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Maintaining an Effective and Low Cost Compliance Program for Rural Hospitals

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The goal of this article is to provide ideas on how to keep your compliance program focused and effective on an organization-wide basis through the use of low-cost means. This article assumes you already have a corporate compliance program in place and are familiar with the basic requirements of a compliance plan. The focus will be on steps that your rural hospital can take to ensure it is keeping up-to-date with compliance issues and ensure that its compliance program is one that would be deemed "effective" by the federal government.

With the plethora of government audits health care providers can be subjected to today, the importance of having an effective corporate compliance program cannot be overstated. The first line of defense and best protection from all government auditors is the establishment of an effective corporate compliance program. The federal government recognizes that compliance programs must be scalable so that they fit an organization with respect to size, sophistication and available resources. While large urban hospitals can afford and are expected to have a Compliance Officer with extended staff, this is not usually the case for small rural hospitals where the entire compliance section may be one person who also has other job duties within the hospital. Rural providers typically have more limited resources than larger providers so they have to find cost-effective ways to maintain an effective compliance program.

Maintaining a culture of compliance

Critical to maintaining a culture of compliance is having a governing board and administration that fully support the hospital's compliance

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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,

I recently attended the U.S. Bank 2009 Economic Outlook Breakfast at the Sheraton hotel in downtown Seattle. John Mitchell, Ph.D., Economist and Michael J. Parks, Publisher of Marple's Pacific Northwest Letter presented charts, graphs and other information to explain the current economic environment. Throughout both presentations it was clear how fortunate we are to do business in health care.

Here are some of the more noteworthy statistics.

- Nationally, between November 2007 and November 2008 about 2,000,000 jobs were lost. However, during the same time period, health care and education (they were combined in the presentation) added over 500,000 jobs.
- Idaho, despite a statewide loss of 18,000 jobs during this period, added 2,000 jobs in health care and education. Oregon lost a total of 32,000 jobs but added 10,000 health care and education jobs.
- Government was the *only* other major sector to add jobs during this time period.

While we've managed to evade much of what other industry sectors have experienced there are clouds on the horizon. A few health care organizations in the Northwest are reporting poor financial results and this may lead to failures or consolidation. However, the vast majority of medium to large size northwest health care organizations are financially sound and will be around to provide care to patients long after the current recession has ended. We should count our blessings.

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

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program efforts. Half-hearted or sporadic support will not help and will probably hurt the hospital's compliance efforts. This is an area where the board and administration must lead by example. As the Office of Inspector General stated in its first Compliance Program Guidance for Hospitals: "Adopting and implementing an effective compliance program **requires a substantial commitment of time, energy, and resources by senior management and the hospital's governing body**. . . . The OIG believes that the long term benefits of implementing the program outweigh the costs."[1] … " [E]very effective compliance program must begin with a formal commitment by the hospital's governing body." *Id.*

If the hospital has not already demonstrated this type of commitment it must do so without delay. If governing board members or administration officials are expected to attend meetings addressing compliance, they must attend these meetings. Missing these meetings or attending these meetings on an erratic basis signals to the rest of the employees that they too can be lackadaisical when it comes to compliance.

With a governing board and administration committed to compliance and setting that example, the Compliance Office is empowered to expect and demand everyone else's best effort towards compliance.

Identifying and investigating your risks

As part of any effective compliance program your Compliance Officer should be constantly monitoring and assessing risk areas. For small rural hospitals the issue becomes one of how to prioritize and address the hundreds of risks that could exist and can seem overwhelming just because of the sheer number of problems that might have to be scrutinized.

If you feel overwhelmed because of the perceived enormity of the task, try to divide up the risk areas to be addressed. Certain issues will appear every year so they should be part of the hospital's routine risk auditing procedures. These areas can include billing, physician contracting (Stark law and anti-kickback issues), and EMTALA. Determine which areas may be beyond your expertise such as technical legal issues and assign those to your outside counsel. This allows you to get the matter off your plate while knowing that it is being addressed. In addition to the routine audit areas, the hospital should also focus on those areas identified by the federal government. The federal government issues a number of publications advising health care providers of their current areas of interest. Among other publications, the Compliance Officer's routine reading materials should include the following government publications:

- OIG Compliance Program Guidance: http://www.oig.hhs.gov/fraud/complianceguidance.asp
- OIG Work Plan: http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf
- OIG "What's New" web page: http://www.oig.hhs.gov/w-new.asp
- OIG "Enforcement Actions" web page: http://www.oig.hhs.gov/fraud/enforcementactions.asp

If you have recently been subjected to a Medicare or Medicaid audit, review the audit results and make sure that any problem areas identified by the audits were corrected and remain corrected.

You need to determine for yourself whether publications promising assistance in identifying compliance risk areas are of value. Some view these publications as helpful while others find them to be an overpriced regurgitation of what is readily available on government web pages. If you already subscribe to publications determine whether you really use them or whether they are just added to a stack of other unread publications. Determine whether the publications offer any real assistance or whether you could obtain the same information at one of the government web sites noted previously.

If you are having difficulty identifying areas to review for risks a good starting point is the original Compliance Guidance for Hospitals (http://www.oig.hhs.gov/authorities/docs/cpghosp.pdf)[2] which listed the following areas of concern by the OIG:

1. billing for items or services not actually rendered
2. providing medically unnecessary services
3. upcoding
4. DRG creep
5. outpatient services rendered in connection with inpatient stays
6. duplicate billing
7. false cost reports
8. unbundling

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9. credit balances—failure to refund
10. hospital incentives that violate Stark or the anti-kickback rules

Any reported wrongdoing must be investigated immediately.

Remediating risks

Once the risks are identified and investigated, any violations discovered must be addressed and corrected. Safeguards need to be put in place to ensure that a new breach does not occur in the future. Modification of the compliance program to improve detection and prevention of like events should be made. Appropriate disciplinary actions need to be taken against offending employees regardless of their place or rank within the organization. The organization should be consistent in its reaction to the discovery of violations and must actively guard against showing any favoritism in terms of what gets investigated and disciplinary measures meted out.

Document all remediation steps. Be sure the documentation is sufficiently detailed to allow the reader (potentially a government investigator) to understand that once a potential violation was detected it was investigated immediately. If the investigation concluded that a violation had occurred you must document that the violation was corrected and appropriate measures taken so it would not occur in the future, any offending employees were properly disciplined, and the appropriate measures were taken to protect any whistleblower from retaliatory actions. If the violation was one that needed to be reported, the paperwork should show that the appropriate government agencies were advised.

Using communication to prevent compliance problems

The Compliance Officer should have open lines of communication with all of the hospital's employees. Some lines of communication are mandated by the corporate compliance program such as the command for compliance program education and training for every employee.[3] In addition to a yearly compliance program update, a hospital can help its employees maintain focus on compliance with periodic reminders about the compliance program. Memos or e-mails can be sent to employees reminding them of the hospital's compliance hot line number, lines of communication for reporting problems, or highlighting the latest areas of concern stated in the OIG Work Plan. If the OIG issues a Special Fraud Alert , copies of that Alert can be distributed to the employees or posted in public places.

Conclusion

The federal government and, in particular the OIG, provide at no charge, a wealth of information regarding compliance programs and the areas most likely to be investigated. All that is required is access to the Internet. By reviewing the appropriate Web sites a rural hospital can keep abreast of the most current investigation trends and topics at little or no cost to the hospital. Upon review of the government publications you can determine which issues can be handled internally and which will require you to engage outside counsel. By using the available free resources a rural hospital can remain current with its compliance efforts while still preserving its financial reserves for those instances where outside attorneys and consultants will be needed.

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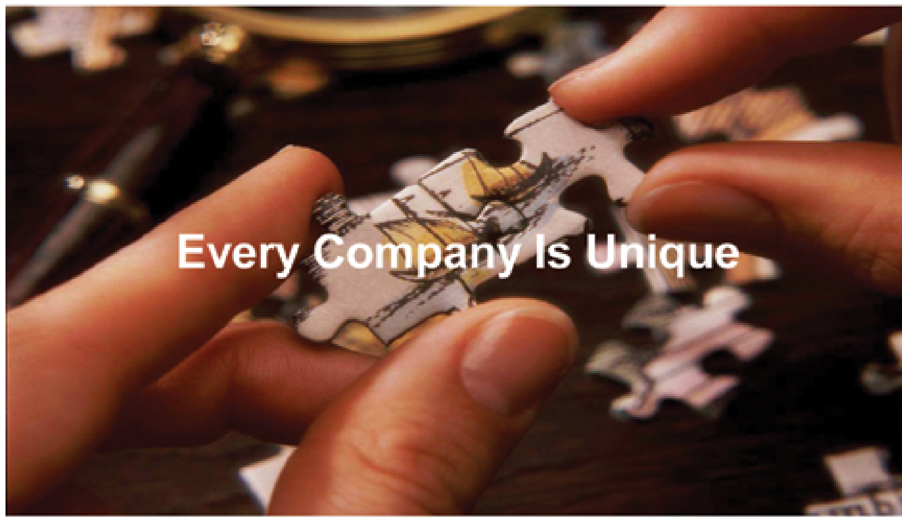
[1]OIG Compliance Guidance For Hospitals, 63 FR 8987 (February 23, 1998): http://oig.hhs.gov/authorities/docs/cpghosp.pdf.

[2]There is also a supplemental guidance for hospitals: http://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf.

[3]http://www.oig.hhs.gov/authorities/docs/cpghosp.pdf, at § II, C, Conducting Effective Training and Education.



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Boost Your Critical Access Hospital Bottom Line with Swing Bed Designation

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Nationally, profit margins are declining for health care facilities and especially in the Critical Access Hospital (CAH). After several years of climbing margins, facilities are experiencing reduced profits; CAHs are especially vulnerable with this trend as they do not have the cash reserves or the volumes to sustain the declines without looking for new ways to gain additional reimbursement. One of the options may be to obtain **swing bed designation** from Medicare. BIPA 2000 established a new reimbursement provision for CAHs that provides a full reasonable cost payment (101%) for CAH swing bed services instead of a payment based on SNF PPS Reimbursement. Differences in payment would be a swing bed payment of $1,500-$2,000 a day versus a RUGS payment of approximately $275 a day. **The swing bed payment methodology is getting paid acute care rates for skilled level of care**.

Critical Access Hospitals wishing to provide swing bed services must apply and receive swing bed certification from CMS to become eligible. See 42CFR 485 for designation, CFR 482.66 for requirements and 42CFR 413.70 for cost based reimbursement. Once approved, the facility is required to maintain Medicare conditions of participation.

Medicare provides CAHs the option of utilizing their inpatient hospital facilities for the provision of extended care services. The total number of beds being used for the furnishing of either acute care or post-acute care inpatient services may not exceed 25 beds. This can occur without the need to physically transfer a patient between different nursing units within the hospital or even between different facilities.

Once swing bed designation is granted, the swing-bed patients in CAHs are considered to be exclusively patients of the CAH. For example, if a CAH has 10 licensed swing beds, then those 10 beds would count towards their 25 acute inpatient bed cap, but the rest of the SNF beds in that separately licensed facility would not count towards the CAH's 25-inpatient bed limit.

Swing beds need not be located in a special section of the CAH. The patient need not change locations in the facility merely because their status changes unless the facility requires it. There must be discharge orders from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to swing-bed status regardless of whether the patient stays in the same facility or transfers to another facility. If the patient does not change facilities, the same medical chart or electronic medical record (EMR) can be utilized but the swing-bed section of the chart or EMR must be distinctly separate from the acute care section with appropriate admission orders, progress notes, and supporting documents.

There is no requirement for a CAH to use the full MDS form for recording the patient assessment or for nursing care planning.

By utilizing swing beds, facilities with higher acute admission rates may be able to manage their acute inpatient beds more effectively; swing bed admissions can contrib-

ute to improved quality of care. For example:

- In rural areas where access to services may be limited, patients ready for acute discharge from a facility may need more care and support than can be achieved through a discharge to home with home health services.
- Psychologically and emotionally, swing bed admissions may be less traumatic and threatening for the patient. Admission to a swing bed feels more like a continued hospital stay to the patient and helps improve continued recovery and a return to independence.

In summary, there are multiple advantages to the effective use of swing beds for the CAH, the physician, the patient and the community. Swing beds can significantly improve both the facility's patient care outcomes as well as financial viability since CAH swing bed services are reimbursed on a cost-related basis.

There are significant reimbursement strategies on the Medicare & Medicaid cost reports for reporting swing beds. Ask a consultant to review your cost report and consider reopening if there are substantial reimbursement impacts for your facility.

See FCAW's upcoming articles in the Washington Healthcare News for other financial options for Critical Access Hospital's to improve their bottom line.

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2009 Joint Commission: Implementing the New Conduct Standards

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The 2009 Joint Commission standards recognize "[d]isruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care." Addressing members of the hospital governing body, senior hospital management, and officers of the organized medical staff as "leaders," the 2009 Joint Commission standards provide:

> "Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members."

To this end, the new Joint Commission leadership standards require hospitals to have a written code of conduct defining acceptable, disruptive, and inappropriate behaviors, as well as a process for managing inappropriate behavior. The Joint Commission standards suggest that any conduct code adopted for the medical staff complement and support existing conduct codes for nonpractitioner staff.

Drafting the conduct code

There is no single correct conduct code. However, some basic principles should be considered in creating or updating a conduct code to conform to the 2009 Joint Commission standards. The following suggestions, based on experience with corrective action procedures, primarily address medical staff conduct codes.

1. <u>Keep it simple.</u> The required conduct code need do only two things: (1) define acceptable and unacceptable behavior in easily understood terms with some illustrative examples; and (2) establish a clear process for reporting, investigating, and addressing incidents of unacceptable behavior.

   Extensive policy statements, statements of general principles of the conduct code or commitments to implement various laudable goals in the future often simply create fodder for legal debate in the course of any corrective-action proceeding.

2. <u>Keep it flexible.</u> Any conduct policy should allow the response to a reported incident of unacceptable conduct to be crafted to fit the nature of the incident, the person(s) involved, and any history of similar incidents. Everyone has the occasional bad day. Keep open the option of dealing with such occasions informally. Every reported conduct incident should not necessarily trigger step one of a multistep progressive response program. At the same time, reserve the ability to go directly to corrective action should the conduct and situation warrant such a response.

3. <u>Preserve your immunities.</u> Courts have been dealing with disruptive-conduct cases for decades because physicians who are subject to corrective action based on unacceptable conduct regularly sue everyone involved in the process. Generally, medical staff bylaws, state law, and federal law provide immunity from civil damage actions for hospitals and members of the medical staff who participate in any corrective action taken with respect to a practitioner.

   These immunities are generally conditional. To apply, they may require, for example, that all actions were in good faith, or that certain procedural rights were provided to the practitioner before any adverse action was taken. When you have completed your code of conduct, confirm that following it will lead you to, and not away from, available immunities.

Implementing the conduct code

The best possible code of conduct is of little value without consistent, disciplined implementation. In our experience, three areas are particularly critical.

1. Investigation. The inquiry should focus on facts: (a) what the actor did or said; (b) the statements or conduct that the actor was responding to; (c) the effect of the actor's statements or conduct on those present; (d) the history of the statements or conduct. While easier to obtain, descriptions or opinions such as "the actor behaved like a jerk" are considerably less helpful.
2. Documentation. Accurate and complete documentation of reported incidents of inappropriate conduct is essential. The intent of the required conduct code is to reduce incidents of behavior that can be harmful to patients. Thus, in addition to the facts of the incident, it is important to document any actual or potential impact on patient care.
3. Accountability. Too many performance improvement plans or personal conduct codes succumb to the "file and forget" syndrome. Any plan or personal conduct code intended to improve an individual's behavior should clearly establish who is responsible for ensuring adherence to all plan elements, both by the individual whose conduct precipitated the plan and by any others who are required to participate in achieving the objectives of the plan. The consequences of noncompliance with the plan or personal code requirements should be clearly stated and the individual responsible for ensuring compliance should be required to promptly report any noncompliance to those with authority to act on the information.

The new Joint Commission standards are premised on the belief that an environment of teamwork and respect for others fosters quality and safety in the delivery of health care services. Creating and enhancing such an environment should be the goal in drafting and implementing the required code of conduct.

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A Perfect Charge Description Master Isn't Enough

By Rob Smull
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What happens when you cross a perfect Charge Description Master (CDM) with imperfect charging processes in your clinical departments?

You lose money. Often lots of it. Conversely, you may get paid too much and run the risk of having to self-report overpayments or even deal with the OIG. Or, you simply are charging for services you shouldn't even if no additional payment is received from Medicare, which can result in an overstatement of charging.

What's the solution? The best way to address this challenge is to integrate outpatient charge capture reviews with the CDM management function.

Your CDM is perfect!

You employ motivated individuals who are highly skilled in coding and have strong interpersonal skills. You are doing everything according to best practices. In addition:

- You use an electronic resource to help ensure the right codes are used and prompt you to check for other charges.
- Your CDM manager meets with each clinical supervisor to make sure every charge requiring a HCPCS code has one that correctly reflects the service provided, is accurate, and is applied and updated in accordance with regulatory guidelines and updates.

> *"Best Practices to ensure appropriate charging, billing and payment include the performance of charge capture reviews or audits."*

- All your revenue codes are correct.
- Your CDM manager works closely with the CDM committee and Compliance Director.
- You have charges in your CDM for everything you can think of and they all make sense.
- Your finance department has policies in place to establish prices.
- Your Business Office no longer assigns CPT codes and modifiers on their own to get charges through the Medicare edits.
- You check to make sure your charges are consistently passing your Medicare edits.
- You assess the accuracy of your outpatient payments.

What's left?

That's all great, but is it enough? Have you done everything you need to do to make sure you are paid correctly? The answer is a resounding "No." The CDM is just one piece in the revenue cycle. CDM management and clinical department charge processes fall into the Middle process, between the Front End (often referred to as Patient Access) and the Back End of the Revenue Cycle, including billing, denials and collections.

What lurks between

Consider the following scenario. You are the hospital CFO. Your hospital handles the billing for the technical and professional components for all radiology services, except for CT Scan where the professional component is billed by the CT Scan physician group. Your Radiology Department Administrator works closely with your CDM manager and tells you everything related to coding and charging is fine. The August radiology statistics indicate that the volume for CT department activity has increased, but revenue dropped significantly. Your department director looks into this. By the time she gets back to you to let you know that she is as puzzled as you, September's statistics are out and you see the same issue. So what is happening?

- Here is the answer: The Medi-

cal Director for Imaging Services has been receiving over-utilization notices from a major payer regarding his physician group's claim submissions for CT Extremity Angiography. To deal with the notices, he instructs the lead CT tech to charge only for a CT Extremity whenever a CT Extremity Angiography is performed. Unfortunately, the lead tech does not inform the hospital's Radiology Administrator of the requested change, and the Radiology Administrator cannot inform the CFO.

- The CT department performs about 500 CT Extremity Angiographies per year at $3,200 per procedure (as opposed to $1,800 for a CT Extremity). As a result, the hospital's annual gross charges decrease by roughly $700,000.

The above scenario is only one of many occurrences in clinical departments that can significantly affect revenue.

Outpatient charge capture reviews

Best practices to ensure appropriate charging, billing and payment include the performance of charge capture reviews or audits. The CDM management department is usually the most practical resource to do this. Effective review processes should be established and consistently performed. Results should first be reported to the Compliance Director in the event seriously non-compliant events are discovered. Results should then be reported to financial management and the CDM management committee.

What's left – in a nutshell

In today's environment, it is important to realize that an effective charge capture review consists of more than confirming the effectiveness of Patient Access processes; a great CDM; and best practice back end billing and collection processes. Hospital clinical departments are often home to elusive, behind-the-scenes issues that can significantly impact the hospital's bottom line and should be addressed in all charge capture reviews.

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How Physician Practices Can Improve Cash Flow

By Lisa Swan
Senior Consultant
Transworld Systems Inc.

Outstanding insurance and patient A/R can negatively impact the cash flow of a practice and cost additional money if it has to borrow working capital.

Define and document your collections policy

Ensure that your terms of payment are clearly stated in writing – on the patient intake form as well as on every invoice or statement. Schedule financial counseling if the patient has a high deductible, will require lengthy care or an expensive procedure not covered by insurance. Payment arrangements can be set up for estimated patient responsibility.

Identify past-due accounts

There are many choices for practice management software, each with its own pros and cons. Your PM software should allow customization of financial and collection reports. The collections module should start identifying accounts by 60 days after patient responsibility and insurance claims by 45 days after filing in order to start the internal follow-up process. If possible, get rid of the "aging boxes" at the bottom of statements as people have a tendency to pay the smallest amount showing in the boxes, no matter the age.

"Statistics show that after 90 days, accounts held in-house depreciate at the rate of 15% per month. The time and financial resources budgeted for collection efforts should be focused within the first 60-90 days where the bulk of your accounts can and should be collected."

Train your staff

This includes front office personnel, who must verify patient address/insurance information at every visit. Here's a strategy they can use when the patient has "forgotten" their wallet and can't pay their co-pay at the office: hand the patient a remittance slip with their account number and co-pay written on it along with a self-addressed envelope and have staff say: "My name is ____, I'm writing my name on this envelope. When you get home, please put your co-pay in this envelope and mail it back to me. I'll be keeping an eye out for it." By making it personal, the patient is more likely to take care of it.

Use a third party sooner

90% of your collections budget is spent pursuing 10% of accounts. Statistics show that after 90 days, accounts held in-house depreciate at the rate of 15% per month[1]. The time and financial resources budgeted for collection efforts should be focused within the first 60-90 days where the bulk of your accounts can and should be collected.

Before paying a percentage to a collection agency, check into using a fixed-fee collection service that keeps your staff in control of the collections process. Make sure that agency is HIPAA compliant and offers a website to place accounts and track activity. Some flat-fee agencies also offer an insurance claim resolution program to save the practice hundreds of hours of "on hold" time by contacting past-due carriers on behalf of the practice and instructing the carrier to send EOB/payment directly to the practice.

[1] Source: US Department of Commerce

Lisa Swan is a Senior Consultant with Transworld Systems Inc. She can be reached by telephone at 888-388-5411 x23 or by email at Lisa.Swan@TransworldSystems.com.

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An Interview with George J. Brown, MD, Chief Executive Officer of Legacy Health System

George J. Brown, MD is the Chief Executive Officer of Legacy Health System with facilities in Oregon and Washington State. Prior to assuming this position in August 2008, Dr. Brown was the Chief Operating Officer of Washington State based MultiCare Health System. David Peel, Publisher of the Washington Healthcare News, asked Dr. Brown a few questions in this January 2009 interview.

What were some of the reasons you accepted this new position?

The main reason for accepting the position was the challenge of leading a successful and growing healthcare system. Legacy is committed to providing the highest quality medicine and serving a broad community, and I am proud to be a part of this team. The system also has a long, illustrative history, and I felt that it would be an honor to be a part of that history. I was also attracted to living in Portland because it is a vibrant community with a great deal to offer my family and me.

How are you adjusting to the CEO position, given your long-standing role as the Multicare COO.

For me, there has not been much of an adjustment for two reasons. First, the positions of COO and CEO have many similar duties, and in some cases, the two positions share a number of responsibilities. Second, I have already served as a CEO before during the course of my military career. The lessons I learned during my military career continue to apply in my role here at Legacy Health System.

I have learned that it is important for a leader to be adaptable and flexible to meet challenges as they arise, and it is important to think strategically about the future. I believe those are both key to the success of any organization.

"My goal is to ensure Legacy is able to emerge on the other side of this recession as a healthy and viable competitor in the markets we serve."

George J. Brown, MD
Chief Executive Officer
Legacy Health system

What are the key differences between the Oregon healthcare system and the Washington healthcare system?

I have found there are more similarities than there are differences between Washington and Oregon. Part of the reason that is so clear to me is because Legacy Health System serves communities in both Oregon and Washington. Legacy Salmon Creek Hospital and its supporting operations serve the people of Vancouver, Washington, so Legacy is acutely aware of the environment in both states.

One difference in Oregon this year is a major push to address the healthcare needs of children. The state Legislature is considering a specific tax on healthcare providers to help fund healthcare for the uninsured, with a specific focus on children. Another difference that I have seen between Oregon and Washington is the distribution of the population in the state, with the Portland metropolitan area serving as the major population center. Consequently, the rural areas of Oregon are sparsely populated, which makes it challenging for hospitals serving those areas.

What are the three main things you plan to accomplish at Legacy during the next five years?

First, I want to continue the strong foundation of patient safety and quality. Legacy has made significant strides in these

key areas, and I want to continue to see gains and improvements in these areas. We have been working with the Institute for Healthcare Improvement and Dr. Jim Reinertsen on setting and achieving what we call our "Big Aims" in patient safety and quality.

Second, I want to continue to develop and expand our Centers of Excellence in our various hospitals. These areas currently include our trauma program at Legacy Emanuel Hospital, the Oregon Burn Center, and Legacy Emanuel Children's Hospital. Other areas where I want to see growth and development include our cardiovascular program, our neurosciences program, oncology, ophthamology and our women's services program. These are all key programs where I see Legacy able to be the leader in the community.

Please see> Brown, P20

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TGB Architects: Building Solutions for Health and Healing

By Roberta Greenwood
Contributing Writer
Washington Healthcare News

Successfully utilizing their team approach in building design and delivery, Taylor Gregory Butterfield Architects (TGBA) joined developer Benchmark Development Company of Bellevue and contractor Aldridge and Associates of Bothell to celebrate the opening of the Covington Medical Office Building at 27005 168th Place SE in Covington, Washington.

TGBA specializes in serving healthcare and ecclesiastic clients, understanding both the complexities of healthcare operations and procedures as well as jurisdictional demands and building technologies. Established in 1993, TGBA serves clients in the Puget Sound area as well as in the greater Northwest, including Washington, Oregon, Idaho and Montana.

Planned to provide health services as a satellite facility for Valley Orthopedic & Valley Medical Center, the Covington Medical Office Building is located in a highly developed urban area yet offers clients and practitioners alike a warm and inviting environment in which to visit and work. That's one of the current trends in designing medical facilities, according to Kent Gregory, AIA and founding principal of TGBA. "It's all about the quality of patient care," he explains. "We seek to deinstitutionalize the look of healthcare facilities and are taking our cues from the 'hospitality designs' of great hotels."

Practicing a "Lean approach" to project execution, TGBA used small, accountable teams to manage and execute all tasks associated with the Medical Office Building. Starting from project inception, TGBA teams worked closely with city of Covington to design a building that would meet the needs of a densely populated, urban area. This "Lean" approach allowed TGBA to "set project goals and schedules, identify and address challenges, make adjustments to tasks as necessary and to respond directly to client needs."

These client needs and the result-

Covington Medical Office Building, Covington, WA

ing attractive perspectives are designed into every aspect of the Covington Medical Office Building. A three-story building, the almost 19,000 square foot facility is comprised of covered parking on the first floor and two upper floors that house outpatient clinics, physicians offices, and specialty imaging centers. “One of the challenges facing health care delivery is the increased facilities costs. As land in the middle of population cores becomes more expensive, lease rates are driven up. Health care reimbursements however are fixed by insurance tables and Medicare guidelines,” Gregory explains. “This makes it more difficult to locate healthcare services in urban settings where they can be conveniently accessed. This building is carefully designed to find the highest and best use of the site and provide the best facilities value.”

Clients arriving at Covington Medical Office Building enter a large, central, first-floor lobby that opens into the parking structure which is the base of the building. Citing minimal space and rising land prices, Gregory says it makes sense to build structured parking facilities whenever feasible. The Covington facility gives the impression it’s a three-story building – not a two-story structure perched up on stilts – which is much more visually pleasing. “The city asked us to design a pedestrian friendly building and the front entrance is very expressive of that desire” Gregory says. “We designed an extroverted building that encourages clients to enter and allows them to see what’s going on all around them.”

Once clients enter the facility, natural materials, soft textures and warm colors add to the gentle ambience of the interior, giving them a sense of entering a contemplative area with rooms that encourage them to be “at rest.” TGBA uses an interior design team which provides quality service and attention to detail, resulting in a more holistic feel to the facility. A cross-referring facility, the design also makes it easy and comfortable for patients to seek additional treatments in the same building. “We design our medical buildings to handle the constant coming and going of patients, physicians and care-givers,” Gregory says. “It’s all about the flow – of people, information, and technologies.” In the Covington Medical Office Building, waiting rooms look out into the lobby and clients are presented with a more “gracious” way to reach their care-takers. Long, narrow hallways and closed doors have been replaced with open

Please see> TGBA, P20

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< Brown, from P17

Finally, I think it will be critical for Legacy to survive these tough economic conditions as a strong organization. We have to be both effective and efficient with the resources we have. My goal is to ensure Legacy is able to emerge on the other side of this recession as a healthy and viable competitor in the markets we serve.

What other important information should our readers know about you and Legacy Health System?

I am proud of the fact that Legacy Health System is the oldest non-profit healthcare provider in Oregon. One of the founding hospitals in the system has been serving patients for more than 130 years. Legacy has a strong connection to the community, with long associations with the Episcopal and Lutheran churches. It continues to grow and develop as a community-based healthcare system with the support of the Portland and Vancouver metropolitan areas. I know that everyone in the system is driven to provide the best possible healthcare for the patients and the communities we serve.

< TGBA, from P19

spaces and suites that feature natural light and large windows. Special imaging suites with MRI, CT and Fluoroscopy capabilities are located within an easy walk to the upper floors. “We encourage the healthcare providers to work together, just by the design of the building,” he adds.

TGBA states their mission is to empathize with clients needs, imagine the most innovative solutions to challenging problems, cultivate an attitude of understanding with clients and team members, embody a spirit that assists their clients to meet their operational objectives, and to enjoy the people they work with and the people they serve.

The Covington Medical Office Building fulfills that mission and is another successful integration of dream, design, and development.

To learn more about TGB Architects, visit their web site at www.tgbarchitects.com, send an email to Info@TGBArchitects.com or call 425-778-1530.

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Requirements:

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Qualifications

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Nurse-Clinical Operations Specialist

Focus on nursing quality measures and competencies. Clinical training of our staff. Support to lead Physician. Serves as a resource and facilitator, in conjunction with the manager, to identify clinical improvement opportunities and subsequent clinical process improvements. Examples include analysis of medication administration by Medical Assistants and appropriate sterilization of instruments.

Requirements:

RN licensure. BSN preferred but not required. Minimum of 5 years nursing experience. Excellent verbal and written communication skills. Experience in leading quality and safety initiatives. Ability to manage multiple projects in varying stages of development

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Requirements:

Minimum 2-3 years supervisory experience in a medical office setting, medical business office setting, or insurance industry setting. Knowledge of clinic operational areas. Strong leadership skills. Strong interpersonal and problem solving skills, and the ability to confront and address issues with staff. PC utilization and software skills required. Ability to assess performance of employees. Ability to select, train, and develop qualified staff.

To Apply:

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Contract Performance Analyst

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Required Qualifications:

Requires a High Schol Diploma or Equivalency and experience in a health care or payor environment. A strong understanding of payor payment rules, CPT/ICD-9 coding, bundling edits and contracting methodologies is preferred.

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Operations Supervisor - Specialty Care Department

Responsible for supervising minimum of 25 Medical Assistants, RN's, Patient Services Reps, Surgery Schedulers and Referral Coordinators.

Requirements:

Minimum 2-3 years supervisory experience in a medical office setting, medical business office setting, or insurance industry setting. Knowledge of clinic operational areas. Strong leadership skills. Strong interpersonal and problem solving skills, and the ability to confront and address issues with staff. PC utilization and software skills required. Ability to assess performance of employees. Ability to select, train, and develop qualified staff.

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Implementation Project Manager

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Bachelor's degree required. Clinical and information technology education preferred. Minimum of five years of healthcare experience, ideally in a physician practice setting. Demonstrated knowledge of ambulatory practice workflow processes essential. Strong project management experience is required. Experience with implementing practice management or electronic medical records software in an ambulatory care setting is preferred.

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Nurse-Clinical Supervisor Special Procedures Suite

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Requirements:

Experience in clinic management in medical office setting. Prefer those with experience in an ambulatory surgery center or endoscopy suite environment. A combination of education and experience equal to a Baccalaureate Degree.

To Apply:

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Senior Training and Development Specialist

This position develops training and department level OD programs to achieve strategic business goals and operational objectives. These programs may include competency development, development planning, leadership development, career development programs and skills training.

Minimum Qualifications

Bachelors degree in Organizational Development, Training and Development, Human Resources or related program.Four years of job related progressive experience in Organizational Development and/or staff development with demonstrated competence in training and development design, service delivery, and evaluation, or a comparable combination of education and experience.

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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 09-30-08	Total Margin YTD 09-30-08	Total Margin/ Total Charges 09-30-08	Total Discharges YTD 09-30-08	Total Days YTD 09-30-08
Swedish Medical Center	WA	$1,694,386,455	$17,272,834	1.0%	26,006	108,592
Providence St. Vincent Medical Ctr.	OR	$930,161,000	$6,165,000	.7%	23,338	106,835
Sacred Heart Medical Ctr.-Spokane	WA	$1,196,738,302	$20,508,702	1.7%	23,192	120,426
OHSU Hospital	OR	$1,192,418,050	$25,055,512	2.1%	21,455	113,878
Sacred Heart Medical Center-Eugene	OR	$600,865,589	$62,169,661	10.3%	19,934	88,715
Providence Reg. Med. Ctr. Everett	WA	$921,305,341	$18,712,205	2.0%	18,836	77,725
St. Joseph Medical Center - Tacoma	WA	$1,181,465,967	$41,633,868	3.5%	17,299	74,145
Providence Portland Medical Center	OR	$743,787,000	$6,057,000	.8%	17,112	78,900
Salem Hospital	OR	$571,542,081	$21,018,030	3.7%	15,436	66,606
University of WA Medical Center	WA	$765,181,864	$32,878,477	4.3%	15,192	82,964
Overlake Hospital Medical Center	WA	$568,102,203	$20,200,797	3.6%	14,842	51,672
Providence St. Peter Hospital	WA	$742,660,425	$11,608,871	1.6%	14,503	64,572
Legacy Emanuel Hosp. & Health Ctr.	OR	$717,171,118	($239,961)	0.0%	14,114	79,667
Harborview Medical Center	WA	$910,884,000	$15,378,000	1.7%	14,093	103,348
Tacoma General Allenmore Hospital	WA	$1,231,591,670	$43,874,364	3.6%	13,736	62,704
Harrison Medical Center	WA	$475,377,852	$17,426,637	3.7%	13,144	50,730
Virginia Mason Medical Center	WA	$918,980,999	$13,465,095	1.5%	12,664	62,041
Valley Medical Center	WA	$599,195,300	$2,508,711	.4%	12,438	41,348
Evergreen Healthcare	WA	$498,285,151	$6,469,456	1.3%	11,749	40,820
St. Joseph Hospital - Bellingham	WA	$451,423,626	$5,070,160	1.1%	11,672	48,797

[1]Source: National Association of Insurance Commissioners. [2]Sources: WA State Department of Health; OR Health Policy & Research. Southwest Washington Medical Center (WA) and Kaiser Sunnyside Medical Center (OR) are among the 20 largest hospitals but they did not report complete information and, accordingly, their financial results were intentionally ommitted.

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