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HITECH Health Reform

Health IT Funding, HIPAA 2.0 and the Impact of the HITECH Act

By David G. Schoolcraft
Member
Ogden Murphy Wallace P.L.L.C.

While the debate heats up again in Washington D.C. over healthcare reform, those tracking developments in the health information technology space know that an initial wave of health reform arrived back in February. When President Obama signed the American Recovery and Reinvestment Act of 2009, including the Health Information Technology for Economic and Clinical Health ("HITECH") Act provisions, the administration scored an initial victory in its efforts to reform the U.S. healthcare system.

The size and scope of the HITECH Act is striking. It will have significant impact on health care providers over the next 5 to 10 years, and beyond.

This article provides a brief overview of some of the key components of the HITECH Act which include funding for health information technology ("health IT") and significant changes to HIPAA. Although the statutory provisions are far reaching, much remains to be developed through the rule making process. Up to date summaries of HITECH Act developments are available on our health law blog at **www.omwhealthlaw.com**.

Billions of Dollars for Health IT

"How can a facility featuring state-of-the-art diagnostic equipment use less sophisticated information technology than my local sushi bar?" asks writer David Goldhill in a recent feature article in *The Atlantic* magazine about the U.S. healthcare system. Similar questions have been discussed by state and federal policy makers for some time. The problem, of course, is that talk is cheap while the cost of developing health IT infrastructure is significant.

Enter the new administration, an economic crisis of epic proportions, and the push to pass a federal economic stimulus at the beginning of 2009. Health information

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LETTERS TO THE EDITOR

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

Letter from the Publisher and Editor

Dear Reader,

We recently finalized our 2010 Editorial Calendar. An Editorial Calender helps our writers know the theme of each edition, lets our advertisers know the last day to reserve advertising space and tells everyone the date each edition will be distributed. Our 2010 Editorial Calendar is shown in the table below.

One of the changes made in 2010 was to make our themes more general. Instead of using themes like "Rural Hospitals" or "Urban Hospitals" we will just use "Hospitals." This allows writers the leeway to focus on hot topics within a broad category and should improve our content.

We also focused on themes most interesting to our readers. We have three months devoted to Clinics, three months to Human Resources, three months to Hospitals, two months to Insurance and one month to Facilities. These popular themes are also better for our writers given many either work or consult in these areas.

We hope these changes are helpful. Thank you for your continued support as we prepare to begin calendar year 2010.

David Peel, Publisher and Editor

Washington Healthcare News 2010 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2010	Clinics	December 1, 2009	December 21, 2009
February 2010	Human Resources	January 2, 2010	January 19, 2010
March 2010	Hospitals	February 1, 2010	February 23, 2010
April 2010	Insurance	March 1, 2010	March 23, 2010
May 2010	Clinics	April 1, 2010	April 20, 2010
June 2010	Human Resources	May 3, 2010	May 25, 2010
July 2010	Hospitals	June 1, 2010	June 22, 2010
August 2010	Insurance	July 6, 2010	July 20, 2010
September 2010	Clinics	August 2, 2010	August 24, 2010
October 2010	Human Resources	September 1, 2010	September 22, 2010
November 2010	Hospitals	October 1, 2010	October 19, 2010
December 2010	Facilities	November 1, 2010	November 23, 2010

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technology was positioned as a "shovel ready" project with the potential to create jobs and promote the dual goals of improving the quality of care while reducing costs.

At the end of the day, the HITECH Act was included as part of the stimulus bill with as much as **$36.5 billion** in funding to create a nationwide network of electronic health records. Largely through enhanced Medicare and Medicaid payments, these funds will be distributed to qualifying providers over the next five to six years.

Incentive Payments for Physicians and Hospitals

The HITECH Act provides incentive payments to hospital and physicians who implement and use qualifying electronic health record systems. Eligible physicians may receive up to $44,000 over five years under Medicare or $63,750 over six years under Medicaid. Eligible hospitals may receive up to four years of financial incentive payments under Medicare beginning in 2011, and up to six years of incentive payments under Medicaid beginning in October 2010.

There are also a range of grants, loans and other funds available. For most providers, however, the incentive payments are the primary source of support for health IT projects.

Carrots, Sticks and "Meaningful Use"

The key to unlocking the incentive payments is being able to show "meaningful use" of certified electronic health record systems. In other words, it's not enough to simply acquire an electronic health record system, but instead providers must be able to demonstrate that they are using the system in a way that the government deems meaningful.

Over this past summer, the newly formed Health IT Policy Committee met and considered various criteria that may ultimately make up the definition of meaningful use. At this point we are waiting for final recommendations to be considered by the Secretary of HHS and for a notice of proposed rule making to be issued. The final rules for meaningful use are not expected to be completed until Spring of 2010.

While the incentive funds represent a carrot to encourage the adoption of health IT, there is also a stick built into the statute in the form of penalties for hospitals and physicians who do not engage in

meaningful use of certified electronic health records by 2015. For larger institutions with established systems already in place, this may not be such a problem, but smaller organizations without existing IT infrastructure may be hard pressed to meet the deadlines and avoid the penalties.

HIPAA 2.0

Along with the push to enhance the health IT infrastructure, new rules governing the privacy and security of health information were also included within the HITECH Act. Privacy advocates have long been working to fill perceived gaps in the original HIPAA rules. The HITECH Act addresses a number of open issues through a series of revisions to the HIPAA Privacy and Security Standards. In particular, healthcare providers should note the following changes:

- **Breach Notification Rule.** Effective September 23, 2009, a new federal standard requires notification to individuals, and in some cases the media, when the HIPAA is violated. Healthcare providers have 60 days from the date a breach is discovered to notify affected individuals. If more than 500 individuals are involved, notice must be provided to major media as well as the Department of Health and Human Services. These rules also require healthcare providers to adopt policies and procedures and train workforce regarding the new notification requirements.
- **Business Associate Agreements.** The updates to HIPAA include new obligations for business associates. For example, starting in February 2010, business associates are subject to civil and criminal penalties under HIPAA. A looming question related to these changes is whether all existing business associate agreements must be revised in order to meet the new requirements. We are anxiously awaiting guidance from HHS/OCR due out this Fall that will address this issue. In the meantime, it is advisable to amend forms and to add terms to all new business associate agreements in order to track the HITECH Act provisions.
- **Penalties and Enforcement.** The revisions to HIPAA within the HITECH Act include significant revisions to the penalties and enforcement

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provisions. Changes include increased civil penalties, as well as the ability for state attorneys general to act on behalf of the government to enforce HIPAA and impose penalties. In addition, starting in 2012, individual victims will have the ability to share in civil penalties levied against those violating HIPAA.

- **Accounting of Disclosures.** Another notable change in HIPAA relates to a healthcare provider's obligation to account for disclosures of protected health information. Under the current HIPAA Privacy Standards, disclosures that are made for "treatment, payment, or healthcare operations purposes" are outside the scope of what must be tracked. Starting as early as January 2011, some providers will have to account for all disclosures of electronic protected health information, even if such disclosures are related to treatment, payment or healthcare operations. As with the other changes noted above, we expect HHS to issue additional guidance over the coming months. Regardless, this is a significant change that will require provider organizations to implement technology solutions and other operational changes in order to ensure compliance.

Are You HITECH Ready?

In light of the funding and changes to HIPAA within the HITECH Act, it is important that all information technology related transactions are reviewed to ensure compatibility with the HITECH Act. Whether it is concern over business associate agreements, or representations and warranties in a software license agreement to ensure the system will enable the provider to achieve meaningful use, careful consideration should be given to the impact of the HITECH Act now, and going forward.

David G. Schoolcraft is a member of the Ogden Murphy Wallace P.L.L.C. law firm. His practice focuses on healthcare and information technology and represents hospitals, physician groups and other medical-related businesses. He is licensed to practice in Washington and Oregon and can be reached at 206-447-7000 or dschoolcraft@omwlaw.com.

Need Help? Legal Issues When Hiring Caregivers

By Stacey Mark
Chair, Labor and Employment Group, Ater Wynne LLP

With Baby Boomers starting to turn 65 in 2011,[1] twenty percent of the U.S. population is likely to be at least 65 by the year 2030. As their health starts to decline, many will need long-term assistance performing the activities of daily living (*e.g.*, meal preparation, laundry, bathing, hygiene). If they do not qualify for Medicare or Medicaid, which is probable, these older Americans must obtain services at their own expense or rely on their families for help.

There are many legal issues to consider when hiring caregivers. Individuals who hire caregivers without understanding the legal ramifications may be shocked to find themselves liable for unpaid wages, taxes, unemployment contributions and, if the caregiver is injured, medical and other expenses. Some of these pitfalls may be avoided by hiring a caregiver through an agency. A few of these issues are discussed below.

Who's the Boss?

The nature of the relationship between the parties dictates whether a worker is an employee or independent contractor. To qualify as an independent contractor, the worker must typically operate an independently established business that performs the same type of service for multiple clients during the year. The most critical factor indicative of an employment relationship is the right to direct and control the work. Although an agency would qualify as an independent contractor, an individual worker who provides the care most likely would not.

Do Wage and Hour Laws Apply?

Caregivers who work in the private homes of their clients are considered "domestic workers." Domestic workers who do not qualify as independent contractors must be paid in accordance with applicable wage and hour law.

Federal law exempts from minimum wage and overtime requirements domestic employees who provide "companionship services," defined as "fellowship, care, and protection for a person who, because of advanced age or physical or mental infirmity, cannot care for his or her own needs." Such services may include general household work related to the care of the aged or infirm person, so long as the work does not exceed 20 percent of the caregiver's total weekly hours.[2] The term does not include care for which specialized training is required (*e.g.*, skilled nursing care). The companionship exemption applies whether or not the employee is hired by an individual or a third-party agency. Oregon has a similar exemption from minimum wage and overtime requirements for companionship services,[3] but Washington does not.

Federal, Oregon and Washington law all exempt from overtime domestic workers who reside in the private home of the employer.[4] The live-in exemption can extend to nurses and other trained professionals not covered by the "companionship" exemption. Caregivers who do not qualify for the live-in exemption must be paid minimum wage for all hours worked, plus applicable overtime.

The employer and caregiver may agree on the amount of sleeping time, meal time, and other periods of free time that will not be counted as "hours worked." Employers may also deduct from compensation the reasonable cost or fair value of food, lodging, and other facilities customarily provided to the employee.

Workers' Compensation

Oregon and Washington law exempt most employers of domestic workers from providing workers' compensation insurance,[5] which covers medical expenses and lost

wages resulting from on-the-job injuries. While providing coverage is not mandatory, it may be prudent, particularly if the duties of the job are physically demanding. In the absence of workers' compensation coverage, an employee injured on the job can sue the employer for negligence.

Record keeping and Tax Issues

Employers are generally required to maintain employment records that include the precise number of hours the employee worked each day. A written agreement documenting the agreed upon time a live-in caregiver is on- and off-duty may be used in lieu of maintaining records of the hours worked. If the caregiver does not qualify under the live-in exemption, the employer must maintain accurate records of all hours worked.

Employers must withhold and pay applicable Social Security, unemployment, and payroll taxes.[6] To facilitate payment of these taxes and, in some cases, workers' compensation premiums, employers must obtain federal and state employer identification numbers and file quarterly tax and payroll reports.

Hire Direct or Through an Agency

Complying with all the responsibilities of an employer can be daunting. Consequently, many people turn to agencies to supply the caregivers to work in their homes. In addition to record keeping, reporting, and tax compliance, agencies may also provide background checks on workers, regular supervision, and substitute workers in the case of an absence or poor performance. For those willing to hire directly, it is a good idea to have an attorney and accountant on board from the outset to help with compliance issues.

Stacey Mark chairs both the Labor and Employment Group and the Sustainable Practice Advisory Group. She focuses her employment practice on developing strategies that enable employers to meet their legal obligations in ways that promote their overall business objectives. She can be reached at 503-226-8612 or sem@aterwynne.com.

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[1]Federal Interagency Forum on Aging-Related Statistics; http://www.aoa.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/Population.aspx.

[2]29 U.S.C. §213(a)(15).

[3]ORS 653.020(14); OAR 839-020-004(11).

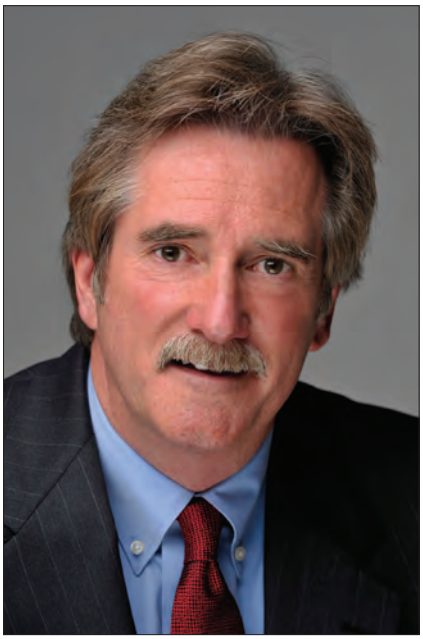
[4]29 USC §213(21); 29 CFR 552.102; OAR 839-020-0125(3)(n); RCW 49.46.010(5)(j).

[5]ORS 656.027(1); RCW 51.12.020(1)

[6]For withholding requirements, *see* Household Employer's Tax Guide for Wages Paid in 2009, http://www.irs.gov/pub/irs-pdf/p926.pdf.

Retirement Plan Management: Exception Management & Replacement

By Rick Tasker
Managing Director
McHenry Partners



You Can't Manage What You Don't Measure

No one likes to receive or deliver bad news. In prior editions of this column, we discussed standards-based benchmarking of retirement plan investments, based upon returns realized, risks taken and expenses paid in the management of investment-based employee retirement plans.

After the last few years of market upheaval, economic uncertainty and the bad acts of certain institutions and individuals, it is ever more important to have policies, processes, procedures and practices to ensure that 401(k), 403(b), 457 and other corporate retirement plans operate in an effective, efficient and ethical manner.

Given the creation of a quarterly performance report based upon objective standards and accurate data, you will be presented with a series of graded or pass/fail results for each of the plan's investment options.

As you review the report's noted exceptions to the plan's investment policy, it's then time to develop procedures for escalation, remediation and possible replacement of investment options.

Understand the Issue

The first step is to understand the exception and the reasons for the failure of the investment fund or product to meet your minimum needs. Why did it happen? Was it due to a change in the fund management, a misplaced "bet" on the markets, or perhaps a deviation from the stated objective or style of the fund? Ask your broker or consultant to explain the exception. They should bring this information to you as part of your exception report. If a conversation with your retirement service provider, insurance company or mutual fund is in order, do not hesitate to pursue a full understanding of the failure and don't be put off with excuses.

Develop Alternatives

If, after a period of time on a "watch list" (usually several quarters or more), the investment fund may be determined to be suitable for replacement. During that time of close oversight, the prudent investment committee will have developed alternatives for consideration and replacement. In today's environment, modern technologies and trusted, objective professional support makes possible "open architecture" and the efficient administration of retirement plan assets provides for the use of active and index mutual funds, enhanced return strategies and Exchange Traded Funds (ETFs).

Take Action

The worst thing a CFO can do is benchmark a vendor's performance, identify long-term performance deficiencies, and then not take action. If you find a better alternative, plan the replacement and then communicate the decision with your plan participants – you will be doing the right thing, the right way.

Your retirement plan vendor/service provider, your broker or consultant should all be engaged to provide your plan participant, eligible employees and staff with a stress-free and educational experience through the process of replacing plan investment options.

Something New Next Month: "Prudent Investment Practices for Foundations & Endowments"

Rick Tasker is a Managing Director with McHenry Partners, a regional investment consulting firm. After college and his CPA, Rick's early career was in Federal law enforcement. For the last twenty-five years, Rick has served corporate retirement plans and individual investors as an investment consultant and advisor. Call him at 1-800-882-7537 or rick.tasker@mchenrypartners.com.

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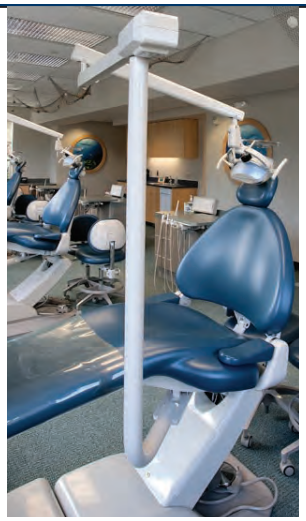

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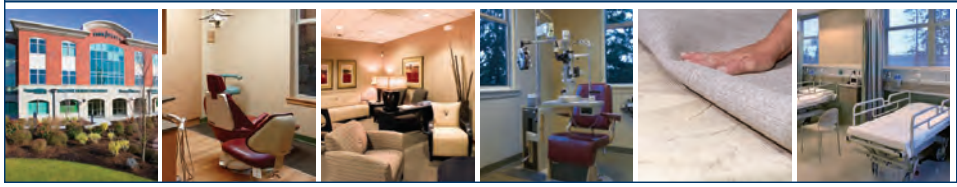

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Coming Dec. 10: Top 10 Employment Issues for 2009. See our website for details.

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Finding What *Does* Work in Healthcare

By Dave Brooks
Chief Executive Officer
Providence Regional
Medical Center Everett

In July, the Institute for Healthcare Improvement along with Dartmouth Atlas sponsored a symposium called *How Do They Do That? Low-Cost, High-Quality Health Care in America.* Healthcare leaders along with federal policy makers and national media from 10 high-performing/high-value regions of the U.S. were invited to share their experiences at the gathering in Washington, D.C. Everett was one of the 10 communities invited to participate.

Representing Everett at the symposium were: The Everett Clinic president and board chairman, Harold Dash, MD, senior vice president for Premera Blue Cross, Richard Maturi, and for Providence Regional Medical Center Everett, me. Each visiting team was asked to describe their local success stories and innovative programs.

One characteristic that emerged as a shared trait in all 10 communities is a culture of genuine alignment between local providers—in our case, Providence Regional Medical Center Everett, and local physicians. At Providence, doctors are active members of the hospital leadership team, involved in day-to-day operations and strategic planning. Their involvement goes far beyond the traditional clinical quality oversight.

Physician champions have introduced many of the programs to reduce costs while improving both clinical quality and patient satisfaction. Our blood management and conservation program is an example. One of our cardiac surgeons, paired with a blood management nurse, implemented a cost-reducing blood conservation program now used in most cardiac and orthopedic surgeries. Our blood conservation program shows that quality care and cost savings often occur in tandem. Studies indicate that red blood cell transfusion during surgery is associated with higher rates of cardiac, neurologic, pulmonary, renal and infectious complications. Based on this evidence, and because blood is costly and in short supply, we use transfusion selectively.

Providence Regional has reduced blood transfusions during knee replacements from 59 percent in 2002 to nine percent last year; the rate is five percent so far in 2009. Similarly, for hip replacement, we've gone from 48 percent with blood transfusion in 2002 to 14 percent in the first half of this year. In addition to reducing costs, blood conservation results indicate shorter lengths of stay, fewer infections, and fewer complications for our patients.

Physicians also led the way in the development of our cardiac surgery single stay unit -- the first of its kind in Washington State. After cardiac surgery, our patients go to private rooms in the single-stay unit and remain there for their entire hospital stay. Their care changes around them—from critical care nursing immediately after surgery, to various therapies and rehabilitative care as they prepare to go home. This approach provides better coordination of care for the patient, improved communication, less handoffs and transfers among caregivers and family members, a higher level of patient satisfaction and comfort, and even quicker recovery.

Hourly nursing rounds are another low cost, high quality strategy recently implemented by nursing in which staff "round" on patients once an hour during the day and every two hours at night. Nurses use this time to ask the patient about pain, bed position and need to use the rest room. They also give medications, check vital signs and survey the room for safety. This methodical, proactive approach has decreased incidence of patient falls, reduced patient use of call lights and improved patient satisfaction.

At the symposium other examples were given of low cost, high quality healthcare. Dr. Harold Dash and Richard Maturi offered valuable insights about their own organizations' successes, and as a team, we discussed the culture of collaboration that we have achieved in Everett. While we compete in some areas, we collaborate for better patient care. It isn't always easy, but it is absolutely necessary if we are to keep our patients' and community's needs first.

As individual entities, and as a unified team of community providers, we don't claim to have achieved perfect performance. We will always strive for improvement, regardless of the way our nation's healthcare system evolves in coming years.

This symposium instilled a sense of possibility and optimism in the midst of today's healthcare debate. I witnessed the extraordinary hard work and dedication of all who are involved in providing heathcare daily in our community, and I appreciated the symposium's recognition of the things that we are doing right in the Everett community.

Dave Brooks is the Chief Executive Officer of Providence Regional Medical Center Everett. This five campus facility has 468 licensed beds and receives over 100,000 annual emergency room visits. Providence Regional Medical Center Everett is part of Providence Health & Services, the largest healthcare organization in the Northwest.

Editor's note: This is this first article in a three-article series devoted to the accomplishments of Providence Regional Medical Center Everett, The Everett Clinic and Premera Blue Cross in their efforts to provide low-cost, high-quality health care in Everett, WA.

In our December 2009 edition we will publish the second article in this series from Richard Maturi of Premera Blue Cross, and in our January 2010 edition we will publish the third article in this series from Harold Dash, MD, of The Everett Clinic.

Are You Prepared for the CMS Paid-Claims Reporting Requirements?

By Gary Morse
Senior Vice President,
General Counsel, and Secretary
Physicians Insurance
A Mutual Company

Starting in 2010, the identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue in a paid liability, no-fault, or workers' compensation claim must be reported to the Centers for Medicare and Medicaid Services (CMS). Insurers and self-insured organizations that pay such claims should have registered with CMS as "required reporting entities" by September 30, 2009. After a testing period during the first quarter of 2010, quarterly reporting of claims paid to Medicare beneficiaries will begin during the second quarter of 2010 for all such claims settled or tried to a verdict on or after January 1, 2010. CMS can impose penalties for failing to report claims and for late reports of up to $1,000 per day per claim.

Who reports paid claims?

All liability, no-fault, and workers compensation insurers are required to report to CMS all claims paid to Medicare beneficiaries. The duty to report also applies to those who are self-insured, i.e., any organization or individual making such payments on their own behalf without insurance.

CMS's rights

When a Medicare beneficiary settles a liability, no-fault, or workers' compensation claim or wins a judgment in court, the beneficiary has a duty to promptly reimburse Medicare for any medical expenses Medicare paid that were recovered by the beneficiary in such a case. Medicare is a secondary payer in such cases. The primary payer under Medicare law is the payer of the claim.

Even though the Medicare beneficiary has a duty to reimburse Medicare out of the proceeds of the settlement or judgment, CMS has, for many years, had the right to recover its reimbursable payments from the primary payer—the payer of the liability, no-fault, or workers' compensation claim—even though the primary payer has already settled with the beneficiary. While CMS's rights in this regard are not new, only the paid-claim reporting law is new, there is a new awareness of these rights, which is a subject beyond the scope of this article. Readers are encouraged to work with their legal advisors on how to protect themselves from a post-settlement CMS claim against them.

The new mandatory reporting law will improve CMS's ability to enforce its right to recover medical expenses it paid when a Medicare beneficiary recovers those expenses in a liability, no-fault, or workers compensation claim. It may also enable CMS to deny payment for future medical expenses recovered by the beneficiary in a paid claim.

Physicians Insurance as an example

As a medical professional liability insurer, Physicians Insurance is a "required reporting entity." In order to comply, we implemented extensive system changes to help us collect and report required data in the format CMS requires. Our staff has worked and will continue to work hard to understand the reporting requirements, program our computers, test the system, train staff, and implement the controls needed to assure accurate and complete reporting.

Stay informed about CMS reporting requirements

For more information, you can explore the CMS web site dedicated to the new reporting requirement at http://www.cms.hhs.gov/MandatoryInsRep/. Key documents to obtain include the latest version of the User's Guide, various alerts, and a schedule of nationwide telephone conferences that will occur twice monthly at least through the end of 2009. All of this information, and more, can be found in the section of the web site labeled "Liability Insurance, Self-Insurance, No-Fault Insurance, and Workers' Compensation."

The telephone conferences can be helpful because CMS officials provide the latest updates on the reporting requirements and answer questions from the callers.

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Leadership in Technology: Harnessing the Power of the Pyramid

By Wes Wright
Vice President &
Chief Technology Officer
Seattle Children's Hospital

Leadership in health information technology seems to be hard to come by, which I find perplexing because it isn't that hard. You just have to harness the power of the pyramid.

Virtually everyone that's ever taken a college level psychology course has heard of or studied Maslow's Hierarchy of Needs. They recognize the "pyramid" and how the physiological needs must first be met before you can make your way up the pyramid to "self actualization." I'm a big fan of the pyramid and using it to illustrate some fundamental principles.

The foundation level of the pyramid is comprised of what I call basic management functions, and what Peter Drucker calls, "Plan, Organize, Staff, Direct, and Control." Many of you probably faintly recognize this from a business class you took ages ago. It's still relevant in my mind. In order to be a good leader, or manager for that matter, you have to have these skills nailed. These skills are basic management competencies and I believe all truly great leaders do possess them.

The next layer of the Leadership Pyramid is communication. There are three components in communication: the information, the sender, and the receiver. If any one of these isn't correct then communication doesn't take place. Seems pretty easy, doesn't it? Then why is it so hard? It's hard because it's important (I've found that most important things are hard, funny how that works). I did discover a useful tool along the way that I can share with you now.

Have you ever been around a group of US Soldiers and heard one of them give the rest of them some information and at the end of that information would say something like "who ah" in a questioning tone, and the group would respond back "who ah" in an affirmative tone? I always thought that was kind of strange but just chocked it up to the weirdness of Army dudes (I'm ex-Air Force). Turns out I was wrong, and the Army actually has a great system to make sure communication takes place by using this series of grunts. You see, what they're actually saying is HUA, which stands for "Heard, Understood, Acknowledged." I must

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Wes Wright's "Leadership Pyramid"

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You can also use the mandatory reporting web site to sign up to be automatically informed by e-mail whenever anything changes on the web site. If we have learned anything about this project, it is that there will be more changes to the reporting system and the reporting requirements, so it is vital to stay abreast of the latest developments.

Is it too late to prepare for 2010 reporting mandates?

If you are a "required reporting entity," you have probably registered with CMS, been assigned a particular week during the calendar quarter to submit your paid-claim reports, and have begun preparing to test the claim reporting system. If you're off to a late start, I encourage you to use the resources on the CMS mandatory reporting web site. You should obtain needed legal advice and consider whether to hire consultants to help you get ready. Your information technology staff should be involved immediately because all reporting will be done electronically. Do so now, because CMS's potential $1,000 per-diem penalties could sting severely.

The information in this article is obtained from sources generally considered to be reliable; however, accuracy and completeness are not guaranteed. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this article should be directed to your attorney.

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<Leadership, from P16

admit that I've acquired this habit with some of my folks and when I have something really important I need to make sure is heard, understood, and then acknowledged, I'll give a "HUA" and expect one in return. It's kind of unusual, but the folks understand why I'm doing it and I think, deep down inside, think it's kind of cool. You cannot move to the next layer of the pyramid, motivate, without being able to communicate! HUA?

If YOU are not motivating your staff, then you are not LEADING your staff. You may be thinking "what about all the folks I have that are self-motivated?" They're not self-motivated, they're self-interested. It's just a happy coincidence that the goals they have for themselves happen to align with the goals you have for your team. You need to align their self-interested goals with the goals of your team. In other words, they need to be motivated in the right direction. Once that happens, that person is "motivated," their self-interest just gives them more momentum to stay motivated. You still have to make sure the movement is in the right direction.

You manage, you communicate, and you motivate – you are now leading. Once you've reached the top of the leadership pyramid, your job is first, to stay there and second, to get better.

There's one major pitfall you need to avoid in order to keep from backsliding down the pyramid. It's giving too much homage to the tools and "tricks" that are at the base of the pyramid. This almost always results in developing a communications problem; which in turn affects Team motivation. Make sure you keep your foundation solid, but not at the expense of the other layers of the pyramid. If you overemphasize any layer, let it be the communication layer.

Getting better at leadership takes a lot more work than just getting to the top of the pyramid. This should be obvious when you look around and see all the leaders (yes, they're truly "leading") but see so few great leaders. The great leaders have cultivated their leadership skills and now have top layers of the pyramid that are almost bigger than the base. As ungainly as that looks, it's what we should all be striving to do.

Wes Wright is VP/CTO at Seattle Children's Hospital. He came to Seattle from Scripps Health, where he was an executive in the IS organization. Wes served 20 years in the US Air Force, retiring at the rank of Major. He was a Health Services Administrator and a Cryptologic Linguist, specializing in Korean. He can be reached at wes.wright@seattlechildrens.org.

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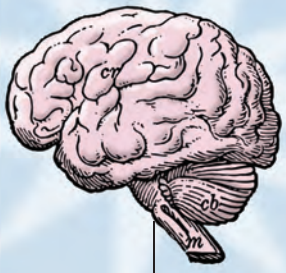

Tuesday evening, 7:59 PM.

Watch *MacGyver* rerun.

Go to fridge for two scoops of butterscotch ice cream.

MacGyver uses fire extinguisher as jet pack to zoom over wall. (Saw it twice before.)

Walk dog.

Decide to take the long route up the hill, past the high school.

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Where to Find the Perfect Practice Manager

By David Peel
Publisher and Editor
Washington Healthcare News

One of the most important decisions a clinic owner will make is to decide who will manage day to day business operations. The most prevalent job title for this leadership position is Practice Manager. This article summarizes the methods available to find the perfect Practice Manager and evaluates each method's costs and benefits.

Methods available

There are several ways to find the perfect Practice Manager. I recommend an incremental approach that first uses low cost, low risk options and then moves to higher cost options as needed. Here are the most commonly used methods:

- Online job posting on your company web site
- Search and contact through social networking web sites
- Craigslist
- Online job postings on association oriented web sites
- Online job postings on national, general public web sites
- Print advertising
- Search firms

Online job posting on your company web site

Clinics don't receive many unsolicited web site visits from Practice Manager candidates so it's unlikely that this method alone will provide a good pool of viable candidates.

Cost: Free or minimal.

Search and contact through social networking web sites

Finding candidates through social networking sites is popular right now. However, there are risks associated with this method. Not all social networking site participants welcome your job related contact. You can still make your job posting available to these participants by using a source like the Washington Healthcare News. The News uploads job postings to LinkedIn, Facebook and others.

Cost: $20 and up per month for premium search capabilities.

Craigslist

This will generate applications but many will not be qualified. The low cost is compelling. Several recent scandals have tarnished its image as a low cost alternative to traditional classified advertising.

Cost: One 30 day posting is $25.

Online job postings on association oriented web sites

Association web sites are the best place to post a Practice Manager position. Even better are sites that combine regional associations and also send feeds to populate "free" meta-search job posting sites like Indeed® and Simply|Hired®. The Washington Healthcare News (wahcnews.com) uses this business model as does at least one other national organization.

Cost: One 30 day posting ranges from $225 to $375.

Online job postings on national, general public web sites

National web sites include sites like Monster.com and CareerBuilders. Placing a job on these sites also populates the various "free" job posting sites. These sites are large and non-specific to healthcare, but have many features for job seekers. Since they tend to be more expensive, often without the best results, use them only when a Practice Manager is in a hard to recruit area and then use them in conjunction with an association oriented web site posting.

Cost: One 30 day posting ranges from $375 to $568.

Print advertising

This could be in newspapers, business journals or magazines. Print advertising can be effective but can also be expensive. Like national, general public web sites, use print advertising in a hard to recruit area and only in conjunction with an association oriented web site posting.

Cost: One full color print ad measuring 2.5" by 5" inches ranges

from $250 to $1,000 or more.

Search firms

This method costs the most and should be used only if all other options fail. You will probably receive multiple viable candidates.

Cost: 20% to 50% of job's salary.

Summary

Finding the perfect Practice Manager is best done incrementally using lower cost options first and then moving to more expensive options as necessary. Most practices can get several viable candidates by posting the job on their own web site and on one or more association oriented sites. Tread lightly through social networks and consider Craigslist only if you have time to sift through many unqualified candidates. Use national sites, print advertising and search firms only in conjunction with or after exhausting other methods.

Learning and Living Lean at KPS Health Plans

By Paul Goldberg
Principal
Paul Goldberg & Associates, LLC
and
By Michelle Yeoman
Internal Lean Consultant
KPS Health Plans
and
By Kimberly Faulkner
Internal Lean Consultant
KPS Health Plans

KPS Health Plans, a 41,000 member health plan based in Bremerton, Washington, is improving processes and reducing costs using a Lean approach of eliminating waste (anything the customer is not willing to pay for). Less than one year into this effort, they have identified opportunities for improvement, streamlined processes, increased cross-functional coordination, and learned valuable lessons about organizational change.

The Decision

Management recognized that the need for internal improvements was great. But with a very competitive market and tight resources, it was not clear how to approach these needs. Richard Marks, KPS President, a successful veteran of the alphabet soup of quality approaches (e.g., CQI, TQM) says, "I wanted to select an approach with a customer focus, early measurable success, sustainability and employee engagement. Lean promised this. But the time and resource commitments, and possible impact on our daily operations, were serious concerns. We saw that other organizations had success with Lean and we decided that this approach could mobilize all our employees in improving our company's performance."

Getting Started

KPS decided to fully adopt Lean as a cultural shift to leverage both Lean philosophy and tools. Marks sponsored the Lean initiative and quickly mobilized a team to lead the effort. He engaged the Executive Management Team for leadership support, along with an experienced group of external Lean consultants (former Toyota quality experts) for training and implementation. Two KPS staff, identified for their interest and leadership potential, were redeployed and trained as internal Lean Consultants.

All staff, starting with the Executive Team, were trained in Lean. The impact of pulling staff from production for multi-day trainings was felt. However, it was central to providing everyone with an understanding of Lean, a common language and tools for quality improvements, and ultimately, an appreciation of KPS's commitment to customer service.

Training and improvements occurred concurrently. Newly trained staff engaged in Lean value-stream mapping and rapid process improvement workshop (RPIW) events. These were initially led by the external Lean consultants and were later transitioned to the internal consultants.

Within nine months of introducing Lean, 100% of staff had been trained and over 60% had participated in a Lean event.

Experiences

Lean engagement happened very quickly. Some examples:

Group Setup and Enrollment: In a 3-day process, both the current and desired future state of this value stream was mapped and improvements were identified. Within a month, a week long RPIW was held focusing on reduced turnaround time from requesting to sending an ID card. Despite being the first RPIW, having a few skeptics on the team, and short preparation time, the event resulted in reducing the turnaround time from 7-10 days to one day - every time

Pre-existing Conditions Verification: This process was mapped and a subsequent RPIW eliminated sufficient waste to improve quality and reduce the process duration by 80%.

In both cases, process improvements were identified and implementation was initiated within the same week. With these and similar successes, more staff became engaged in Lean and interest in Lean became more widespread. It became essential to carefully manage the pace of the work.

Not all Lean events were so successful. Some events led to minor improvements and others to opportunities that were deemed too expensive and/or complex to implement. Most challenging were those requiring IT changes. At

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times, limited resources and competing priorities required less than optimal solutions.

Managers and their staff have started incorporating Lean into their daily work, using short RPIWs (sometimes less than a day) to solve problems and implement changes.

Lessons Learned

1. *This is a marathon, not a sprint.* The initial Lean experiences with training and implementation were rapid. The more improvement work that was accomplished, the more opportunities were revealed. Demand for Lean support outgrew the ability to provide it. A slowdown in events and a schedule helped prioritize work, manage expectations, and improve follow-through.
2. *Top level support is key.* Success would not have been possible without the significant commitment and participation of Executive Management. It was a tremendous boost to the effort when Executives visited RPIW events and participated on guidance teams.
3. *Lean can have a bigger impact as a cultural change and not solely a set of tools.* Lean tools can be used to make incremental changes. However, using tools alone contributes to fragmented success rather than sustainable improvements.
4. *Be patient and persistent.* The pace of Lean adoption varies across the organization, some staff will readily participate and others will be resistant skeptics. Be persistent and as successes add up, even the skeptics will see the value and begin to participate.

The Future

KPS plans to build on Lean success with more advanced training, a continual shift towards staff empowerment, and, a greater degree of competency in continuous improvement. The goal is to eliminate the differentiation between "daily work" and "Lean work" - the Lean approach and philosophy will be the way work is done.

Paul Goldberg & Associates, LLC, provides product and program development, as well as project management services, to organizations in and out of health care. Paul can be reached at 206.372.5158 or paulg@pgoldbergconsulting.com. Michelle Yeoman and Kimberly Faulkner are Internal Lean Consultants at KPS Health Plans and can be reached at 306.415.6522.

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Qualifications:

•Bachelor's degree in business, nursing or health information. •Equivalent experience of 5 years or more in healthcare management, coding, billing. Relevant nursing experience may substitute for educational requirements. •Professional fee coding certification required. Experience working with current CPT and HCPCS coding nomenclature and rules, ICD-9-CM coding conventions and clinical documentation standards. •Teaching physicians experience is required; Experience with pediatric patient populations preferred. •Minimum two years of experience working directly with physicians on professional fee billing compliance. •In depth and comprehensive knowledge of regulatory billing, government payer rules and regulations required. •Experience in presentations and reports (Visio, PowerPoint and dashboard reports). •Professional, positive communication skills.

Please email your cover letter and resume with the title of Compliance Specialist in the subject line to:

cumghr@uwp.washington.edu

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TO APPLY: Send cover letter & resume to:

Vibra Specialty Hospital, Recruitment Coordinator, 10300 Hancock, Portland, OR 97220

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