	Director of Finance	Jan '08	Virginia Mason Medical Center	Promoted
Meg		Paul	Vice President	Apr '07	Aon Consulting	Promoted
Jane		Perry	Director of Charge Capture	Oct '07	University of Washington Physicians	Promoted
Jennifer		Petritz	Director of Human Resources	Jan '08	University of Washington Medical Center	Promoted
Ross		Ronish MD	Chief Medical Officer	Jan '08	Yakima Valley Farm Workers Clinic	New
Kristi		Spurgeon	Director of Marketing	Dec '07	Walla Walla General Hospital	New
Paul		Tegenfeldt	VP for Program and Services Development	Feb '08	Highline West Seattle Mental Health	New

To announce a new or recently promoted Director or higher level individual at your organization, e-mail David Peel at dpeel@wahcnews.com.

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Save the date for the WSHHRA Spring Conference!

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Suncadia Lodge
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Interested in joining an association of human resource professionals focused on issues relevant to health care?

The Washington State Healthcare Human Resources Association (WSHHRA) is a statewide professional organization of human resources professionals who work in health care. We have an affiliation with the national association, the American Society for Healthcare Human Resource Administration (ASHHRA). If you are interested in joining the organization, or to learn more, visit www.wshhra.org, and click on the "Membership" tab.

Career Opportunities

REGIONAL VP FINANCE/CFO

The Communication.
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The Spirit of PeaceHealth.

At PeaceHealth, we value the involvement, cooperation, and creativity of all who work together to promote the health of the communities we serve. Serving five regions in Alaska, Oregon, and Washington, this opportunity is located in the Lower Columbia Region in Longview, WA at our 200-bed level III St. John Medical Center.

Regional VP Finance/ Chief Financial Officer

Develop overall financial management policy, oversee and coordinate all fiscal affairs of the lower Columbia Region. This position serves as a member of the Regional Executive Team (RET) collaboratively providing advice concerning resource allocations, setting performance standards, and financial implications of regional strategies and operating decisions, evaluation, and financial planning for PeaceHealth Lower Columbia Region. Conducts the long range financial and capital planning process.

Qualifications: Bachelors in Business Administration, Finance/Accounting or equivalent required. Masters in relevant field desired. A minimum of six years experience in healthcare financial management and accounting in a healthcare setting and/or with a major accounting firm with good exposure to third party reimbursement and managed care. Must possess thorough knowledge and extensive experience in accounting theory and practice, financial management and healthcare finance.

To view the entire job description and apply online please visit:

http://www.peacehealth.org/apps/JobsOnline/Default.asp

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FINANCE

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Oversees and directs the Accounting and Accounts Payable functions. Bachelor's degree in accounting, graduate degree, and CPA preferred. The ideal candidate will have at least five years experience in a healthcare setting, previous Federal or NIH Grant experience, and at least five years accounting experience.

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Responsible for the planning, coordination, and direction of operations for our new 42-bed ED, which includes 4 trauma rooms and 10 fast track beds. Collaborates with medical staff, and services within the organization to achieve the goals and objectives of the Nursing Division, Evergreen Hospital Medical Center, and the District at large. Minimum of 3-5 years Emergency Department Director-level experience required. Advanced Degree in Nursing, Business, or related Health Care field is strongly preferred.

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Candidates must have 7 years experience in the health insurance industry, including 5 years working with clients/brokers and 4 years account management. Extensive knowledge and understanding of ERISA and Benefit Plan Management, Self-Funded Benefit Plans and Stop Loss. BA degree (or combination of education and experience). State Agent's License, Life & Disability or other professional designation (i.e., CEBS, HIAA). Excellent presentation, verbal and written communication, project and time management and computer skills. Salary DOE + Quarterly Incentives + opportunity for Profit Sharing Bonus.

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Career Opportunities

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Chief Financial Officer

Deering and Associates, has been retained to assist the Family Health Center's of Okanogan in recruiting for their Chief Financial Officer.

FHC enjoys strong community support and is strong financially. The Center has 136 employees, 13 medical providers, and 4 dentists.

The CFO is responsible for the overall financial activities of FHC and serves as a member of the Board Finance Committee.

This is a rewarding opportunity to assist a very successful community based health center. Okanogan is large enough to provide community amenities and retain its small town feeling and sense of community.

A Bachelors degree in Business Management, Finance or Accounting is required, a CPA or MBA preferred. 5 years experience in community health centers is highly desirable, with at least 3 years executive level experience.

If you or anyone you know might be interested in this opportunity, please reply in the strictest confidence with a resume to Deering and Associates by calling toll free (888) 321-6016 or email at dewey@deering-associates.com.

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Required Qualifications:

Bachelors degree in business administration, finance, health services administration, or equivalent combination of education and experience; Five years experience in health care field with an emphasis on claims administration and/or contract management; Knowledge of local payor market, desirable; Comprehensive understanding of physician practice plan operations with emphasis on operational issues relating to contracting / and payor requirements.

For information on the application process, visit www.uwphysicians.org and click on "Careers at UW Physicians."

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Career Opportunities

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COMMUNITY HEALTH ASSOC. OF SPOKANE

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Duties include: Examining patients to determine general physical condition, performing physical examination and preventive health visits, prescribing or recommending drugs or other forms of treatment under the direct supervision of a physician, and developing practice plans and a relationship with the supervisory physician.

Qualifications: Valid licensure in Washington State, Board Certified or Eligible, able to apply for prescriptive privileges, graduation from an accredited school, CPR/ACLS certification, effective oral and written communication skills, ability to secure credentialing through identified agencies (Medicare, Medicaid, etc.)

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To apply for either position, complete and download application from www.wsha.org and send with cover letter and resume to:

Connie Ray
Washington State Hospital Association
300 Elliott Avenue West, STE 300
Seattle, WA 98119
E-mail: connier@wsha.org

REGIONAL DIRECTOR

The Communication.
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At PeaceHealth, we value the involvement, cooperation, and creativity of all who work together to promote the health of the communities we serve. Serving five regions in Alaska, Oregon, and Washington, this opportunity is located in the Lower Columbia Region, in Longview, WA at our 200-bed level III St. John Medical Center.

Regional Director, PeaceHealth Medical Group

Two positions: Primary Care and Specialty Care. Directs medical group primary care operations, evaluates the development of new and continuation of existing services, participates in physician compensation plan administration and revisions as needed, evaluates the impact of future technologies on physician practices and patient satisfaction, creates a patient centered environment that is highly satisfying to physicians and staff, manages community and interdepartmental relations, and coaches/mentors physician manager team to improve team leadership effectiveness.

Qualifications: Bachelor's Degree in healthcare or related field. Minimum of 4 years of progressive leadership in physician practice management required. Previous progressive senior leadership experience in health care administration, and experience in medical group administration required. Strong understanding of principals of patient centered care, physician compensation systems, medical technology, including electronic medical records, and quality/service improvement strategies.

To view the entire job description and apply please visit:

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Clinical Quality Program Coordinator

Skagit Valley Medical Center, located in Mount Vernon, WA, represents a multi-specialty team of healthcare professionals dedicated to excellence and patient satisfaction at every level of our organization.

We are seeking a Clinical Quality Program Coordinator to assist in developing and managing the clinical quality improvement program at our company. Additional responsibilities include collection and analysis of data, preparation of reports for providers and clinical staff and presentation of material to small and large groups.

Qualifications: Experience with paper and electronic medical records and data extraction. Familiarity with clinical quality measures (NCQA, etc.) and coding schemes (CPT, etc.). Excellent verbal and written communication skills. Formal training in clinical medicine (such as RN with bachelors degree) or training in health information appropriate experience.

Applicants should download and complete application from our website (www.svmc.net) and send with cover letter and resume to:

Skagit Valley Medical Center, Human Resources
1400 E. Kincaid, Mt. Vernon, WA 98274

or fax to (360) 428-6485

Next month in the News-

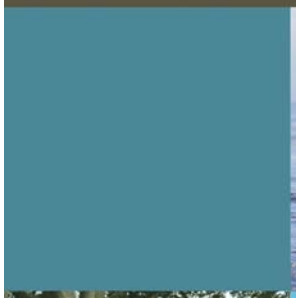
- ***An analysis of 2007 versus 2006 financial results of domestic health insurance carriers***
- ***A Healthcare Company profile on Northwest Health Care Linen***
- ***An interview with David Weber, MD, CEO of Wenatchee Valley Medical Center***
- ***A Healthcare Opinion article from State Senator Linda Evans Parlette and State Senator Mark Schoesler***
- ***A Healthcare Opinion article from Linda Tieman, RN, MN, FACHE, Executive Director of the Washington Center for Nursing***

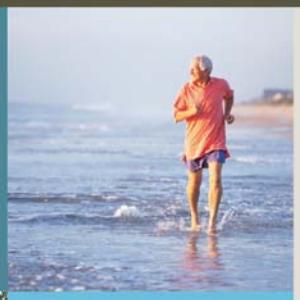
To receive your complimentary copy contact David Peel at dpeel@wahcnews.com.

Plan and Hospital Financial Information

YTD Net Income and Members through 09/30/07 for the Largest Health Plans in Washington State[1]					
Plan Name	**Net Income**	**Members**	**Plan Name**	**Net Income**	**Members**
Health Plans:			LifeWise Health Plans of AZ.	($11,164,137)	31,266
Regence BlueShield	$66,554,186	885,521	Arcadian Health Plan	($924,311)	19,090
Premera Blue Cross	$76,438,960	726,319	Timber Prod. Manuf. Trust	$460,174	9,611
Group Health Cooperative	$72,789,487	401,888	Washington Employers Trust	($1,560,699)	9,122
Molina Healthcare of WA	$32,585,577	283,931	Aetna Health, Inc.	$1,977,998	6,708
Community HP of WA	$9,300,708	232,579	Washington State Auto Ins. Trust	($1,654,448)	3,100
Group Health Options	$114,549	103,491	Puget Sound Health Partners	($1,675,215)	0
Asuris Northwest Health	$4,047,694	90,828	**Vision or Dental Plans:**		
LifeWise Health Plan of WA	$1,623,819	89,102	Washington Dental Service	$12,560,083	907,902
Pacificare	$33,427,691	52,399	Vision Service Plan	$6,141,567	544,640
KPS Health Plans	($943,114)	45,740	Willamette Dental	$461,985	70,043
Columbia United Providers	($1,570,608)	35,681	Dental Health Services	($1,003,741)	25,664
YTD Margin and Days through 09/30/07 for the Largest Hospitals in Washington State [2]					
Hospital Name	**Margin**	**Days**	**Hospital Name**	**Margin**	**Days**
Sacred Heart Medical Center	$41,858,163	112,800	St. Joseph Hospital Bellingham	$13,364,759	43,285
Swedish Medical Center	$79,937,119	107,202	Good Sam. Comm. Healthcare	$36,754,790	41,629
Harborview Medical Center	$11,535,000	101,165	Valley Medical Center	$24,428,199	40,121
Providence Everett Med Ctr.	$23,002,895	75,599	Yakima Valley Memorial	$5,485,968	37,569
University of WA Med Ctr.	$24,366,972	73,583	Highline Medical Center	$6,459,112	35,552
St. Joseph Medical Center	$59,093,249	69,277	Northwest Hospital	$4,222,277	30,934
Virginia Mason Medical Ctr.	$11,629,102	64,481	Swedish Cherry Hill Campus	($10,398,308)	30,925
Southwest WA Med Ctr.	$2,382,889	63,986	Kadlec Medical Center	$6,098,901	30,386
Providence St. Peter Hospital	$20,180,986	62,386	Central Washington Hospital	$10,563,706	30,235
Tacoma General Hospital	$37,433,609	62,046	Holy Family Hospital	$799,029	28,828
Children's Hospital	$34,197,000	49,936	Legacy Salmon Creek Hospital	($4,541,322)	24,029
Deaconess Medical Center	($687,439)	49,514	Auburn Regional Medical Ctr.	($1,650,027)	23,463
Harrison Medical Center	$20,068,173	48,955	St. Clare Hospital	$9,523,855	21,384
Overlake Hospital Med. Ctr.	$10,582,844	44,677	Yakima Regional Medical Ctr.	$8,585,803	20,969

[1]Per filings with the WA State Office of Insurance Commissioner. [2]Per filings with the WA State Department of Health. Evergreen Healthcare and Stevens Hospital were among the largest hospitals but their complete financial information wasn't available on the WA State Department of Health website at press time and therefore wasn't reported.





MedRisk Welcomes its Newest Client, Puget Sound Health Partners

Puget Sound Health Partners, Washington's new, local health plan, is focused on the needs of people on Medicare in Thurston, Pierce and King Counties.

Learn more at www.OurPSHP.com

"MedRisk went the extra mile in preparing our Medicare Advantage plan against the financial risk of catastrophic claims. They designed a reinsurance program specific to our unique needs. This allowed us to focus on the things that will make Puget Sound Health Partners successful."

Sharon Waymire, Chief Financial Officer
Puget Sound Health Partners

To learn how MedRisk can help lower your risk and transform your business, call one of our representatives today.

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