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Articles, Interviews and Statistics for the Healthcare Executive

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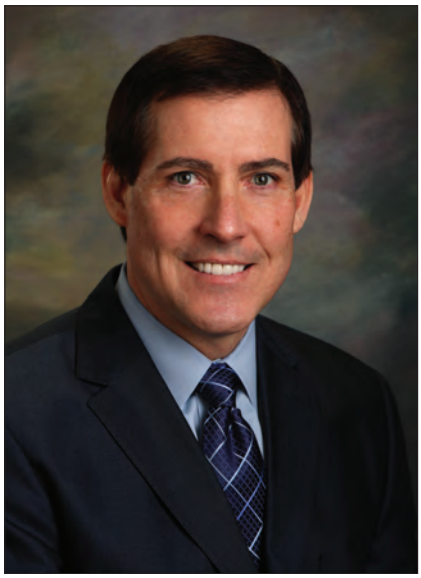
Washington Hospitals Post Strong 2010 Margins

By David Peel
Publisher and Editor
Washington Healthcare News



Washington hospitals posted strong margins in 2010 as thirty-seven of the largest forty hospitals reported positive total margins. The 2010 figures were similar to 2009, when thirty-six of the largest forty hospitals reported positive total margins. See our report on page five to view other key financial information.

Compiling the Information

Of the Pacific Northwest States, Washington is best at making hospital financial information available to the general public. However, it is difficult to report accurate, comparative financial information for several reasons:

- Most hospitals report and are audited on a calendar year basis. However, some large hospitals report and are audited on a fiscal year basis, making comparisons impossible without adjustments.
- All hospitals report to the Washington State Department of Health, Center for Health Statistics (CHS) on a quarterly basis but the figures are unaudited and there's no requirement to restate figures when adjustments are necessary.
- A few hospitals don't regularly meet reporting deadlines.
- Some hospitals and their auditors present dollars received from tax assessments differently than the way CHS requires it be presented. CHS considers it Operating Revenues.

In consideration of these issues, we compiled quarterly figures from the CHS web site and prepared a report similar to the report on page five. We then sent the report to hospital representatives at all forty hospitals and asked them to confirm their hospital's figures. We also asked for correct figures if the figures in the report were wrong.

Hospitals with a "2" to the right of the name provided a reply and confirmed or changed their figures. If a hospital didn't provide a reply, or decided to not provide a reply, there is no "2" to the right of the name and CHS quarterly report web site figures were used. We only had one entity, represent-

Please see> Hospitals, P4

Inside This Issue

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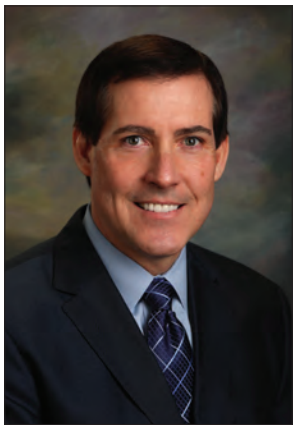
LETTERS TO THE EDITOR

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 send an email to our readers when our web site content changes. Over the last year or so, I've included the statement, "The economy is heating up and healthcare employers are hiring again." This month, one of our readers replied, "The Economy is Heating Up? Where?" This was a fair response.

However, this particular reader works in a reasonably large metropolitan area with a 6.7% unemployment rate, well below the national average rate of 8.7% for metropolitan areas.[1] In addition, the reader has a very high demand occupation.

Since the reader is clearly in good shape with regard to employment and job security, my assumption is he's talking about national economics. Unfortunately, it is nearly impossible to listen to anything our legislators are currently saying without feeling like we're driving off a cliff.

In reality, there are .37 unemployed healthcare workers for every job opening.[2] We've had positive GDP growth each quarter beginning with the 3rd quarter of 2009.[3] Most hospitals, plans and clinics are profitable and forecast the same going forward. Unemployment rates in other industries are high but increases in private sector hiring are being offset by decreases in governmental hiring making it difficult to reduce the overall unemployment rate.

I think it's important to consider our personal situation and not let national concerns take over our thinking, attitude and mindset. We're fortunate to work in an industry that the recession essentially bypassed and is the focus of much of America's current and future spending. My cup is half full.

David Peel, Publisher and Editor

[1]Bureau of Labor Statistics, May 2011. [2]The Conference Board's *Help Wanted Online Report*, May 2011. [3]Burea of Economic Analysis, December 2009.

Washington Healthcare News 2011 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2011	Hospitals	December 1, 2010	December 27, 2010
February 2011	ASCs	January 4, 2011	January 24, 2011
March 2011	Hospitals	February 1, 2011	February 21, 2011
April 2011	Insurance	March 1, 2011	March 21, 2011
May 2011	Clinics	April 1, 2011	April 18, 2011
June 2011	Human Resources	May 2, 2011	May 23, 2011
July 2011	Hospitals	June 1, 2011	June 20, 2011
August 2011	Hospitals	July 5, 2011	July 18, 2011
September 2011	Clinics	August 1, 2011	August 22, 2011
October 2011	Human Resources	September 1, 2011	September 19, 2011
November 2011	Hospitals	October 3, 2011	October 24, 2011
December 2011	Clinics	November 1, 2011	November 21, 2011

< Hospitals, from P1

ing several hospitals, decide to not provide a reply.

We left hospitals out of the report that didn't have complete reporting on the CHS web site.

Operating Revenues

Operating revenues include inpatient and outpatient revenue for all patient care services (less deductions from revenue), tax revenues, the value of donated commodities, revenue from non-patient care services and sales, and activities to persons other than patients.

Thirty-six of the forty hospitals reported higher 2010 operating revenues than 2009. This demonstrates, at a minimum, the Washington hospital industry has leverage with payers and can exert a measure of control over revenues.

Operating Margin

Operating margin is the excess of revenue over expense except for net non-operating gains and losses. This is a key financial metric given it excludes investment gains and losses, a part of net non-operating gains and losses. Investment balances have gyrated up and down since 2008 and can distort an evaluation of hospital industry finances.

Twenty-eight of the forty hospitals reported a lower operating margin in 2010 compared to 2009. This is in sharp contrast to 2009 (not shown) when only eleven of the largest forty hospitals reported a lower operating margin than 2008. Despite an ability to generate increased revenues, in many cases it was not enough to maintain operating margins at 2009 levels.

Operating Margin/Operating Revenue

This statistic, measured as a percentage, is one many hospital administrators target to measure financial health. A range between 4% and 8% is considered healthy and normal for Washington. Percentages higher or lower than this range generally bear further examination, particularly if it has occurred over a two year period. However, that level of analysis is beyond the scope of this article.

Net Non-Operating Gains and Losses

Revenue and expenses not directly tied to patient care, related patient services, or the sale of related goods, are net non-operating gains and losses. The stock market made a remarkable rebound in 2009 and should be considered when comparing to 2010 numbers.

Total Margin

The excess of revenue over expenses and gains over losses generated from all sources is the total margin. Twenty-three of the forty hospitals reported a lower total margin in 2010 than 2009. This can be compared to 2009 (not shown) when only seven of the forty hospitals reported a lower total margin than 2008.

Final Observations

Washington hospitals are in good financial shape and have demonstrated the ability to exert control over revenues and expenses. However, the trend downward in total operating margin is concerning in light of healthcare reform and state and federal cuts targeting reimbursement to hospitals.

Washington State Hospital Financial Results (000's)

Forty Largest Hospitals Sorted by 2010 Operating Revenues[1]

Hospital Name	Operating Revenues			Operating Margin			Op. Margin/Operating Revenues			Net Non-Operating Gains/Losses			Total Margin		
	YTD 12/10	YTD 12/09	Change	YTD 12/10	YTD 12/09	Change	YTD 12/10	YTD 12/09	Change	YTD 12/10	YTD 12/09	Change	YTD 12/10	YTD 12/09	Change
Swedish First Hill[2]	968,033	927,026	41,007	87,044	67,952	19,092	9.0%	7.3%	1.7%	49,987	76,537	-26,550	137,031	144,489	-7,458
Virginia Mason Medical Center[2]	852,752	819,931	32,821	38,891	47,383	-8,492	4.6%	5.8%	-1.2%	3,908	69	3,839	42,799	47,452	-4,653
University of Washington Medical Ctr.	825,737	782,474	43,263	56,027	60,066	-4,039	6.8%	7.7%	-0.9%	5,916	3,198	2,718	61,943	63,264	-1,321
Harborview Medical Center	778,285	754,942	23,343	-20,215	8,624	-28,839	-2.6%	1.1%	-3.7%	-553	6,676	-7,229	-20,768	15,300	-36,068
Seattle Children's Hospital[2]	768,221	723,948	44,273	50,835	66,245	-15,410	6.6%	9.2%	-2.5%	9,277	36,155	-26,878	60,112	102,400	-42,288
Providence Sacred Heart Medical Center[2]	715,600	700,696	14,904	40,948	38,847	2,101	5.7%	5.5%	0.2%	12,013	6,403	5,610	52,961	45,249	7,712
Tacoma General Allenmore Hospital[2]	655,920	644,630	11,290	52,692	70,761	-18,069	8.0%	11.0%	-2.9%	-411	-363	-48	52,281	70,398	-18,117
St. Joseph Medical Center - Tacoma[2]	618,491	572,556	45,935	78,153	66,628	11,525	12.6%	11.6%	1.0%	4,957	4,336	621	83,111	70,964	12,147
Providence Reg. Medical Center Everett[2]	527,909	501,764	26,145	32,605	37,261	-4,656	6.2%	7.4%	-1.2%	-3,391	91	-3,482	29,213	37,352	-8,139
PeaceHealth Southwest Medical Ctr.	527,250	494,667	32,583	4,837	11,348	-6,511	0.9%	2.3%	-1.4%	42,218	642	41,576	47,055	11,990	35,065
Valley Medical Center	423,110	401,744	21,366	12,801	18,343	-5,542	3.0%	4.6%	-1.5%	-2,686	-496	-2,190	10,115	17,847	-7,732
Evergreen Hospital Medical Center	417,779	406,662	11,117	-11,016	17,879	-28,895	-2.6%	4.4%	-7.0%	26,447	-9,445	35,892	15,431	8,434	6,997
Overlake Hospital Medical Center[2]	411,981	392,572	19,409	34,359	36,316	-1,957	8.3%	9.3%	-0.9%	6,966	-17,031	23,997	41,324	19,285	22,039
Providence St. Peter Hospital[2]	390,766	372,262	18,504	25,851	22,674	3,177	6.6%	6.1%	0.5%	-1,056	-274	-782	24,795	22,400	2,395
PeaceHealth St. Joseph Medical Center	390,044	380,429	9,615	19,609	13,934	5,675	5.0%	3.7%	1.4%	0	0	0	19,609	13,934	5,675
Harrison Medical Center	360,599	329,934	30,665	15,586	18,574	-2,988	4.3%	5.6%	-1.3%	3,161	-2,897	6,058	18,747	15,677	3,070
Swedish Cherry Hill[2]	337,640	317,117	20,523	20,297	14,731	5,566	6.0%	4.6%	1.4%	1,361	1,343	18	21,658	16,074	5,584
Multicare Good Samaritan Hospital[2]	323,061	301,292	21,769	60,743	65,738	-4,995	18.8%	21.8%	-3.0%	17,284	42,729	-25,445	78,027	108,467	-30,440
Yakima Valley Memorial Hospital	298,605	320,802	-22,197	15,457	1,575	13,882	5.2%	0.5%	4.7%	175	-17,541	17,716	15,632	-15,967	31,599
Seattle Cancer Care Alliance	298,222	271,795	26,427	15,525	19,777	-4,252	5.2%	7.3%	-2.1%	2,106	2,730	-624	17,631	17,047	584
Kadlec Regional Medical Center[2]	277,608	255,914	21,694	12,917	16,909	-3,992	4.7%	6.6%	-2.0%	7,040	15,463	-8,423	19,957	32,372	-12,415
Deaconess Medical Center	250,582	229,006	21,576	-520	-7,216	6,696	-0.2%	-3.2%	2.9%	0	0	0	-520	-7,216	6,696
Northwest Hospital	250,185	250,323	-138	-10,925	6,293	-17,218	-4.4%	2.5%	-6.9%	2,323	1,049	1,274	-8,602	7,342	-15,944
PeaceHealth St. John Medical Center	246,482	235,764	10,718	17,421	17,662	-241	7.1%	7.5%	-0.4%	8,998	12,432	-3,434	26,419	30,093	-3,674
Highline Medical Center[2]	229,540	226,369	3,171	2,510	4,118	-1,608	1.1%	1.8%	-0.7%	25	793	-768	2,535	4,911	-2,376
St. Francis Hospital[2]	224,415	223,027	1,388	33,937	39,347	-5,410	15.1%	17.6%	-2.5%	4,999	3,110	1,889	38,936	42,457	-3,521
Mary Bridge Children's Hospital[2]	194,602	191,108	3,494	23,087	28,828	-5,741	11.9%	15.1%	-3.2%	-1	-21	20	23,086	28,807	-5,721
Legacy Salmon Creek Hospital[2]	190,834	178,502	12,332	9,766	1,247	8,519	5.1%	0.7%	4.4%	1,836	-2,105	3,941	11,602	-858	12,460
Providence Holy Family Hospital[2]	186,791	186,649	142	1,981	11,172	-9,191	1.1%	6.0%	-4.9%	623	-47	670	2,604	11,125	-8,521
Central Washington Hospital[2]	180,210	174,901	5,309	967	1,275	-308	0.5%	0.7%	-0.2%	3,879	4,927	-1,048	4,846	6,202	-1,356
St. Clare Hospital[2]	163,675	149,207	14,468	9,978	12,113	-2,135	6.1%	8.1%	-2.0%	4,498	4,106	392	14,475	16,219	-1,744
Providence Centralia Hospital[2]	148,715	127,970	20,745	16,925	15,443	1,482	11.4%	12.1%	-0.7%	-203	-9	-194	16,723	15,434	1,289
Auburn Regional Medical Center	136,774	125,074	11,700	646	1,015	-369	0.5%	0.8%	-0.3%	0	0	0	646	1,015	-369
Olympic Medical Center[2]	135,395	134,140	1,255	939	3,790	-2,851	0.7%	2.8%	-2.1%	2,190	1,324	866	3,129	5,114	-1,985
Kennewick General Hospital	126,366	119,946	6,420	1,767	3,692	-1,925	1.4%	3.1%	-1.7%	458	656	-198	2,225	4,348	-2,123
Providence St. Mary Medical Center[2]	126,176	134,775	-8,599	6,007	7,328	-1,321	4.8%	5.4%	-0.7%	2,825	556	2,269	8,833	7,885	948
Yakima Regional Medical Center	119,691	119,636	55	10,506	11,148	-642	8.8%	9.3%	-0.5%	0	0	0	10,506	11,148	-642
St. Anthony Hospital[2]	115,199	68,155	47,044	7,318	-13,987	21,305	6.4%	-20.5%	26.9%	816	68	748	8,134	-13,919	22,052
Grays Harbor Community Hospital[2]	107,935	108,204	-269	-1,043	6,145	-7,188	-1.0%	5.7%	-6.6%	1,227	690	537	184	6,836	-6,652
Valley Hospital & Medical Center	93,151	84,514	8,637	5,603	4,507	1,096	6.0%	5.3%	0.7%	0	0	0	5,603	3,724	1,879

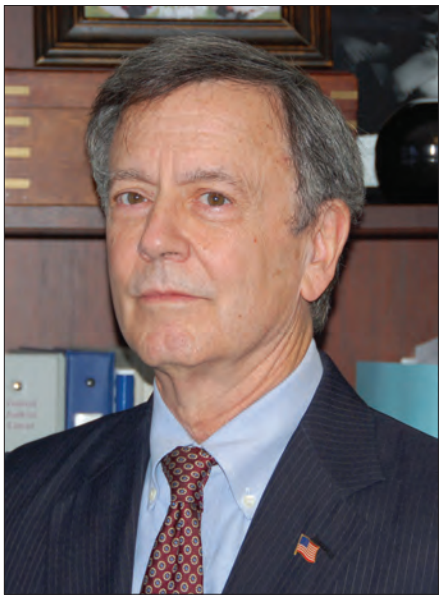
[1]Figures from the WA State Department of Health Center for Health (DOH CHS) Statistics web site as of June 28, 2011 unless footnoted with a [2].

[2]Figures were provided directly from the hospital and either confirmed or corrected the DOH reported figures.

Glossary: *Operating Revenues:* Inpatient and outpatient revenue for all patient care services (less deductions from revenue), tax revenues, the value of donated commodities, revenue from non-patient care services to patients and sales and activities to persons other than patients. *Operating Margin:* The excess of revenue over expense except for non-operating gains and losses. *Non-operating Gains/Losses:* The revenue and expenses of a hospital that are not directly related to patient care, related patient services or the sale of related goods. *Total Margin:* The excess of revenue over expense and gains over losses generated from all sources.

When the Commission Calls

By Tom Fain
Member
Fain Anderson VanDerhoef, PLLC



Darrel Royal used to have a saying about a forward pass: "Three things can happen, and two of them are bad." The same saying applies to an investigation by the Medical Quality Assurance Commission – three things can happen, and two of them are bad. An investigation can lead to either: 1) closure (good), or 2) a Stipulation to Informal Disposition (bad), or 3) a Statement of Charges (really bad).

You have to cooperate – but so do they. Whenever an MQAC investigation is undertaken, a physician has a duty to cooperate with the investigation, including a duty to provide information to the Commission. A failure to cooperate can even lead to its own sanctions. HOWEVER, because state disciplinary proceedings are quasi-criminal in nature, the physician has a constitutional right to consult with an attorney, and a legal right to know what the allegations are, before he has to respond to questioning.

Investigations are always serious business. To appreciate the seriousness of the disciplinary process, look at the sanctions the Commission is authorized to take, including restriction, suspension or revocation of your license. No sanction is without consequence. With the multitude of provider plans funding reimbursement, the consequences of any discipline may be significant. Some plans provide for a termination of credentials for any sanction, while others may limit termination to specific sanctions such as revocation or suspension. These same concerns may arise with credentialing for hospital privileges, employment by your group, or even your board certification.

Notice. Most (but not all) investigations start with written notice. But the notice doesn't tell you what the investigation is about. The notice will even tell you that you are free to submit a response at this time. DON'T! Instead, wait until you know the issues.

Investigations then progress to either: a) an inquiry letter asking for a written explanation, or b) a personal visit from the investigator.

The Inquiry Letter. If you get an inquiry letter, it will inform you of the nature of the complaint.[1] This is your chance to tell your story. Tell it wisely. The quality of your response is largely determinative of what steps the Commission takes next. Before submitting a response, you should review the entire chart of the patient(s) involved, consult counsel (and maybe even a colleague) and consider conducting a literature search to support your decisions. Your response can have even farther-reaching effect. SHB 1403 went into effect July 22, 2011 to require that copies of your reply to an inquiry letter be provided to the complainant. Not only can the MQAC use a poorly drafted response against you in a disciplinary proceeding, but the complainant can use your response against you in a medical malpractice case.

The Interview. If the investigator drops by for a visit, it is *not just a social call*. He has reviewed the file, and everything the complainant has said about you, long before the visit. You, on the other hand, probably haven't seen the patient for quite some time, and have little recollection of the care or issues involved. Now is not the time to demonstrate your skills at extemporaneous speaking. If you

haven't already done so, get a lawyer now.

Politely inform the investigator that you do want to cooperate, but that you also want a reasonable opportunity to consult with counsel and review the allegations and chart before responding. Otherwise, listen – don't talk. If the investigator has not by now presented you with a letter outlining the allegations to which you are to respond, now is the time to ask for it (he has it with him). Then, set up an appointment in the near future that provides you with an opportunity to review the records, meet with counsel, and adequately prepare for the interview.

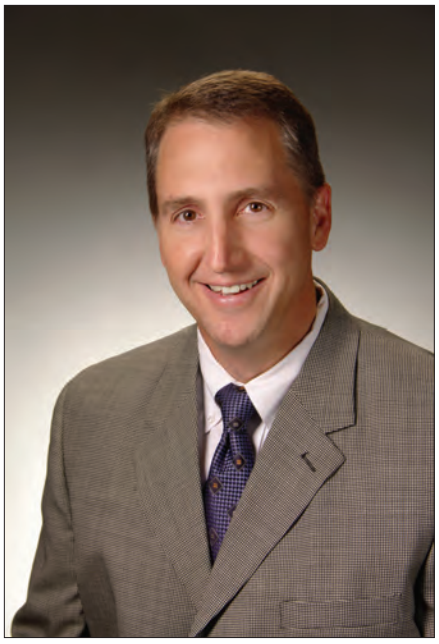
But lawyers cost money. True. However, most professional liability policies provide coverage for legal expenses associated with disciplinary proceedings. Some have deductibles, some have caps, some are direct pay, and some are reimbursement. If your lawyer doesn't mention this to you, be sure to mention it to him. If your insurance company prefers a certain lawyer, find out why. If you prefer someone else, insist on the right to use him or her. It is your license at stake, not theirs.

Tom Fain is a member of the Seattle law firm Fain Anderson VanDerhoef, PLLC, a Fellow in the American College of Trial Lawyers, and an Advocate in the American Board of Trial Advocates. Fain has tried cases in state and federal courts and administrative agencies. He has represented hundreds of health care professionals over the past 35 years, and tried their cases before civil juries, professional disciplinary boards, hospital fair hearing panels and provider plan panels. The firm's attorneys deal extensively with professional liability and disciplinary matters on a daily basis. The firm website is www.favfirm.com.

[1]The actual complaint may not be provided with the inquiry. If it is only paraphrased, the actual complaint should be requested. It is not exempt from disclosure. The DOH sometimes does not agree with this position, but (in my humble opinion) they are wrong.

ACOs and Shared Savings: Making a New Health Care Model Work

Partner, National Health Care Practice Leader
Moss Adams LLP



Health care reform has always been complicated, but the complexity is escalating at an accelerated pace.

One of the reasons for this growing intricacy is the Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, which requires the Department of Health and Human Services to establish a Medicare Shared Savings Program by the start of 2012.

The Shared Savings Program is designed to encourage physicians, hospitals, and certain other types of providers and suppliers to form accountable care organizations (ACOs) that deliver cost-effective, coordinated care to Medicare beneficiaries.

The PPACA established the administrative framework for this new health care architecture, but the proposed rules were only recently released by the Centers for Medicare & Medicaid Services (CMS). These proposed rules lay out the specifics when it comes to formation of an ACO, Medicare beneficiary assignment, establishment of quality standards, incentive payments, and the monitoring of ACOs, among other issues.

For those providers who want to take part in the Medicare Shared Savings Program, CMS has set a high bar. The proposed government rules say that ACOs must demonstrate a commitment to evidence-based medicine, work hard to stimulate beneficiary engagement, rigorously report on quality and cost metrics, and show a definite willingness to coordinate care.

The biggest hurdle for ACOs, however, may well be the CMS requirement that calls for a serious embrace of patient-centric care. According to CMS, an ACO is patient-centered if it:

- Has a beneficiary care survey
- Allows patient involvement in its governance
- Shows an ability to evaluate and address the health needs of an assigned population group
- Provides the tools to identify high-risk patients
- Offers a cogent process for communicating and sharing decisions with patients
- Uses electronic health records in a meaningful way
- Has established written standards and a method of measuring physician performance

Not surprisingly, CMS predicts that only 75 to 150 Medicare ACOs will ultimately be formed. So, with 230,000 medical practices and 5,800 hospitals in the United States, most providers won't be part of a qualifying Medicare ACO. But you may be putting your organization's future in jeopardy if you assume this permits you to ignore what could ultimately prove to be one of the most significant health care transformations in the history of the United States.

Indeed, ACOs and the Shared Savings Program are here to stay—regardless of any revisions that may eventually be made to the PPACA. This model for reimbursement and

health care delivery is already being embraced by a number of visionary providers, including some commercial insurance carriers. Additionally, certain states, such as Oregon, are already busy developing similar vehicles for the Medicaid population.

A deep understanding of the changing health care environment will be critical to proactively controlling the future of your organization. It may be the difference between sitting at the table, aggressively participating in the process, or lying on the table, waiting to be carved up and hollowed out by stronger competitors who are able to harness the latest dynamics of a changing health care world.

These dynamics revolve around two key risk areas: performance and utilization. Successful ACOs will be built around an acute care enterprise that provides exceptional service as effectively and efficiently as possible. Successful ACOs will also require establishing comprehensive ambulatory medical networks that consist of robust primary care platforms geared toward population health management. ACOs must decrease the cost of care per patient while attempting to increase appropriate utilization by accessing a larger panel of patients.

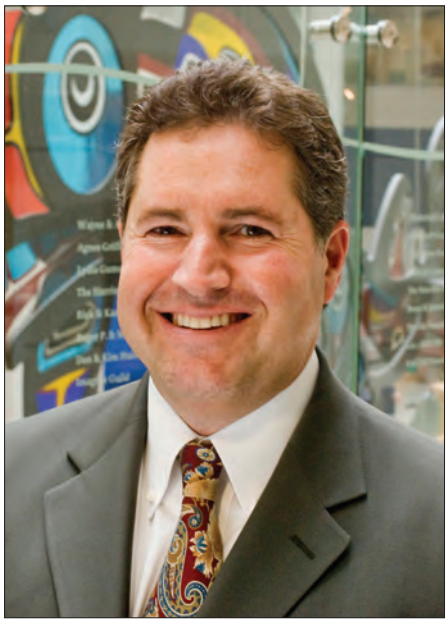
Here's a strategic checklist designed to help early-stage ACOs cope—and thrive—in the new health care environment that's clearly taking hold:

- Assess your ACO "assets" as well as "liabilities" and proactively determine where you fit in the emerging landscape.
- Remember that primary care and the connection to patients is still the key driver.
- Change your mind-set to view traditional profit centers as cost centers.
- Focus on the fact that high-quality medical care should result in lower cost.
- Understand that the majority of health care outlays are spent treating what are essentially preventable diseases, such as obesity, smoking, high blood pressure, high blood sugar, and high cholesterol. To have a meaningful impact on these conditions, you must help pa-

Please see> ACOs, P14

Moving to a Pay-for-Performance System at Seattle Children's

By Steven Hurwitz
Vice President of Human Resources
Seattle Children's



History

In 2009 Seattle Children's updated and revised its compensation practices to provide managers with better tools to recognize and reward workplace performance for our more than 4,000 employees.

Before 2009, Children's performance evaluation system operated on a three-point scale (needs improvement, meets and exceeds expectations). Evaluations under the three-point system resulted in a significant number of staff receiving an "exceeds" rating, and therefore we did not have the ability to recognize and reward high levels of performance.

Assessment

Work to improve Children's performance evaluation system started with focus groups representing a cross-section of the organization's supervisors, managers and directors. A senior leadership steering committee was also established to provide overall governance and to endorse recommendations that would be presented to executive leadership.

The focus groups uncovered the need for a better way to identify, recognize and reward high performing employees. As a result, the group determined that the following steps should be taken:

- Streamline and standardize job descriptions to better reflect key responsibilities, expectations and desired customer service behaviors.
- Refine and implement compensation philosophy to ensure market competitiveness.
- Develop guidelines to enable consistent application of compensation decisions impacting hiring, promotion, payment for additional work and for salary increases.
- Improve correlation between pay and performance and provide leaders with tools.
- Improve leadership training.

Development

The outcome of the focus groups and steering committee meetings indicated a clear theme: a lack of standardized systems and processes.

We started with revisiting policies on all salary issues for new hires, promotions, job reclassifications and pay for temporary assignments or for additional work. We developed a new job description format (simpler to read) with standardized qualifications and competencies, outlining customer service expectations and leadership competencies for management positions.

We also decreased the number of job descriptions by 47% and standardized job titling guidelines and leadership definitions (supervisor, manager and director) to further clarify roles. The compensation team expanded its salary survey data so that 93% of Children's employees were classified in a job having external benchmark salary data.

Regular formal management train-

ing covering performance management, compensation principles, performance evaluation and other related topics was instituted. A SharePoint site was developed to give managers online access to policies and guidelines, real-time salary modeling tools and other salary administration information, reports and tools.

In addition to our pay-for-performance plan, we implemented an employee-incentive plan to recognize and reward organization-wide improvements in patient and family experience (satisfaction) scores.

A key change was development of a new 5-point rating scale with the following classifications: Non-Performer; Developing Performer; Solid Performer; Leading Performer; and Top Performer.

The rating scales and definitions were developed by Children's managers and also included "observed or expected behaviors" associated with each performance level. They are intended to measure employee performance based on Children's standards and expectations.

The team also developed a merit matrix that provides salary increases based on performance rating and employee salary placement within their range (compa-ratio.) For example, top performers who are low in their salary range receive increases up to twice the merit budget, while developing performers whose salaries are in the upper portion of their salary range receive increases that are half the salary budget.

Results

Results to date have been promising. The 5-point scale is now familiar to our employees and has become easier for our managers to use. We are now able to reward our best performers with a large enough differentiation in annual increase to make it meaningful.

We have also conducted annual manager surveys to get their feedback on the pay-for-performance system. Managers have noted an appreciation for the standard format for job description and performance evaluations. They also feel the new performance levels have helped identify strong performance and areas for continued improvement.

As we enter our third year using this new scale, we continue to refine and deliver training, especially to newly hired or appointed managers.

Please see> Performance, P14

New Restriction on Billing for Anatomic Pathology Services

By Jane Pine Wood
Member
McDonald Hopkins LLC

On June 1, 2011, the State of Washington joined 17 other states in restricting the ability of physicians to purchase anatomic pathology services and re-bill the services to patients and payors. Prior to the enactment of House Bill 1190, which will be codified as a new section added to Chapter 48.43 RCW, state law did not clearly prohibit a physician from purchasing an anatomic pathology service at a discount from a pathology laboratory or other pathology provider, marking up the price of the anatomic pathology service, and re-billing the service to the physician's patients and their payors. A 2005 Washington Attorney General Opinion raised serious concerns regarding this type of arrangement under the Washington fee splitting laws, but re-billing with a markup for purchased anatomic pathology services continued among many physicians, most commonly including urologists, gastroenterologists, and dermatologists, absent a specific statutory prohibition.

This practice of purchasing and re-billing anatomic pathology services with a markup in price has raised numerous concerns among medical professionals as well as legislators. Patients do not have the benefit of the discounted price paid by their physician who purchases the services (because the services are re-billed typically with a significant markup in price). The medical decision-making of the referring physician may be compromised because of the profit potential from the billing arrangement. The referring physician may select the provider of the anatomic pathology services (which are the critical diagnostic services with respect to cancer diagnosis) based upon the lowest cost to the physician (thereby permitting the largest markup in price) rather than on the basis of quality or turnaround time. Furthermore, there have been concerns that some physicians may be more aggressive with respect to biopsy procedures for their patients (such as a greater number of prostate specimens taken by urologists) in order to increase profits from the billing of the additional pathology services.

The new Washington law, like the so-called direct billing laws in other states, is designed to remove the profit making potential, and realigns the medical decision making of the physician with the best interest of the patient. For purposes of this new law, anatomic pathology services include histopathology or surgical pathology services, cytopathology services (which include Pap smears, for example), hematology services, subcellular or molecular pathology services, and blood banking services. The new law explains that a laboratory or physician, whether located in Washington or in another state, that provides anatomic pathology services for patients who reside in Washington, may only bill the following persons or entities for the anatomic pathology services: (a) the patient, (b) the responsible insurer or third party payor, (c) the hospital, public health clinic, or non-profit health clinic ordering such services, (d) the referring laboratory, but excluding a laboratory in a physician practice that does not perform the professional component of the anatomic pathology services, or (e) governmental agencies on behalf of the recipient of the service. The law also explains

that no licensed practitioner in the state may directly or indirectly bill for anatomic pathology services unless such anatomic pathology services were rendered personally by the licensed practitioner or under his or her direct supervision. The new restriction does not prohibit billing a referring laboratory in instances where a specimen must be sent to the laboratory for consultation or histologic processing, but this "lab to lab" exemption does not include a laboratory of a physician group practice that does not perform the professional component of the anatomic pathology service.

The reason for excluding physician practice laboratory that does not perform the professional component is that many referring physician practices have limited laboratories that perform a narrow range of clinical laboratory services. If physicians were able to take advantage of the "lab to lab" exemption under the new law, by claiming that their practices have laboratories and they therefore be permitted to purchase and re-bill the anatomic pathology service, the intent of the law could be subverted.

It is important to note that no patient, insurer, third party payor, hospital, public health clinic, or non-profit health clinic is required to reimburse any licensed practitioner for charges for anatomic pathology services that are submitted in violation of the new law. Moreover, any licensed practitioner who violates these provisions is subject to disciplinary action under the Washington Medical Practice Act.

Jane Pine Wood is a member of the national health law practice of McDonald Hopkins LLC and has been representing physicians, clinical and anatomic laboratories, imaging centers, home health agencies, clinics, hospitals, other healthcare providers, and professional societies in corporate, regulatory, reimbursement, contractual, and other matters for 24 years. The primary focus of her practice is on issues affecting pathology providers and laboratories. She can be reached at jwood@mcdonaldhopkins.com or 508-385-5227.

< ACOs, from P9

tients participate in their own health care process.

- Center physician alignment structures around premium partners who share a common vision.
- Organize around proceduralists, who will comprise an efficient acute care surgical enterprise, and primary care physicians, who will operate an effective ambulatory care management network.
- Engage stakeholders from multiple levels and sites of care.
- Choose early strategies that maximize profitability to provide funding for longer-term strategies.
- Synchronize clinical transformations that reduce demand with reimbursement changes that reward efficient utilization and quality.
- Design payer contracting strategies that create and share value rather than relying on the traditional "biggest stick" leverage approach.
- Reorient clinical operations around process design and care standardization to unlock the value of information technology investments.
- Invest in, and use, data analytics and business intelligence to optimize your clinical model and patient management systems.
- Budget for technologies that facilitate remote and virtual access to medical advice and monitoring.

There are, without question, significant challenges in stepping up to accountable care. But, in the words of noted business management author Tom Peters, "The winners of tomorrow will deal proactively with the chaos per se as the source of market advantage, not as a problem to be got around."

Welcome to the future of health care.

Chris Rivard has served health care organizations for more than 25 years. He is a frequent speaker and author on a variety of topics, including health care reform and accountable care organizations. He can be reached at (509) 834-2456 or chris.rivard@mossadams.com.

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To address manager paperwork issues, we will continue to streamline job descriptions and evaluation forms to give managers more one-on-one time with their employees. Finally, considering our process is paper-based, we are working on an automated performance evaluation system to expedite the process.

Conclusion

The changes Children's made to our compensation and performance evaluation processes met the needs identified by our management focus groups and executive leadership.

Providing managers with the training, tools and support they need has enabled our employees to receive a more definitive assessment of their annual performance. Because our managers created our performance definitions, the change to the new rating scale was readily accepted.

Overall, our compensation and pay-for-performance system is enabling Children's to attract, retain and reward employee performance that continues to move us toward our goal of becoming the best children's hospital.

Steven Hurwitz is currently the Vice President of Human Resources for Seattle Children's. He joined Children's in this role during March, 2008 and has overall responsibility for the Human Resource organization supporting the Hospital, Research Institute and Foundation. He ensures strategic alignment with his executive counterparts to ensure that integrated and leveraged solutions are realized throughout the organization.

Prior to joining Children's, Hurwitz worked at Starbucks Coffee for 9 years with his last role being Vice President, Human Resources. He also brings diverse HR experience from working at Macromedia Corporation, Nabisco Biscuit Company, and Harris Corporation. In these previous roles, He led major projects in the areas of Performance management, Succession planning, HR strategic planning, Global compensation, Organization development and Employee/union relations.

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PeaceHealth

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REGIONAL MEDICAL DIRECTOR

Longview, Washington

PeaceHealth is a nonprofit, mission and values-oriented regional healthcare delivery system with operations in Washington, Oregon, and Alaska. Our core values are: respect for individual dignity and worth, collaboration, stewardship, and social justice. In Longview, WA, PeaceHealth consists of a 200-bed Level III Trauma and Medical Center, and a growing 120+ multi-specialty practice PeaceHealth Medical Group(PHMG). This is an exciting time to join PeaceHealth!

This is a new position that will have both system level and regional leadership responsibilities focused on system-wide standards, strategies, and objectives for operational, financial, and clinical performance aligning PHMG mission, vision, values, and strategic goals with needs of patients and caregivers in local markets and communities. This position reports dually to the PHMG CEO and the Regional CEO.

Requirements: MD or DO and a minimum of 7 years experience in healthcare, with at least 3 years progressive leadership experience in a large multi-specialty medical group; experience implementing evidence based protocols into clinical practice in multi-site, multi-specialty medical groups, and integrated delivery system.

Apply online at: **www.peacehealth.org/careers**
Inquiries to: **dtroyer@peacehealth.org**

Chief Executive Officer

(Brewster, WA)

Position Summary: To implement the strategic goals and objectives of Okanogan Douglas District Hospital. Enable the Board of Directors to fulfill its governance function. To give direction and leadership toward the achievement of the hospital's philosophy, mission, strategy, and its annual goals and objectives.

Essential Job Duties: The CEO effectively oversees the hospital administration to ensure its efficiency and operations, leadership, organizational goals, strategic planning, operates consistently and ethically within the mission and values of the hospital and conform to the current laws and regulations. Supports operations and administration of Board by advising and informing Board members and interfacing between Board and staff. Oversees design, marketing, promotion, delivery and quality of programs, products and services. The CEO sets the direction for all strategic planning and delegates related duties to appropriate staff. The CEO develops budgets, forms partnerships, and implements a team to steer the hospital accordingly. Creates a vision that promotes top-quality care and services. Endorses a culture that creates good morale and security among departments and staff. Sets the tone for company culture with positive interactions, effective tolerance, and motivation. Must be available for Administrative call for the hospital.

Qualifications: Bachelor degree in Business Administration or Healthcare Administration, or other applicable specialty. A minimum of 5 years experience in a leadership role at the administrative level. Must be in good standing at the employer, community, state and federal levels.

Interested Candidates may apply in person or by mailing their resume to:

Okanogan Douglas District Hospital
Anita Fisk, HR Generalist
PO Box 577
Brewster, WA 98812
(509) 689-2517 x 3343

Or for quicker submission:
Send resume to: **afisk@oddh.org**
Apply on-line at: **www.oddh.org**

EOE

Columbia Valley Community Health

Controller

(Wenatchee, WA)

The Controller will provide leadership for the Finance Department and will maintain agency financial information, prepare financial reports, maintain and balance accounting ledgers and provide direct oversight of the Purchasing, Accounts Payable, Cash Receipts, Payroll and General Ledger functions. The Controller is responsible for maintaining compliance with external stakeholders by ensuring the accuracy and timeliness of required reporting.

CVCH is a dynamic community health center with fully integrated EMR. Our services include Medical, Dental and Behavioral Health services with our main clinic in Wenatchee and a site in Chelan. We serve 20,000+ people in a geographically stunning part of the world and are proud to be a progressive group of mission-focused employees committed to serving the underserved. We are leaders in the Medical Home Model, are Joint Commission accredited and are routinely recognized as one of the highest quality Community Health Centers in Washington.

The successful candidate will have a Bachelor's degree in Accounting with five years accounting and supervisory experience. CPA preferred. Visit our website at **www.cvch.org**.

To apply, contact Sarah Wilkinson, HR, @ 509-664-3587 or **swilkinson@cvch.org**

Jefferson Healthcare

Director, Human Resources

Jefferson Healthcare, in Port Townsend, Washington, is recruiting for a Director, Human Resources.

Jefferson Healthcare is a full service, publicly owned, 37 bed, self supporting acute care hospital.

The hospital has approximately 350 employees and four clinics.

Jefferson Healthcare has all of the standard acute care services plus Cardiac Rehab, Chemotherapy, Pulmonary Rehab, Rehabilitation Services, Support Groups and a Surgical Center.

The Director, Human Resources supervises a staff of five employees.

A Bachelor's Degree in Human Resources is required. Five or more years of progressive Human Resources experience in a healthcare facility as a Director or Assistant Director is also required.

Labor relations experience along with PHR or SPHR is preferred.

Jefferson Healthcare is very well managed in an idyllic setting.

For more information please contact:

George C. Deering
President
Deering and Associates
(425) 264-0865 (Office)
(888) 321-6016 (Toll Free)

Alameda County Medical Center

Director, Corporate Communications & Marketing

(Oakland, CA)

Reporting to the Chief Strategy & Integration Officer, this position is responsible for the development and management of an integrated marketing/public relations communications strategy designed to enhance Alameda County Medical Center's (ACMC) reputation within key target communities. The successful candidate will provide strategic leadership for the design and growth of system-wide corporate communication priorities that support ACMC's senior management, business mission and objectives. Involves oversight of all digital/traditional advertising, website development and public relations activities -- media relations, public affairs, internal communications, community relations, etc. -- as well as development/maintenance of relationships with key public officials, community organizations and advocacy groups.

The qualified professional will have a minimum of 7-10 years marketing and/or public relations experience in a corporate or agency environment; healthcare background strongly desired. Also requires a Bachelor's degree in Marketing, Public Relations, Communications, Journalism or a related field; Master's degree preferred. You must be a proven leader with exceptional networking and team building skills, as well as expertise in the development and evaluation of strategic communications plans. Excellent presentation and verbal/written communication skills are essential.

Fulfill your career goals while enjoying a stimulating work environment and excellent benefits.

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www.acmedctr.org and reference Req# 8370.

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