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Articles, Interviews and Statistics for the Healthcare Executive

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Hospital Medicare Reimbursement: Moving to Reimbursement Based on Quality of Care

By Carla M. DewBerry
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By Stephen Rose
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The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education Affordability Reconciliation Act of 2010 (collectively "Healthcare Reform") will force a dramatic change in the Medicare payment methodology.[1] Within the next two-and-a-half years Medicare will undergo a complete transformation so that Medicare reimbursement will be based on *quality* of care delivered and not just *quantity* of care delivered. In order to compel this change in Medicare payment methodology, Healthcare Reform not only sets in place the process to establish financial rewards for hospitals that attain certain quality measures and improve from baseline measurements, but also penalizes hospitals financially for poor performance or failure to improve.

This article explores a few of the ways in which changes to Medicare reimbursement for hospitals will create winners and losers under Medicare since some hospitals will receive additional money under Medicare and others will receive less.

A Carrot (maybe)—Hospital Value-Based Purchasing

Healthcare Reform directs the Secretary of the Department of Health and Human Services (HHS) to establish for implementation by fiscal year 2013, a hospital value-based purchasing (HVBP) program. The HVBP will establish positive incentive payments for each fiscal year for hospitals that meet or exceed the performance standards of the HVBP for that fiscal year. Since the HVBP is to be implemented for fiscal year 2013, it will apply to Medicare payments for discharges occurring on or after October 1, 2012.

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If you need help setting this up, call me at 425-577-1334 and I'll walk you through the process. Until next month,

David Peel, Publisher and Editor

Washington Healthcare News 2010 Editorial Calendar

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

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< **Reimbursement, from P1**

The performance standards or measurements, once decided upon, must be posted on the "Hospital Compare" website maintained by HHS. No measure may be included for use in the HVBP unless it has been identified and posted on "Hospital Compare" at least 60 days before the beginning of the fiscal year.

For fiscal year 2013, HHS is directed to contain measures that include at least the following five specific conditions or procedures: (1) acute myocardial infarction; (2) heart failure; (3) pneumonia; (4) surgeries; and (5) healthcare associated infections.

For fiscal year 2014 and beyond, HHS is directed to establish performance standards taking into account factors such as: (1) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during the previous performance periods; (2) historical performance standards; (3) improvement rates; and (4) the opportunity for continued improvement.

HHS is directed to develop a methodology for assessing the "total performance" for each hospital based on the performance standards established which will result in a "hospital performance score." The methodology established must ensure an "appropriate distribution" of value-based incentive payments among hospitals achieving different hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments. Each hospital will receive as its "hospital performance score" the achievement score, which measures its ability to meet or exceed the performance standards, or its improvement score, which measures its improvement as compared to an established baseline, whichever is higher.

The starting point for Medicare payments for hospitals will be their "base DRG payment amount." Beginning in fiscal year 2013, every hospital will have its "base DRG payment amount" reduced for each fiscal year (prior to considering any value-based incentive payments awarded to the hospital) as follows:

(i) Fiscal year 2013 base DRG payment reduction, 1.0 percent;

(ii) Fiscal year 2014 base DRG payment reduction, 1.25 percent;

(iii) Fiscal year 2015 base DRG

payment reduction, 1.50 percent;

(iv) Fiscal year 2016 base DRG payment reduction, 1.75 percent; and

(v) Fiscal year 2017 and beyond, base DRG payment reduction, 2.00 percent.

The reductions in Medicare payments noted above will then be used to fund the payments for the hospital value-based incentives. The total cost to Medicare for the HVBP program must be budget neutral. Therefore, the amount paid out for value-based incentives cannot exceed the amount collected by the base DRG payment reductions noted above.

The bottom line for hospitals is that their Medicare payments will be reduced automatically and they will suffer overall reductions in Medicare payments unless they can recoup these guaranteed loses through the HVBP program or some other new payment source.

The First Stick—
"Excessive Readmissions"

In addition to the financial incentives noted above, Healthcare Reform also contains financial reductions in Medicare payments as disincentives. For example, beginning in fiscal year 2013, if a hospital experiences "excessive readmissions" when compared to "expected" levels of readmissions for certain conditions, the hospital's Medicare inpatient payments will be reduced. Healthcare Reform identifies three initial conditions to evaluate for "excessive readmissions": (1) heart attack; (2) heart failure; and (3) pneumonia. The reduction in Medicare payments would be the larger of a floor adjustment factor established under the Healthcare Reform laws[2] and the "excess readmissions ratio."[3] Beginning with fiscal year 2015, HHS is instructed to expand the list of applicable conditions beyond the three noted above to include the conditions identified by the Medicare Payment Advisory Commission in its report to Congress in June of 2007 and also include "other conditions and procedures as determined appropriate by [HHS]." HHS is also instructed to make all of the readmission rate information available to the public. Hospitals will be provided with the opportunity to review and comment on their hospital-specific data prior to this information being made public.

It should be noted that this portion of the Medicare payment changes does not apply to critical access hos-

Please see> Reimbursement, P6

< Reimbursement, from P5

pitals or post-acute care providers.

The Second Stick—Payment Adjustments for "Hospital Acquired Conditions"

Beginning in fiscal year 2015, and thereafter, hospitals in the top 25 percent of all hospitals for certain hospital acquired conditions ("HAC") for the previous fiscal year will have their payments for discharges for the current fiscal year set at 99 percent of the amount of payment that would otherwise have applied to the discharges. In other words, hospitals that make it into the top 25 percent for HACs for the prior fiscal year will have their payments reduced by 1 percent in the current fiscal year.

The Inpatient Prospective Payment System (IPPS) Final Rule issued in

fiscal year 2009 by CMS included 10 categories of conditions that were identified as "Hospital Acquired Conditions": (1) foreign objects retained by the patient after surgery; (2) air embolisms; (3) blood incompatibility; (4) Stage III and Stage IV pressure ulcers; (5) falls and traumas (e.g. fractures and dislocations); (6) manifestations of poor glycemic control such as diabetic ketoacidosis; (7) catheter-associated urinary tract infections; (8) vascular catheter-associated infections; (9) surgical site infections; and (10) deep vein thrombosis (DVT)/pulmonary embolism associated with total knee replacement or hip replacement.

In addition to the 10 identified above, HACs will also include "any other condition determined appropriate by [HHS] that an individual acquires during a stay in an applicable hospital. . . ."

Conclusion

This article touches on only a very small portion of Healthcare Reform and its impact on Medicare payments to hospitals. There are many other incentives and disincentives included within the Healthcare Reform laws. Healthcare Reform will directly impact what Medicare pays and how hospital payments are calculated. Hospitals should begin now assessing their capabilities to meet the expected new quality standards and make the necessary adjustments to ensure full Medicare payments in the future.

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[1]The "official" name of Title III of the Patient Protection and Affordable Care Act is "Title III—Improving the Quality and Efficiency of Health Care; Subtitle A—Transforming the Health Care Delivery System; Part 1—Linking Payment to Quality Outcomes Under the Medicare Program.

[2]The floor adjustment factors are: for fiscal year 2013, 1 percent; for fiscal year 2014, 2 percent; and for fiscal year 2015 and subsequent fiscal years, 3 percent.

[3]The excess readmissions ratio is defined as 1 minus the ratio of the aggregate payments for excess readmissions and the aggregate payments for all discharges.

$15.6 Billion Returned to the Medicare Trust Fund from all Fraud Audit Recoveries Since Inception in 1997

By Donna Herbert
President and Founder
Financial Consultants of AK & WA

The Health Care Fraud and Abuse Control Program (HCFAC) has returned over $15.6 Billion to the Medicare Trust Fund since the inception of the program in 1997.

The Affordable Care Act (ACT) will provide an additional $350 million over the next ten years, beginning in fiscal year 2011. The ACT will coordinate detection and prevention of fraudulent Medicare and Medicaid billing practices and reduction of related payment errors under the newly created CMS Center for Program Integrity. This builds on recent successes of the Department of Justice (DOJ) and Office of Inspector General's (OIG) joint administration of the Health Care Fraud & Abuse Control (HCFAC) Program. The Health Care Fraud Prevention & Enforcement Action Team (HEAT) is responsible for recovering over a billion dollars in Medicare and Medicaid improper payments under the False Claims Act.

HCFAC reported that in fiscal year 2009, $2.51 billion in Medicare and $441 million in Medicaid payments were recovered, a 29% and 28% increase over 2008 respectively. There has been $4 billion in court-ordered fines, penalties, monetary restitution and settlements resulting from OIG investigations and criminal prosecution. CMS estimates that $24.1 billion in Medicare payments, or 7.8% of all Medicare fee-for-service claims, were *improperly* paid.

Similarly, CMS reports that a sample of Medicaid claims in 17 states, (one-third of the country including Alaska, Washington, Oregon, Montana and Hawaii) were audited under its Medicaid Payment Error Rate Measurement (PERM) program. The audit showed that 8.71% claims were improperly paid in fiscal year 2008, compared to a Medicaid payment error rate of 10.5% in fiscal year 2007 for claims audited in 17 other states (including California). CMS' extrapolation of these results estimates $35 billion in improper payments of the federal share of the Medicaid program were made during fiscal years 2007 through 2008.

Medicaid fee-for-service claims audited in fiscal year 2008 showed reported top causes for payment error were: Insufficient or No Documentation (35%) including non-response to documentation request; Non-Covered Service (17%) including billing unit errors; and Administrative/Data Processing (14%) errors, including ineligible patient or provider, or untimely claim filing.

Recovery Audit Contractors (RAC) and Medicaid Integrity Contractors (MIC) have many differences, according to the Director of Field Operations for the CMS MIG. As an entity, the MIC is more imposing than RAC, but their impact is more likely to be focused on a smaller number of providers while leaving others unscathed. Some of the differences are important. MIC's are not paid based on contingency fee. MIC audits can "Look-Back" at accounts older than three years. The exact "Look-Back" period is state specific. MIC auditors can review accounts that have been previously reviewed by another entity. MIC audits can request unlimited numbers of records, and most troubling is that the provider has only two weeks to prepare what could be hundreds of accounts.

In May 2010, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced a new collaborative initiative between the Department of Health and Human

Services (OIG) and (DOJ) that expands anti-fraud, waste, abuse and payment recovery enforcement activities. This will include a significant increase of provider post-payment audits, recoupments, civil and criminal actions.

It's no wonder that the Affordable Care Act also authorizes the expansion of the Recovery Audit Contractor (RAC) program to Medicaid, Medicare Part C (Medicare Advantage plans) and Part D (Medicare Prescription Drug program). This will be implemented no later than December 31, 2010. Final rules that detail specific contingency-based audit program requirements for Medicaid, and mandate individual states to contract with one or more RACs by year-end, are expected for release by this Fall. This will be in addition to the currently expanding MIC.

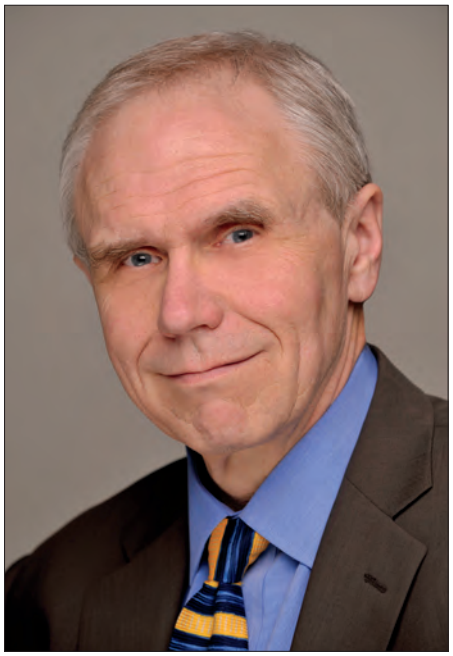
Unfavorable PERM audit trends, mounting budget deficits, and increasing federal pressure to comply with CMS program accountability requirements and reduce Medicaid program costs will be contributing factors to an expected new wave of aggressive program audit and payment recovery activities at the state level. As data mining and analysis technology improves, an auditor will be able to compare provider payment patterns to quickly target abhorrent trends that indicate possible fraudulent billing. The MIC Auditor for the western region states is Health Management Systems (HMS). HMS will be sending out provider audit notification letters, so it is critical that facilities ensure that their point-of-contact information is up to date and designates a centralized coordinator of the compliance audit response team. HMS is still in the process of finalizing its audit rollout procedures and document request requirements for our region in coordination with state officials, but is expected to begin the provider notification process by late summer/early fall.

Donna Herbert is the founder of Financial Consultants of Alaska & Washington (FCAW). Since 1979, she has provided advice and counsel to healthcare providers in Alaska, Washington, Oregon and California concerning all aspects of budget, finance, and preparation of third-party cost reports. She can be reached at fcaw@fcawreimbursement.com.

FCAW clients include acute care, critical access facilities, long term care facilities, rural clinics and federally qualified health centers. To learn more visit the FCAW web site at www.fcawreimbursement.com.

Leadership 101: Are You Paying Retail?

By Ward Harris
Managing Director
McHenry / Epoch, Inc.



Lake Tahoe

I was recently honored to attend the 58th Annual Meeting of the Association of California Healthcare Districts (ACHD).

On the shores of Lake Tahoe, representatives from the member districts listened to industry leaders on topics important to management of these government instrumentalities in the midst of very trying times.

Hospital and healthcare district leadership face a diverse range of challenges and opportunities.

Their work is important and often difficult - especially in light of today's economic, regulatory and investment environments. These challenges are beyond their control or influence.

Trustees and staff also deal with expanded responsibilities that come with the role of retirement plan trustee and fiduciary.

In this role, a key question is how to effectively manage organizational, professional and personal risks.

At the conference, I delivered a presentation on the subject of fiduciary oversight of hospital retirement plans and foundation investment accounts.

For this audience, the proffered perspective was that of a board member, trustee or senior executive.

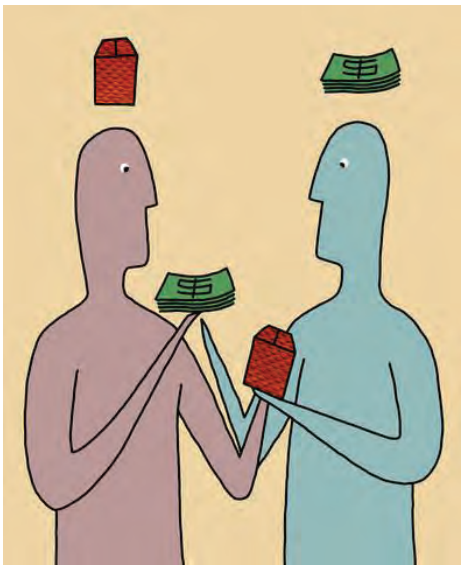
Timely Topics

At the core of our presentation were issues related to best practices in the role of institutional employer and investor.

Popular themes for the attendees were regulatory changes and investment trends for:

- 403(b) plans
- 457 plans
- 401(k) plans
- pension plans
- executive compensation plans
- foundation & endowment portfolios

Investment risk and return, operating expense and the efficacy of



investment advice were all popular segments of the presentation.

The Big Question

One of the district trustees asked an astute question: "How do we know if our benefits / finance team is getting a good deal on our retirement plan services for our district and our employees?"

A reasonable question and one that bears a considered answer.

"If you can't measure it, you can't manage it" is a quote variously attributed to Lord Kelvin, Albert Einstein, Bill Hewlett and Arthur Deming, among others.

They Were Right

Fiduciary standards and regulations require that employers manage their responsibilities with the skill and diligence of a prudent person. If you don't measure, compare and document your review of

your own performance, how can you show a regulator, a plan participant or an outside board member that you have "done the right thing"?

Key elements of a plan compliance process include:

1. Plan Performance & Expenses;
2. Peer Data & Your Comparative Performance; and
3. Provider Pricing / Best Practices

If it appears that you are paying more than others for investment and administrative services, best practices suggest that you: negotiate, seek alternatives and if necessary, change vendors.

Unfortunately, industry practices and vendor business interests often result in poor access or inaccurate data on peer pricing and reasonable service costs.

Why Can't We Get The Data?

You can.

There are hundreds of hospitals and clinics in the Western states, all dealing with the same issue. It requires a little expense, a bit of effort and a commitment to the process.

Can We Get Better Service Pricing?

You can and should. Everything is negotiable.

Today, healthcare providers partner to buy supplies, equipment and services through the power of combined price negotiation.

It is possible to realize similar economies in the acquisition and management of employee retirement plans, as well as foundation and endowment investment accounts.

Good micro (plan) and macro (peer) data is required to benchmark your results and costs, while industry access and information is required to effectively negotiate with vendors.

See the Presentation?

If you would like to view a recording of the ACHD presentation on board/management oversight of retirement plans and investment accounts, send an email to:

info@mchenrypartners.com

We will send you the link via email.

There are over 150 public health and hospital districts in the Western states and hundreds more hospitals and clinics in the for-profit and not-for-profit space.

From experience, we see that many healthcare employers are over-paying for services. At the very least, they should be tracking their relative performance and expenses.

Find Friends

As a group, you have a great opportunity - whether small, medium or large employers or investors.

Build shared resources with organizations and fellow professionals with a desire to measure and manage these issues at the board or staff level.

You Are Not Alone

Institutional employers and investors deserve better information, access and leverage.

If you would like to network with other interested organizations, please give me a call.

Good data, some benchmarking and a common sense approach to vendor management can pay great dividends in the form of risk management and plan performance - not to mention reduced operating costs.

Ward Harris supports institutional employers and investors through data management services and fiduciary consulting relationships. He can be reached at 1-800-638-8121 or ward.harris@mchenrypartners.com.

How Outpatient Hospital Reimbursement Works

By Dwight Johnson, FHFMA
Executive Director
of Provider Contracting
Coopersmith Health Law Group

Outpatient hospital reimbursement has undergone a dramatic evolution. In the "old days" (circa 1986) outpatient hospital reimbursement was often an afterthought. DRG based inpatient reimbursement was still relatively new. Many commercial contracts paid outpatient activity on a percent of charges.

Things were beginning to change, though. The catalyst was the federal government. The feds realized that the DRG system established by Medicare in 1983 was beginning to control inpatient expense.

However, Medicare also recognized that outpatient activity was still uncontrolled and the volume of outpatient care was increasing dramatically. As such, Congress passed legislation in 1986 ordering the old Healthcare Financing Administration (HCFA, remember?) to begin laying the groundwork for an outpatient prospective payment system (OPPS) which would affect outpatient reimbursement in a manner similar to DRGs.

After many years and many fee schedules HCFA implemented Ambulatory Patient Groupings (APGs). I helped implement APGs for the old Blue Cross of Washington and Alaska (BCWA, remember them?)/Premera in the mid-late 1990s. Note the general pattern of the federal government establishing a payment methodology which was subsequently mimicked by the commercial insurance industry. True to form, when the government moved away from APGs in favor of the more comprehensive Ambulatory Patient Classifications (APCs), most commercial carriers followed suit.

Today most outpatient hospital reimbursement is OPPS based, increasingly driven by APCs, and attempts to eliminate as much percent-of-charge based reimbursement as possible. It is tempting to think of APCs as "outpatient DRG's." In reality, APCs are very complex and a more sophisticated reimbursement format than DRGs and their variants.

OPPS based payment methodologies typically include fixed payments for surgeries and significant procedures, emergency department treatments, radiology, chemotherapy, radiation therapy, pathology, clinic visits, diagnostic services and implants and supplies.

Additionally, most carriers have linked reimbursement for drugs, especially high cost drugs, to OPPS even though they may not technically fall under a methodology like APCs.

The wizards who gave us APCs created a system that groups outpatient care into classifications based on resource consumption. Like DRGs, APCs are assigned weights which are multiplied by a conversion factor to arrive at an amount of reimbursement. Unlike DRGs, there can be multiple APCs on a given claim. If a patient has two outpatient procedures with a hip x-ray, three APCs will potentially be assigned and paid. If someone has an outpatient procedure with a hand x-ray, two APCs may be assigned and paid. Conversely, if these types of care were delivered on an inpatient basis, there would only be one DRG assigned in each separate case.

The increased complexity of the APC methodologies often confounded hospital billers and expected reimbursement systems when they were rolled out, especially when the number of APCs on a single claim were 9 or 10 instead of 2 or 3.

The government and commercial carriers also established APC bun-

dling and packaging techniques often described benignly as measures encouraging increased hospital efficiency when delivering outpatient services. That is a polite way of saying that services that used to be reimbursed would no longer be paid. Bundled and packaged services typically include anesthesia, supplies, and drugs, which are often grouped into the payment for a particular APC on a claim, usually one for a significant procedure performed.

APC based OPPS also include multiple procedure discounting. This occurs when more than one significant procedure is allowed on a claim, but full payment is made only on the procedure with the highest weighted APC. Procedures performed with lower weighting are paid at a discount of the regular APC allowable, often 50%. Many carriers use a 100/50/25% format, meaning they will pay 100% of the allowable of the highest weighted procedure, 50% of the allowable of the next highest weighted procedure, and 25% of the allowable on any procedures remaining.

Depending on the carrier, OPPS/APCs can become much more complex. Think Geometric Means, Wage Index Adjusting, Status Indicators (including the notorious Status Indicator C) and the like.

Finally, those remaining services not paid via OPPS are typically reimbursed on some variant of a CMS fee schedule; the commercial carriers' frequent use of the CMS clinical lab fee schedule is a prime example.

In conclusion, outpatient hospital reimbursement has evolved from being an afterthought to perhaps the most complex piece of the hospital reimbursement puzzle. As such, a thorough understanding of outpatient hospital reimbursement can only benefit a hospital's bottom line, now and in the future.

Dwight Johnson is the Executive Director of Provider Contracting at Coopersmith Health Law Group. Dwight has an extensive background in provider contracting. His experience includes six years as the Assistant Director of Provider Contracting at Regence BlueShield, where he was responsible for all provider contracting, and five years with Premera BlueCross where he was responsible for all hospital and ancillary contracting in Washington and Alaska. He can be reached at 206-343-1000 or dwight@coopersmithlaw.com.

Washington Courts Confirm Scope of Washington Peer Review Act and Award Attorney Fees to Prevailing Hospital

By Renee M. Howard
Shareholder
Bennett Bigelow & Leedom, P.S.

Hospitals, physicians and other healthcare providers who engage in peer review should familiarize themselves with Washington's Peer Review Act, RCW 7.71 *et seq.*, a statute that provides substantial protections to participants in peer review, and mandates the award of attorney fees to victorious parties in peer review challenges.

The Peer Review Act is "the exclusive remedy" in Washington for an "action taken by a professional peer review body of health care providers . . . that is found to be based on matters not related to the competence or professional conduct of a health care provider." The Act adopts the provisions of the federal Health Care Quality Improvement Act ("HCQIA"), which protects participants in peer review from damages liability under state law, provided certain procedural requirements of the HCQIA are met.

Through the Peer Review Act, the Washington legislature has limited peer review actions to "appropriate injunctive relief," and, if HCQIA damages immunity is found not to apply, limits damages to "lost earnings directly attributable to the action taken by the professional review body." The Act also provides for a mandatory award of attorney fees to the party that prevails in a peer review case.

Until recently, there were few court interpretations of the scope of the Peer Review Act. In the earliest opinion to consider the Act, *Morgan v. PeaceHealth*, 101 Wn. App. 750, 14 P.3d 771 (2000) (Div. 1), the court of appeals devoted most of its analysis to the HCQIA, and found that the defendant had met the requirements for damages immunity. While the court did discuss a request for an award of attorney fees, it analyzed the appropriateness of fees under the HCQIA, and did not address the attorney fee provision of the Peer Review Act.

Since *Morgan*, two divisions of the court of appeals have affirmed the applicability of the Peer Review Act to hospital disciplinary actions, and saddled the complaining physician with substantial attorney fee liability as a result. Most recently, on April 22, 2010, the Division III Court of Appeals affirmed that a hospital appropriately terminated a physician's medical staff privileges, and affirmed the award of substantial attorney fees associated with the lawsuit. *Perry v. Rado*, -- P.3d --, 2010 WL 1610746 (Apr. 22, 2010). In *Perry*, an obstetrician challenged his termination in a suit against Kadlec Regional Medical Center, its medical staff, a now-defunct competitor group practice, and various individual physicians. He initially filed suit in federal court, alleging antitrust violations, but his federal claims were dismissed due to a failure to adequately allege harm to consumers, a decision affirmed last year. 504 F. Supp. 2d 1043 (E.D. Wash. 2007), *aff'd*, No. 07-35684 (9th Cir. Aug. 6, 2009). His state court case sought damages and reinstatement of his privileges. The court of appeals affirmed that the hospital was immune from damages liability under the HCQIA, and that his state common law claims were barred because the Peer Review Act provides the exclusive remedy for peer review discipline. The defendants were awarded more than $386,000 in trial court attorney fees plus their fees on appeal.

At around the same time, Division

I of the Court of Appeals issued an opinion in another peer review case, *Cowell v. Good Samaritan Community Health Care*, 153 Wn. App. 911, 225 P.3d 294 (2009). There, the court affirmed that Good Samaritan was immune from damages liability under the HCQIA, and also affirmed an award of about the same sum of attorney fees as was awarded in *Perry*, despite the plaintiff's protest that she was "merely testing the scope of a statute on which there is no law."

A final, but significant, aspect of the Peer Review Act is its very short statute of limitations. The Act requires that all claims be asserted within one year of the peer review body's action. The author recently represented a hospital that successfully argued that a physician's claims for breach of contract and tortious interference stemming from his previous voluntary relinquishment of his clinical privileges arose under the Peer Review Act, and thus were untimely under the Act's one-year statute of limitations. *Sambasivan v. Kadlec Regional Medical Center*, No. 08-2-01534-1 (Benton County). As the prevailing party, the hospital was again awarded its attorney fees.

The legislature designed the Washington Peer Review Act to create a formidable barrier to suits by physicians who are unhappy with peer review actions. Recent decisions in three different cases demonstrate judicial antipathy towards such cases, and confirm the threat of substantial liability for physicians who wrongfully accuse a hospital of misbehaving. Hospitals and physicians should take note that physician challenges to peer review action face a steep uphill battle before the Washington courts.

For additional information, please contact Renee M. Howard or David B. Robbins at (206) 622-5511.

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healthcare marketing reform

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Founded in 1936, The Vancouver Clinic is a multi-specialty clinic located in Vancouver Washington, just north of Portland Oregon. The Clinic is a privately held, physician-owned clinic, with over 700 staff members and 190 providers. The Clinic is one of the region's principal health care providers, offering extensive services to our patients. We are currently seeking the following key positions.

Clinic Manager

We are looking for an energetic, experienced professional to lead a team of staff providing compassionate medical care. Must have excellent communication and problem solving skills. The manager will work through supervisory staff to oversee the daily operations of specialty departments such as ENT, Orthopedics, Podiatry, Surgery, urology and our Special Procedures Suite. The successful candidate will have approximately 5 years of previous medical experience, preferably in an ambulatory care setting. Prefer those with a Bachelors degree or equivalent combination of education and experience.

Clinic Supervisor

We are looking for an experienced clinic supervisor with the ability to mentor staff and help them flourish. You will provide supervision of clinical and office staff, facilitate staff and patient workflow, and control expenditures. Requires demonstrated ability to interview, select, train, and develop qualified staff. Must be comfortable in a fast-paced environment, detail oriented, and self-directed. The successful candidate will have a min of 2 years supervisory experience in a medical setting.

Clinical Operations Specialist - RN

Would you enjoy a position where you will serve as a resource and facilitator to identify clinical improvement opportunities and subsequent process improvements? Do you enjoy educating others? Be our site clinical educator and trainer for new and existing staff and assure standardization of care and the clinical environment. Looking for nurse with experience leading quality and safety initiatives and ability to manage multiple projects in varying stages.

To apply for any of these positions visit www.tvc.org or call 360-397-3273 for information.

PeaceHealth

Dedicated to Exceptional Medicine and Compassionate Care

CLINIC MANAGEMENT OPPORTUNITIES

PeaceHealth, in Longview, Washington operates PeaceHealth Medical Group, a multi-specialty physician practice, as well as St. John Medical Center, a 200 bed acute care medical center. We currently have the following management opportunities available:

Clinic Manager – SPECIALTY CLINIC:

Our Specialty clinic specializes in Cardiology, Gastroenterology, Neurology,Nephrology, and Pulmonology. Ideal candidate will be an RN with previous management experience in physician clinics or ambulatory care.

Clinic Manager – INMOTION/ORTHO CLINIC

Our InMotion clinics specialize in Orthopedic Surgery, Rheumatology, Interventional Pain Management, and physical medicine and rehab. Ideal candidate will be an RN with orthopedic and management experience.

Positions have responsibility for assessment, analysis, coordination and evaluation of patient care provided within the team. Will facilitate an interdisciplinary, collaborative approach in the delivery of care, evaluates patient care appropriate to the age specific needs of all patients, has the supervisory responsibility and accountability for resource management, including; budgeting, staffing, performance evaluations, handling of grievances, counseling and progressive discipline.

Require a minimum of an AA degree in Nursing, or a Bachelors degree in Business Administration, Accounting, or related discipline, or an equivalent combination of education and prior clinic management experience. Skills in critical thinking, problem solving, communication, customer service, and financial management are required as well.

We offer a competitive salary range and a comprehensive benefits plan. Interested candidates may apply online via our website at www.peacehealth.org. Resumes may be submitted in addition to application, to Lwishard@peacehealth.org:

EOE

VIBRA SPECIALTY HOSPITAL

Pharmacy Director

Exciting Opportunity!

Portland, OR

Looking to turn your hospital pharmacy and management skills in a new direction? We have an immediate opening for an experienced pharmacy manager or director in an exciting new concept and venture in Oregon.

Vibra Specialty Hospital of Portland specializes in acute care for the medically complex patient for an extended stay. Our patients are admitted on a referral basis from local hospitals. We provide progressive care for our patients as part of a care plan that will ready them for rehab, skilled nursing or home care.

We have an outstanding wound care program, significantly higher than the national average vent weaning rates, and daily rounding and interventions by our hospitalist and specialist medical staff team.

Qualifications: Pharmacist with a B.S. degree in Pharmacy from a NABP accredited College of Pharmacy program, Pharm D strongly preferred, must possess a current Oregon license and have previous acute care hospital pharmacy experience. Must be knowledgeable of acute care hospital Pharmacy regulations and practices. 3 years of previous Pharmacy management experience is required.

You will be excited about the potential and the possibilities of our unique, new venture! Join us!

Please apply online only at:
WWW.VibraJobs.com

Equal Opportunity Employer
A Vibra Healthcare Facility

Career Opportunities

To advertise call 425-577–1334
Visit **wahcnews.com** to see all available jobs.

Family Birth Center Director

Grays Harbor Community Hospital has an excellent career opportunity for a dynamic individual to manage and grow our Family Birth Center.

Summary: Registered Nurse responsible for the 24-hour, seven days per week administration and supervision of the Family Birth Center. The Director is a member of the Nursing Administration Team and reports directly to the Chief Nursing Officer.

Requirements: BSN preferred; current RN licensure in Washington State; minimum 3 years clinical experience in OB/L&D/post-partum; and 2 years leadership/supervisory experience.

This position is full time with excellent salary and benefits provided. For further information please visit our website at: **www.ghchwa.org**. Please submit your resume and application to the Human Resource Department.

Grays Harbor Community Hospital
915 Anderson Drive
Aberdeen, WA 98520
Fax (360) 537-5051

Nursing Director, Medical-Surgical and Critical Care

The nursing department director provides 24-hour direction for the nursing care and related operational/personnel activities for a specific department. Under the guidance of the Patient Care Administrator/CNO ensures the effective operation of the nursing department. This position is also responsible for performing duties consistent with the policies, procedures, mission, vision, guiding principles and manager accountabilities of KVCH.

REQUIREMENTS

Required: BSN. Previous related nursing experience. Previous related Leadership/Supervisory experience.

Preferred: Masters degree in nursing, business or related health field.

Qualifications: Experience in improving organizational performance. Experience in facilitating and leading multidisciplinary teams. Clear, concise and persuasive writing and presentations skills. Ability to present data to professional groups and institute changes based on the data presented. Decisive and capable of exercising good judgment under pressure. Demonstrated ability to organize and work with diverse groups of people. Strong orientation to deadline and detail. Effective problem solving, decision-making and team development skills. Ability to manage a diverse and demanding workload. PC Skills, knowledge or MS Word, PowerPoint and Excel essential. Working knowledge of Patient Centered Care and Lean concepts desired.

Additional Salary Information: DOE

Apply at www.kvch.com

Executive Medical Director

The Children's Hospital at Providence in Anchorage, AK is recruiting for an experienced physician leader to serve as its new Executive Medical Director. Position is responsible for the overall operational, financial and business effectiveness of The Children's Hospital at Providence. Accountabilities include: formulate strategy, implement strategic plans, develop and ensure attainment of operating goals and objectives consistent with the strategic objectives and policies established by PAMC and TCHAP. Will oversee recruitment of physicians to TCHAP and manage $130 million facility expansion project that will kick off in 2010. Excellent compensation package, including relocation assistance. Amazing quality of life in Alaska's largest and most modern city.

Requirements:

Advanced graduate training in health or business administration: at least five years of experience in health care; and at least five years of high-level leadership experience. Must be a board-certified Pediatrician or Pediatric Subspecialist physician (M.D. or D.O.).

Contact:

Cindy McCasker
(503) 216-5469 Direct (866) 504-8178 Toll Free
Cindy.mccasker@providence.org

Oncology Practice Manager

Department: KGS Physicians Clinics
Schedule: Full Time-Exempt
Shift: Day Shift
Requisition Number: 9189
Salary: DOQ

Directs the business, technical and nursing support activities in the Oncology Outpatient Clinic. Works with clinic physicians, staff and Oncology Nurse Coordinator to maintain and improve support services. Functional areas may include infusion, laboratory, radiology, pharmacy and other specialty services. Supervises clinic staff, prepares budgets and reports. Responsible for space planning, maintenance, procurement of supplies, and contract services.

Requirements

- Associate Degree Required
- 2-3 year recent oncology clinical experience
- Two Years Supervisory Experience

To apply and learn more contact:

Mike Herber
Senior Leader - Employment & Recruitment
(509) 586-5650 **mike.herber@kphd.org**

Nurse Recruiter

Do you love Kadlec Regional Medical Center? Do you love calling people out of the blue to strike up conversations? Do you love talking about Kadlec Regional Medical Center and why this is such a great place to work? Is customer service your #1 priority? Then, this might be the job for you…

Under the general direction of the Recruitment Coordinator, this position is primarily responsible for the recruitment and retention of RNs, including experienced RN candidates, RN new graduates, Nurse Techs., and Nurse Externs.

Minimum Requirements:

Bachelor's Degree, preferably in Nursing, Human Resources or related field, or an equivalent blend of education and experience; 3 years recruiting experience. Experience in health care recruitment is preferred.

For more information, please contact:

Jennifer Cooper (509) 942-2112
Email: Jennifer.Cooper@kadlecmed.org
or
Kris Gauntt (509) 942-2247.

Director of Surgical Services

The Director of Surgical Services is responsible for optimizing available resources while collaboratively assessing, planning, implementing and evaluating the care of the patient in the OR/PACU/ OPS/GI/Anesthesia. He/she is responsible for leadership and direction to the members of the Surgical Services Health Care Team. This role must coordinate all activities within the Surgical Services departments.

Minimum Requirements

- Bachelor's Degree.
- Current WA State RN License.
- 5 years clinical experience in acute care setting or surgical services.
- BLS, ACLS. Prefer PALS, TNCC

To apply and learn more contact:

Mike Herber
Senior Leader -
Employment & Recruitment
(509) 586-5650 **mike.herber@kphd.org**

Career Opportunities

KGH

Chief Financial Officer

At least 5 years or more comparable experience. To serve as a member of the Executive Team and to direct all functions within the Finance Division, including general accounting, patient financial services, patient access services, property management and information systems. Also, to prepare and monitor annual operating and capital budgets for KPHD and to support all efforts and responsibilities of the Finance and Audit Committee and the Board of Commissioners.

Minimum Requirements

- Bachelor's Degree.
- 5 years related experience.
- Master's Degree and CPA Preferred.

To apply and learn more contact:

Mike Herber
Senior Leader -
Employment & Recruitment
(509) 586-5650 **mike.herber@kphd.org**

WENATCHEE VALLEY MEDICAL CENTER

Assistant Director of Revenue Cycle Management

Responsible for the daily administrative duties associated with charge capture, management and collection of insurance and patient revenue in the Business Office and branch campuses. Position will have a strong focus on hospital business operations and serves as a key member of the hospital management team. Candidates will have strong working knowledge of front and back office operations as they relate to the revenue cycle. Manages a staff of 80 employees. Requires BA degree or significant relevant exp. Coding cert is pref. Min of 5 yrs previous mgmt exp in a hospital business office reqd. Exp managing in a large healthcare business dept strongly desired. Visit us at **www.wvmedical.com** for more info or to apply.

GroupHealth

Clinical Operations Managers

***We* think** you should do something that makes a difference. At Group Health, you'll have a role in changing lives, saving lives, and strengthening the community around us. Management has an important role as part of the team delivering innovative practice and superior patient care service at our Group Health Medical Centers. If you thrive on providing outstanding customer service and the very best patient care, you can use your motivation and management skills to contribute and flourish in this exciting team environment. You will be challenged to grow and learn new management techniques and use cutting-edge technology, so see what's new with Group Health by visiting us on **www.ghc.org**.

Responsibilities include:

By pairing nursing leadership with medical staff in every clinic, we further our goal of ensuring that clinical leaders are engaged directly with front-line staff in the delivery of optimal patient care.

The individual selected for this position in partnership with their physician dyad partner will support and lead the clinical staff and physicians in the implementation of standard processes across service-lines using the LEAN methodology to engage staff and benefit our patients.

The focus of the Clinical Operations Manager will include:

- Spending a significant amount of time in your front line areas.
- Ability to understand and willingness to implement standard work throughout your service lines.
- Desire to observe, mentor, and coach your front line teams.
- Ability and willingness to use visual systems to monitor standard work.
- Ability and willingness to routinely conduct 4-step problem solving sessions (A3 thinking).
- Ability and willingness to create a culture of accountability for achieving results.
- Willingness to engage your local teams in a manner that fosters continual improvement.

Clinics are located in Seattle, Bellevue, Tacoma and Olympia.

Must have BSN or RN w/ related Bachelor's degree and current Washington RN license.

Managerial experience and the ability to lead teams in the development of standard work are essential.

Competitive salary and excellent benefits.

Visit our website for detailed job descriptions
and to complete an application at **www.ghc.org**.

Call Becky Petersen, Nurse Recruiter at
(206) 448-6079;
Petersen.b@ghc.org

Group Health is an Equal Opportunity Employer committed to a diverse and inclusive workforce.

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CIVIL LITIGATION & TRIAL PRACTIC
INSURANCE COVERAGE & BAD FAITH LITIGATIO
HOSPITALS & HEALTH SYSTEMS
FRAUD AND ABUSE COMPLIANCE/DEFENS
HEALTH INFORMATION TECHNOLOGY AND REGULATIO
HEALTH PROFESSIONALS & ORGANIZATIONS
FEDERAL TAXATION
EMPLOYMENT LAW
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HEALTH PLANS
BUSINESS STRUCTURES AND TRANSACTIONS
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David B. Robbins: Litigation & Regulatory Compliance
Amy T. Forbis: Medical Malpractice, Civil Litigation and Trial Practice
Anne M. Redman: Healthcare Business Transaction Regulatory Matters

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