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Employer Beware: 2009 to Bring Significant Employment Law Changes

By Josephine B. Vestal
Employment Attorney and Member
Williams Kastner

Healthcare employers will encounter significant changes in the legal landscape as new legislation giving more rights to employees become effective in 2009. Some of the more significant are discussed below. We can also anticipate that the trend of granting employees additional protections will continue and even accelerate in 2009 with the changing of the guard nationally.

Americans With Disabilities Amendments Act

The Americans With Disabilities Amendments Act of 2008 (ADAAA), effective as of January 1, 2009, will significantly broaden the scope and impact of the ADA. While the term "disability" will continue to be defined as an impairment which substantially limits one or more major life activities, a record of such impairment or being regarded as having such an impairment, the ADAAA makes significant changes to the definition of the key terms "substantially limits" and "major life activities." The legislation does not define "substantially limits," but it expressly rejects the U.S. Supreme Court's definition as requiring an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people's daily life. According to Congress, this threshold is too high. The ADAAA directs the EEOC to issue regulations consistent with this viewpoint. So far the EEOC has not been able to do so, but we can anticipate a much lower standard requiring limitation of only one major life activity, which limitation may or may not impact the individual's employment. With regard to covered "major life activities" the non-exclusive list of such activities has been broadened and includes reading, lifting, bending, communicating and thinking among others. Major life activities also include "the operation of a major bodily function" which non-exclusively includes normal growth, bowel and bladder, respiratory, immune, neurological and brain, circulatory, endocrine and reproductive functions.

In addition to the ADAAA's expansion of the definition of "disability," the legislation expressly states that: (1) "mitigating mea-

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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,

Some of you noticed we recently improved the look and feel of the hard copy version of the **Washington Healthcare News**. Our goal has always been to produce the highest quality print publication possible within our financial means and now we are a step closer.

We started the **News** with 500 readers in the summer of 2006. Our 4 page newsletter was printed on a personal printer and designed using Microsoft® Publisher software, an application within the Microsoft Office Professional suite of software products. It uses a three color RGB (Red, Green and Blue) printing process that while acceptable for personal printers and small production jobs, doesn't produce the highest quality color.

During 2007 and 2008, when our number of readers ranged between 2,000 and our current 6,000, we changed to a Konica Minolta bizhub digital printer. This printer is basically a large copy machine with the latest imaging technology and we obtained a measurable increase in quality.

In January 2009 we changed to an offset printing press using an external printing company. We also switched design software from Publisher to Adobe® InDesign. InDesign is specifically tailored for professional publishers and is highly rated by users. This new combination of machine and software uses a four color CMYK (Cyan (C), Magenta (M), Yellow (Y) and Black (K or Key)) printing process and produces a very high quality print publication. We now upload one set of files to our printer's web site and pick up the hard copies when ready.

Many of the articles published in the **Washington Healthcare News** emphasize the importance of continuous quality improvement. To demonstrate continued improvement in the quality of the **News** is not only consistent with our goal but what our writers recommend.

David Peel, Publisher and Editor

Washington Healthcare News 2009 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2009	Urban Medical Clinics	December 1, 2008	December 22, 2008
February 2009	Human Resources	January 2, 2009	January 19, 2009
March 2009	Rural Hospitals	February 2, 2009	February 23, 2009
April 2009	Insurance Carriers	March 2, 2009	March 23, 2009
May 2009	Information Technology	April 1, 2009	April 20, 2009
June 2009	Rural Medical Clinics	May 1, 2009	May 25, 2009
July 2009	Facilities	June 1, 2009	June 22, 2009
August 2009	Human Resources	July 3, 2009	July 20, 2009
September 2009	Finance	August 3, 2009	August 24, 2009
October 2009	Community Health Centers	September 1, 2009	September 22, 2009
November 2009	Senior Living	October 1, 2009	October 19, 2009
December 2009	Urban Hospitals	November 2, 2009	November 23, 2009

Lisa Swan
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sures" (like medication, equipment, learned behavior, and devices (other than eyeglasses or contact lenses) etc.) are not to be considered in determining whether someone has a disability; and (2) an impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active. In other words, all conditions are to be evaluated in their active, untreated state, regardless of the actual abilities of the individual.

The ADAAA also requires that "disability" be interpreted broadly. This broadened definition of "disability" also applies to other sections of the ADA including public accommodation and transportation, as well as the Rehabilitation Act. With the expanded definitions of "disability" "major life activity" and "impairment" Congress is moving in the same direction as the expansive Washington Law Against Discrimination (WLAD), but the WLAD goes further in covering a person who has a condition that is not currently a disability, but which with reasonable medical likelihood would become substantially limiting without the proposed accommodation.

Family and Medical Leave Act Amendments

In 2008, Congress amended the Family and Medical Leave Act to permit a spouse, son, daughter, parent or next of kin to take up to 26 work weeks of leave to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is on outpatient status, or is otherwise on the temporary disability retired list because of a serious injury or illness incurred in the line of duty. The individual for whom care is provided may not be a former member of the military. This leave may be taken once per service member per caregiver unless he or she has a new covered condition. An employee may take an additional 26 week leave in a different 12 month period to care for another covered service member or the same service member with a new covered condition. Leave to care for the covered service member together with any other FMLA leave taken during the 12 month period may not exceed 26 weeks.

Amendments to the FMLA also permit an employee to take regular FMLA leave for "any qualifying exigency" arising out of the fact that a spouse, son, daughter or parent of the employee is on active duty in the Armed Forces (or has been notified of an impending call or order to active duty) in support of a contingency operation. The Department of Labor was charged with defining "exigency" and has done so by regulations effective on January 16, 2009. The regulations provide that "exigency" means to address events which arise out of the military member's active duty status, like making arrangements for childcare or schooling, attending programs, certain rest and recuperation activities, and additional events if the employer and employee agree that the event is an exigency and agree to the timing and duration of the leave. The new regulations also address issues regarding regular FMLA leave and contain new certification and other forms.

Domestic Violence Leave Law

Passed in 2008 and effective on

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April 1, 2008, the Domestic Violence Leave Law (RCW 49.76) allows victims of domestic violence, sexual assault or stalking to take reasonable leave from work (paid or unpaid) to take care of legal or law enforcement needs and to obtain health care including counseling and participate in safety planning including relocation. Family members may also take leave to assist the victim. This law applies to all employers, regardless of size. The employee is entitled to restoration to pre-leave position upon return and maintenance of health insurance benefits during the leave. Retaliation against an employee for exercising rights under this legislation is prohibited. The legislation contains no limitation on the duration of the leave.

409A Deferred Compensation

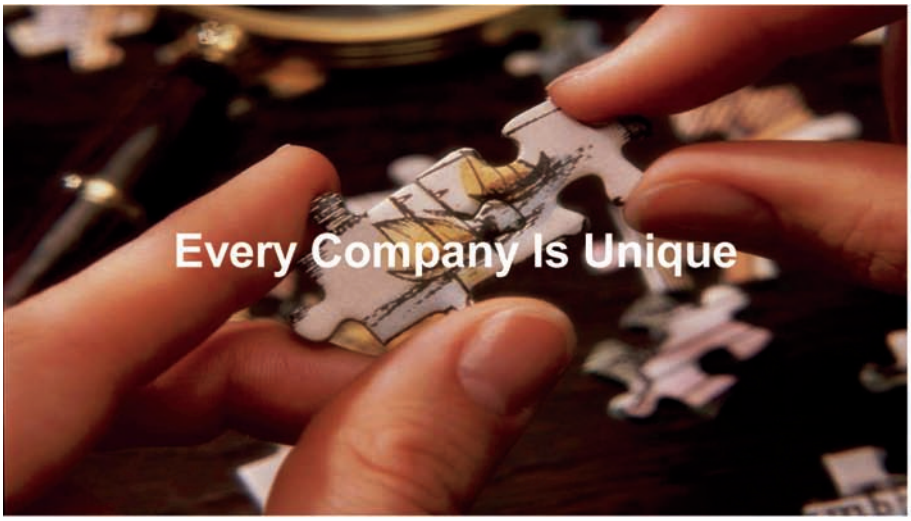
Section 409A of the Internal Revenue Code made significant changes to tax rules governing non-qualified deferred compensation plans—which includes any plan agreement or arrangement between an employee and employer in which there is a legally binding requirement for compensation that is or may be payable in a later tax year. Transitional regulations effectively delayed the date most employers needed to be in compliance to January 1, 2009. However, as of January 1, 2009, all 409A transition relief expired and all formerly non-compliant plans must be in full documentary compliance. Failure to comply (either operational or documentary) may subject affected employees to immediate taxation on amounts payable plus penalties and interest. On December 5, 2008, the IRS issued new guidance under Section 409A that dealt with (1) calculation of amounts includable in income under, and additional taxes imposed by, Section 409A; and (2) correction methods for specific types of failures, though at this time not plan document failures.

Mental Health Parity

As part of 2008 bailout legislation, Congress passed and President Bush signed the Mental Health Parity and Addiction Equity Act of 2008. The law becomes effective on January 1, 2010. This law was designed to end the disparity in insurance benefits between mental health/substance abuse disorders and medical/surgical benefits for group health plans with more than 50 employees. This covers financial requirements (deductibles, copays, etc.) and treatment limitations (frequency, number of visits as well as annual and lifetime limits). There is a provision allowing a plan to elect temporary exemption from the parity law if the group health plan experiences an increase in actual total costs under defined circumstances.

The foregoing is only a general summary of the new legislation, portions of which are very complex. Employers are advised to consult with legal counsel regarding requirements in any particular situation.

Josephine B. Vestal is an employment attorney and Member of Williams Kastner. She can be reached at jvestal@williamskastner.com. Williams Kastner has been providing legal service to health care providers and other clients since 1929. It has offices in Seattle and Tacoma, Washington and Portland, Oregon.



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Personal Financial Planning: Not Just for the Rich

By Lars Landrie, CFP®
Partner and Investment Advisor
Moss Adams Wealth Advisors

Do you picture yourself putting your children through college, creating a trust to protect your family, and being able to retire on a schedule that allows you to enjoy your retirement? These are a few of the financial goals that may be important to you, and each comes with a price tag attached.

That's where personal financial planning comes in.

What is personal financial planning?

Personal financial planning is a process to help you reach your goals by evaluating your entire financial picture then outlining strategies tailored to your individual needs and available resources.

Why is personal financial planning important?

A comprehensive personal financial plan serves as a framework for organizing and balancing the pieces of your financial picture. With a personal financial plan in place, you'll be better able to focus on your goals, understand what it will take to reach them, and how they are related to one another. For example, how does saving for your children's college education impact your ability to save for retirement? Knowing the answers to questions such as this can help you prioritize your goals, implement specific strategies, and choose suitable services. Best of all, you'll have the peace of mind that comes from knowing that your financial life is planned and on track.

What is typically covered in a personal financial plan?

Your personal financial plan addresses the following:

- Financial independence
- Liquidity needs
- Tax efficiencies
- Risk management and asset protection

How do I create and preserve financial independence?

The uncertainty of the future, including market changes, the impact of inflation, Social Security, and the increasing costs of health care has never been greater. Retirement can create fear and emotional insecurity. For many, this fear is driven by not knowing their complete financial picture.

The personal financial planning process can help minimize this insecurity by allowing you to set financial boundaries and offering direction on lifestyle spending and goal funding. Knowing you are on the right track for funding your retirement goals is invaluable when making pre-retirement spending choices. If you are not on track to meet your goals, the plan recommendations will give you guidance on what adjustments are necessary. Knowing this before retirement will allow you a much better opportunity to reach all of your goals.

What are my liquidity needs?

Having sufficient net worth to provide for retirement does not necessarily mean those funds will be available when you need them. A cash flow analysis can show you how to match your investments with your income needs to cover your expenses. Investing in a diversified manner within various asset classes can provide the necessary cash flow for liquidity during market cycles and help prevent non-liquid investments from being sold at an inopportune time. Finding the proper balance between your current liquidity needs and long-term investment requirements is a fundamental goal for your personal financial plan.

How can I maximize tax efficiencies?

There is a balance between the need to reduce taxes and the desire to increase income, which can, increase taxes. Personal financial planning considers the benefits of deferring taxable income into the future and/or accelerating tax deductions to offset current income.

Some assets are more tax efficient than others. Allocating assets to take advantage of efficiencies and

individual circumstances are accomplished through a personal financial plan.

How can I minimize risk?

Accumulated assets are prematurely depleted when certain events occur. Knowing you are financially prepared can provide you with some security. A financial plan includes an analysis of property and casualty insurance, life insurance, disability insurance, umbrella insurance, and an analysis of projected long-term care expense needs.

Determining the types and amounts of insurance needed is a complex and personal process. It should be considered in conjunction with estate planning, business planning, and personal financial planning. Your insurance planning should occur through a coordinated dialogue between your CPA, personal financial planner, attorney, and insurance advisor.

What can you do?

Most people spend little or no time setting goals or planning for their future. Procrastination is the single biggest factor in why people do not have a personal financial plan. Ego or overconfidence is the second major contributor and the third reason is many people believe financial planning is only for the rich.

It is recommended you engage a financial planner who is a CFP certificant and develop a customized personal financial plan that fits your goals and objectives.

Lars Landrie is a Partner and Investment Advisor with Moss Adams Wealth Advisors, an independent registered investment advisory corporation. Mr. Landrie also holds the CFP certification and can be reached at 425-303-3032 or lars.landrie@mossadams.com. To learn more about Moss Adams Wealth Advisors visit the web site at www.mossadamswealthadvisors.com.

Update Your Policies Now to Comply with ADAAA

By Kathryn L. Feldman
Partner
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Ater Wynne LLP

If you thought you were up to speed on the Americans with Disabilities Act, think again.

In the most sweeping change to employment law in more than a decade, the ADA Amendments Act of 2008 significantly expands the protections of the original ADA – to include more individuals with less severe impairments. The new law took effect January 1, 2009.

The ADA is the federal law that protects disabled workers against discrimination and requires that their employers provide them with reasonable accommodations to help them perform the essential functions of their jobs.

Under the ADA, "disability" is defined as (1) having a physical or mental impairment that substantially limits one or more major life activities; (2) having a record of such an impairment; or (3) being regarded as having such an impairment.

Over the past 18 years, the U.S. Supreme Court has construed this definition of disability very narrowly. The ADAAA overturns these court decisions and unequivocally states that the ADA is intended to provide a "broad scope of protection."

"...the ADA Amendments Act of 2008 significantly expands the protections of the original ADA - to include more individuals with less severe impairments."

Substantially limits – In the ADAAA, Congress explicitly rejects the strict standard created by the U.S. Supreme Court and commands a broad reading of the term "disability." The Equal Employment Opportunity Commission has been directed to issue new regulations that will re-define "substantially limits."

The U.S. Supreme Court, for example, had ruled that a qualifying impairment must restrict activities that are of "central importance to most people's daily lives." The ADAAA requires only that an impairment substantially limit a single major life activity – regardless of whether it is of "central" importance.

Mitigating measures – The ADAAA clearly states that a determination of whether an individual is substantially limited in a major life activity shall be made without regard to mitigating measures – medication, medical supplies, equipment, and other auxiliary aids or services. This does not include ordinary prescription eyeglasses and contact lenses.

Major life activities – Under the ADAAA, "major life activities" include (but are not limited to) caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.

"Major life activities" also includes a new category -- the operation of "major bodily functions" like the immune system, normal cell growth, digestive, bowel and bladder, neurological and brain, respiratory and circulatory, endocrine, and reproductive functions.

Under the ADAAA, impairments that are episodic or in remission can be considered a "disability" if they would substantially limit a major life activity when they are active. Documentary evidence of disability from a healthcare practitioner is still required.

Regarded as disabled – To make a claim under the old law, an employee had to prove that an employer regarded the employee as being

substantially limited in a major life activity because of a qualified disability. Under the ADAAA, the employee needs to demonstrate only that he or she was subjected to a prohibited action because of an actual or perceived physical or mental impairment – whether or not the impairment limits or is perceived to limit a major life activity.

"Regarded as disabled" does not include employees with a minor or transitory impairment. Employers need not provide reasonable accommodations to employees who are "regarded as disabled" unless those individuals also satisfy another part of the three-part definition of a disability.

In addition, under the new ADAAA, employees who were not considered disabled before will now be protected. Consequently, employers will need to document and engage in the interactive and accommodation process with these employees. Accommodations must be offered only when they are reasonable and do not impose undue hardship. Documentation of a legitimate interactive process will provide an employer – if faced with a lawsuit -- with an important defense.

Reasonable accommodations can include acquiring certain equipment, adjusting exams, training materials or policies, providing qualified interpreters, reallocating nonessential job functions, permitting part-time or modified work schedules, and reassigning employees to equivalent vacant positions.

Healthcare employers should review the policies and practices that govern their interactive process and revisit the essential functions of jobs to determine which core responsibilities may require accommodations under the ADAAA. They should review their forms to reflect changes, review handbook policies, train supervisors and managers, and anticipate the pending EEOC comprehensive regulations in 2009.

Many claims will likely be filed in the wake of the ADAAA. Protect yourselves by anticipating these changes -- and making them part of your policies and practices.

Kathryn L. Feldman is an employment lawyer in the Seattle office of law firm Ater Wynne LLP (www.aterwynne.com), where she develops preventive strategies to help employers create a loyal workforce and avoid litigation. For more information, contact her at (206) 623-4711 or klf@aterwynne.com.

What Happens When the (Career) Thrill is Gone

Helping Physicians and Senior Healthcare Executives Overcome Frustration and Burn-out

By Edward A. Walker, MD, MHA
Professor, Departments of Psychiatry and Health Services
University of Washington

"Look to your left, look to your right – one of you will not make it to graduation."

Many physicians heard a version of this comment from a grey-haired dean on their first day of medical school. Although we had been admitted as acolytes to a sacred profession, it was going to be hard work, and many of us would not be up to the challenge.

I felt lucky on my first day of medical school. Our dean told us that this would not happen at UW, and that they would help all of us be successful. True to his word, nearly every one of us graduated four years later. I remember sitting with my classmates on that remarkable day when, together, we recited our Hippocratic Oath. We were going to be different. We were going to change the world and enjoy our work until our mid 70's.

"Look to your left, look to your right – one of you will not make it to retirement."

Twenty-five years later, there is a new problem. A surprising number of physicians don't enjoy their work. In fact, some have already left Medicine long before they thought they would, or are in the process of making plans for another career. Physicians who once burned with a passionate fire to heal and would have sacrificed nearly anything to attain the dream of becoming a doctor now can't even find their pilot light.

A recent national survey of 150,000 doctors by the Physicians' Foundation (www.physiciansfoundation.org) found that 49% of primary care physicians are planning to reduce the number of patients they see or to stop practicing entirely in the next three years. Three quarters of them reported that medicine was "no longer rewarding" or "less rewarding," and 42% reported that their colleagues morale was "poor" or "very low." Few recommend the profession to younger aspirants.

UW Med School is the only medical school serving a five state region encompassing 26% of the land mass of the U.S. Our regional workforce problem used to be getting enough qualified applicants in the pipeline to keep up with retirements of aging physicians who practiced until they were Medicare eligible. We now also need to replace physicians who are leaving in their 40's or 50's and seeking other careers.

You probably know several physicians who are electing this early retirement or career change due to practice dissatisfaction. What you probably don't know is that for every one you can identify, there are several you can't. Most physicians are remarkably stoic and patient-centered, and, despite their dissatisfaction, they soldier on, carrying forward the promises from that Hippocratic Oath. Likewise, frustration is at an all time high, and job satisfaction at an all time low among healthcare executives and administrators who are equally committed to service in healthcare. Nevertheless, it's clear that stoicism and principle have their limits.

Dissatisfaction has many sources. Many are burned out from dealing with difficult roles they never envisioned in a system that doesn't support the kind of care they signed up to give. Some are clinically depressed and demoralized. Others are motivated to step up and lead but don't know how to get started. Still others need advice on reorganizing their practices within medicine so that their frustration doesn't cause them to leave the profession. This isn't just a problem for physicians – many senior healthcare executives have similar stories.

A new program at the UW is beginning to focus on this problem.

The School of Public Health and School of Medicine have traditionally had the mission of caring for the public's health by training the next generation of healthcare providers. But who is caring for those who care for the public's health?

The Healthcare Leadership Development Alliance (HLDA) aspires to help physicians and senior healthcare executives as they sort through their career options and job satisfaction concerns. The mission of the HLDA is to assist physicians and senior executives in evaluating their career dissatisfaction and then choosing paths that redirect their talents and energies back into satisfying careers.

Many of the burnout and practice design problems that fuel this dissatisfaction are appropriate targets for coaching and educational interventions. The HLDA takes a strengths-based approach that examines the individual's support needs and assists in identifying community resources that can help the physician or executive regain confidence and satisfaction in practice.

For some physicians, this re-engagement of practice satisfaction may involve a process of stepping up to lead – to take the reins of the system they find so frustrating and to make the positive changes needed to move it forward. It also involves leadership succession planning and alignment of incentives so that physicians and administrators remain engaged and strongly partnered in the provision of high quality healthcare.

If you'd like to learn more about the Healthcare Leadership Development Alliance you can contact the program at 206-543-9371 or check out our website at depts.washington.edu/HLDA.

Edward A. Walker, MD, MHA, is the founding director of the UW Healthcare Leadership Development Alliance. He holds two academic appointments at the university, the Cheryl M Scott / Group Health Cooperative Professor of Health Services and Professor of Psychiatry and Behavioral Sciences. Dr. Walker is nationally recognized for his expertise in coaching and developing physicians and other senior healthcare leaders, improving quality measures, and leading change in medical institutions.

A seasoned physician executive and active clinician, he brings together expertise in clinical systems improvement and a clinically-informed coaching style that has allowed him to assist physicians and senior executives in their journey of self-improvement and professional growth.

Thriving in Tough Economic Times Through a Bundle of Best Bedside Practices

By Ruth I. Hansten, PhD, RN, FACHE
Principal Consultant
Hansten Healthcare PLLC

Foul financial forecasts preview hospitals' diminishing reimbursements, increased uncompensated care, pressure to avoid unpaid "never" events while publicly proclaiming outcomes with fresh transparency. But retrenchment, paralysis, or waiting for better times won't necessarily spell survival. Thriving in tense economic times calls for energizing efficiencies and effectiveness at each step of care and attention to transforming care at every touchpoint. The best care is the most cost-effective, when patients are able to achieve their own priorities (not ours) within healing relationships and streamlined processes. Patient loyalty, employee engagement, and provider satisfaction soar along with improved patient safety and clinical outcomes.

Seasoned by 20 years as a consultant with 160 hospitals nationally, it has become clear to me that essential elements are missing from many healthcare employees' work, and not all leaders are expert at cultural transformation. Personnel lack an organizational care philosophy, common language, and focus on the patients' and families' intended results.

"A Pacific Northwest Medical system's turnover decreased by 50%, and leader retention was significantly improved through RROHC™ program coaching initiatives."

Whether practitioners are novices or seasoned, they are faced with complexity compression and an unpredictable unit workforce, lacking a mental construct for "A Day in the Life of an Expert." Entire interdisciplinary teams benefit by a shared map for the patient's journey and expert skill development to recognize and reach the intended destination. By creating mental structures through a consistent practice model and language, care efficiencies and effectiveness along with improved patient safety have been achieved though the framework of the interdisciplinary Relationship & Results Oriented Healthcare model (RROHC) and 3 level education program. The RROHC concepts parallel safety goals and regulatory initiatives. The basics must be present, employees must be proficient at implementing the bundle of 10 best practices, and leaders must evaluate and coach the processes, for hospitals to enjoy peak, economically sustainable performance.

Our field results nationally provide evidence:

Employee retention

Retention of one RN saves an estimated $15,000 to $40,000 per nurse recruitment, plus costly travelling nurses' salaries. After instituting the RROHC program, 20% more nurses felt they truly connected with patient/families. Another Pacific Northwest Medical system's turnover decreased by 50%, and leader retention was significantly improved through RROHC program coaching initiatives.

Saving time

Nurses at a Michigan hospital spend 10-15 minutes for shift handoffs, each nurse daily gaining 30 more minutes for other professional duties. Improving skills necessary for streamlining care and avoiding re-work, RROHC certified nurses reflected 21% better assigning skills. Graduates showed improved team engagement (+20% RN planning), better supervision of task completion (+9%) and use of planned checkpoints (+36%). In Ohio, interdepartmental RROHC implementation improved throughput from the emergency department, improving the time from admission order to

actual patient transfer to an average time of 54 minutes at 75% frequency.

Patient and physician satisfaction

Market share is enhanced with improved patient satisfaction and when physicians are loyal. At an Ohio hospital, Press Ganey satisfaction improved from 13% nursing overall in 2001 to 99% in 2006, earning national awards. Physician satisfaction grew from 10% to 60-80% in 2006-2007, nurse retention and recruitment skyrocketed, and market share increased. A Midwest hospital's overall rating of inpatient care grew from 40-60% in 2006 to 80% 2008 values. During 2008, the Pediatrics Unit at Harrison Medical Center (HMC) Silverdale WA, achieved 99% Press Ganey scores and ED levels reached 80-90% mean patient satisfaction.

Patient safety and quality

Correlating with RROHC program education and practice changes, nurse sensitive indicators such as fewer falls and pressure ulcers, and less frequent restraint usage, have been realized, thus avoiding unreimbursed "never events."

When staff consistently perform at an expert level, with care based on knowledge rather than assumptions, safety, efficiency, improved quality, and reduced costs can be achieved. When all disciplines and employees use a shared mental model, they communicate more quickly and clearly, and can streamline the path toward a patient-designated picture of success. By using a patient/family focused bundle of best practices, along with skill development and coaching, organizations pressed by tough times can fuse frugality with quality, refine care processes while retaining staff, and proudly promote their results to the public they serve.

Ruth I. Hansten, PhD, RN, FACHE is Principal Consultant of Hansten Healthcare, PLLC headquartered in Port Ludlow, WA. Dr. Hansten developed the nationally acclaimed Relationship & Results Oriented Healthcare Certification Program (RROHC). RROHC care delivery combines patient and family-centered care with high impact interdisciplinary team practices. Dr. Hansten can be reached at 360-437-8060 or by email at ruth@hansten.com.

For more information on RROHC and other services provided by Hansten Healthcare PLLC visit the web site at www.hansten.com.

Washington State Association for Health Care Recruitment

Working Together - Enriching Care

By Valerie Albano, SPHR
President
Washington State Association for Health Care Recruitment
Director, Human Resources
The Regional Hospital for Respiratory and Complex Care

The Washington State Association for Health Care Recruitment (WSAHCR) is a group of over eighty human resources professionals from all over the state of Washington sharing information through our bi-monthly meetings and an annual retreat.

At our meetings, members share current happenings and challenges in their respective organizations in a lively and supportive environment. In our "roundtable" discussions, we discuss the ups and downs of filling in-demand positions as staff moves from one institution to another. Rather than viewing each other as "competitors" for staff, we see each other as partners working together in a challenging field. We also invite guest speakers to update us on current trends and issues relevant to our members.

We recently had our annual educational retreat in November. This year's topics included managing multiple commitments and having difficult conversations. Since recruiting and retention are so critical in today's employment world, two of our speakers spoke on those topics.

This is a group of human resource professionals who work to meet the needs of their organizations, seeing the big picture as well as the details. For example, we are keenly aware of the tremendous expense it is to an organization to have positions unfilled. At the same time we also know how important it is to fill them with the right candidate who will be good for patient care and an asset to the organization. Each day we balance this fine line.

"This is a group of human resource professionals who work to meet the needs of their organizations, seeing the big picture as well as the details. For example, we are keenly aware of the tremendous expense it is to an organization to have positions unfilled."

Additionally, many of us are responsible for other areas of human resources, including employee and labor relations. This gives us the additional dimension of getting to know the staff and understanding their concerns. It also reinforces just how important it is to hire good candidates, treat them well, and keep them committed to the organization. At the same time, we serve as the intermediary; serving as advocate for both management and staff. All of this is critical as it addresses the ongoing challenges of employee retention. We know how critical it is to keep good employees, to provide a working environment in which they want to stay.

We are a unique group in that while we are all working to fill similar positions, we do not look at each other as competition, per se. Rather, we know that we each offer something different. Some of us are from large healthcare systems, both local and national, while others are from small hospitals. We represent both urban and rural hospitals, along with for-profit and not-for-profit organizations. These differences are important as they can and do affect what we can offer a prospective candidate. For some, a larger organization, with a wide variety of career paths is attractive. For others, a smaller hospital where everyone knows everyone suits his or her needs. Regardless, our aim is to hire the right person and provide an environment in which they want to stay.

Valerie Albano is the President of the Washington State Association for Health Care Recruitment and can be reached at valbano@regionalhospital.org.

Ms. Albano is also the Director, Human Resources for The Regional Hospital for Respiratory and Complex Care in Seattle. For more information on the Washington State Association for Health Care Recruitment, to include membership information, visit the web site at www.wsahcr.org.

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Toppenish Community Hospital: "Life Transitions" Opens Doors for Geriatric Mental Health Services

By Roberta Greenwood
Contributing Writer
Washington Healthcare News

Opening its doors in July 2008, Life Transitions (LT) of Toppenish Community Hospital, located at 502 West 4th Avenue, Toppenish, WA, began offering a short-stay behavioral health program for older adults who suffer from psychiatric, emotional and behavioral disorders. Featuring intensive, comprehensive mental health care in an inpatient setting, LT provides a warm and welcoming environment for adults 55 years and older, according to Joyce Ruff-Delgado MS, LMHC, BCPC, and Program Director. The 15-bed inpatient facility is designed for persons with symptoms or behaviors that are interfering with social, emotional, physical and relational/familial functioning. "Our patients are referred to us from as far away as Oregon," Ruff-Delgado explains. "With several hospitals closing or losing beds, the need is great and we can provide the patient-centered care that uniquely benefits our clients."

Patients who've not benefited from other treatment options, are experiencing an emotional decline or mental changes, or patients exhibiting signs of Post-Trauma Stress Disorder are assessed for inpatient treatment and voluntary placement in the facility. This short-stay (typically 10 days or less) inpatient program provides 24-hour oversight, individual and group therapy, adult daily learning skills, group activities and assists clients in setting goals for continuing treatment objectives once they leave LT. Ruff-Delgado believes the small and flexible nature of the program encourages open communication between patient, family and treatment specialists – and sharing the hospital's location is an added benefit to clients. "Our wing is the envy of the entire hospital community," says Ruff-Delgado. "With a renovation of over two million dollars, our unit offers updated facilities that still manage to be comfortable and homey for our clients while providing access to all the features and functions of the hospital."

As at Toppenish Community Hospital, LT delivers care using a team approach. Multi-disciplinary teams consisting of nurses, social workers, professional counselors, mental health staff, and physicians provide individualized care that stresses dignity and helping the patient live life to its fullest. Ruff-Delgado has more than thirty years experience in the field of behavioral health and believes LT meets the growing needs for seniors re-

Please see> Toppenish, P20

<Toppenish, from P18

quiring mental health support. "Almost 20% of people over the age of 55 experience behavioral problems not related to aging," she explains. Symptoms such as a lack of energy or motivation, constant worrying, poor appetite, difficulty sleeping, confused thinking, feelings of sadness, or a change in temperament can be indications that an assessment is warranted.

Once a free mental health assessment is completed by Ruff-Delgado or her staff, inpatient treatment may offer the most benefit to the client. "Our primary objective is to return the patient to their previous level of functioning," adds Ruff-Delgado. "We rule out any medical issues, establish trusting therapeutic relationships and provide a structured, personalized program for each client."

Although LT is a secure, locked facility, Ruff-Delgado stresses that clients share a unique and informal atmosphere with both staff and family; open communication is valued, individual and cultural issues are discussed openly, and visitation by family and friends is encouraged. Utilizing warm, cream tones and natural fabrics, the semi-private and private rooms of LT are somewhat "spa-like" – each room features specialized beds, double paned windows, bedding and privacy curtains in rich, forest hues, and a TV/VCR combination. Common areas are decorated in the same warm tones and art work and fresh flower arrangements add a welcoming touch; an on-site kitchenette is also available.

Once a patient has received a diagnosis of an Axis I Psychiatric Disorder, voluntary placement at LT is possible. Patients receive the benefits of overall healthcare, treatment planning, grief and loss resolution, medication management, education, stress management, coping and living skills and discharge planning. In addition to the skilled nursing staff, a psychiatrist is on the unit Monday – Friday. "A market feasibility study conducted by Diamond Health Care supported the need for Life Transitions in our community," concludes Ruff-Delgado. "The demand for senior behavioral health services is going to continue to grow – and we will provide customized care to help our clients deal with these unique issues in a caring and dignified manner."

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- 082931-Manager Radiology
- 082579-Radiology Services Director
- 082767-RN Practice Team Manager - Specialty Care
- 081715-RN Practice Team Manager - Specialty Center

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Plan and Hospital Financial Information

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Financial Results for the 20 Largest Health Plans in the Northwest (Ranked by Total Revenues)[1]

Plan Name	State of Domicile	Total Revenues YTD 09-30-08	Net Income YTD 09-30-08	Net Income/ Total Revenues 09-30-08	Statutory Capital as of 09-30-08	Enrollment as of 09-30-08
Regence BCBS of OR	OR	$2,026,653,692	$3,457,310	0.2%	$520,930,342	992,444
Premera Blue Cross	WA	$1,945,039,655	$25,525,729	1.3%	$766,636,771	682,973
Group Health Cooperative	WA	$1,765,415,812	$96,482,351	5.5%	$757,452,891	393,770
Kaiser Foundation HP of the NW	OR	$1,740,884,081	$19,889,740	1.1%	$512,806,614	467,554
Regence BlueShield	WA	$1,707,960,696	($1,633,945)	(0.0%)	$866,325,811	797,907
Blue Cross of Idaho Health Service	ID	$746,106,080	$32,077,384	4.3%	$271,721,412	453,488
Providence Health Plan	OR	$648,771,413	$21,946,889	3.4%	$346,184,219	186,687
Molina Healthcare of WA	WA	$530,985,564	$32,157,200	6.1%	$108,636,089	294,697
Community Health Plan of WA	WA	$396,149,038	($4,398,953)	(1.1%)	$69,075,689	234,488
Blue Cross Blue Shield of MT	MT	$386,517,423	$16,318,265	4.2%	$130,597,866	225,384
Regence BlueShield of ID	ID	$381,808,729	$3,698,593	1.0%	$124,470,985	210,975
PacificSource Health Plans	OR	$362,298,604	$2,743,340	0.8%	$103,828,098	143,004
Group Health Options	WA	$347,727,908	$833,037	2.3%	$31,525,288	126,948
PacifiCare of WA	WA	$329,247,499	$40,409,405	12.3%	$246,465,221	45,085
Health Net Health Plan of OR	OR	$315,988,534	$2,055,404	0.7%	$58,601,671	127,287
PacifiCare of OR	OR	$210,446,433	$25,157,314	12.0%	$41,770,891	29,682
LifeWise Health Plan of OR	OR	$207,538,113	($7,075,045)	(3.4%)	$62,727,445	88,503
Arcadian Health Plan	WA	$170,973,915	$3,494,152	2.0%	$29,761,142	25,558
LifeWise Health Plan of WA	WA	$156,012,122	$4,146,411	3.5%	$35,797,243	87,990
Asuris Northwest Health	WA	$142,195,001	($568,459)	(0.4%)	$33,775,833	77,879

Financial Results for the 20 Largest Hospitals in Washington & Oregon (Ranked by Total Discharges)[2]

Hospital Name	State	Total Charges YTD 06-30-08	Total Margin YTD 06-30-08	Total Margin/ Total Charges 06-30-08	Total Discharges YTD 06-30-08	Total Days YTD 06-30-08
Swedish Medical Center	WA	$1,112,359,629	$30,481,757	2.7%	16,788	71,651
Providence St. Vincent Medical Ctr.	OR	$625,328,000	$15,205,000	2.4%	15,703	72,176
Sacred Heart Medical Ctr.-Spokane	WA	$793,130,352	$18,565,356	2.3%	15,592	80,956
OHSU Hospital	OR	$781,280,865	$21,370,108	2.7%	14,412	75,924
Sacred Heart Medical Ctr.-Eugene	OR	$396,014,607	$58,682,163	14.8%	13,292	59,506
Providence Reg. Med. Ctr. Everett	WA	$612,910,831	$14,037,759	2.3%	12,615	52,485
Providence Portland Medical Center	OR	$497,421,000	$7,271,000	1.5%	11,613	53,587
St. Joseph Medical Center - Tacoma	WA	$780,278,685	$30,051,839	3.9%	11,568	49,931
Southwest WA Medical Ctr.	WA	$532,241,570	($952,680)	(0.2%)	10,185	44,329
Salem Hospital	OR	$376,426,331	$20,322,670	5.4%	10,159	44,817
University of WA Medical Center	WA	$498,269,767	$23,083,396	4.6%	10,068	55,560
Providence St. Peter Hospital	WA	$491,611,998	$14,669,615	3.0%	9,762	43,449
Overlake Hospital Medical Center	WA	$359,822,955	$12,204,702	3.4%	9,578	33,820
Legacy Emanuel Hosp. & Health Ctr.	OR	$462,141,824	$1,606,698	0.3%	9,544	53,242
Harborview Medical Center	WA	$591,210,000	$8,738,000	1.5%	9,227	67,903
Tacoma General Allenmore Hospital	WA	$820,646,323	$31,181,987	3.8%	9,202	42,281
Harrison Medical Center	WA	$305,208,551	$14,330,084	4.7%	8,947	34,522
Virginia Mason Medical Center	WA	$609,017,270	$11,577,223	1.9%	8,634	41,776
Valley Medical Center	WA	$396,424,833	$1,240,102	.3%	8,354	28,317
St. Joseph Hospital - Bellingham	WA	$290,139,319	$6,528,884	2.3%	7,983	32,824

[1]Source: National Association of Insurance Commissioners. [2]Sources: WA State Department of Health; OR Health Policy & Research.

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