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Grandview's Birch Street Clinic: Rural Health Care Measures Up

By David Peel
Publisher & Editor
Washington Healthcare News

Grandview, in the heart of Yakima Valley, boasts a growing community of 8,700 and truly grand views of Mt. Rainier and Mt. Adams. Agriculturally focused, most employment relates to storing, packing or processing many of Washington's key crops. In March 2008 at the invitation of Jon Smiley, the CEO of Sunnyside Community Hospital, I went to Grandview to learn about the state of rural health care from the perspective of an individual rural clinic.

Of the five clinics the hospital owns in the Sunnyside area, I chose the Birch Street Clinic in Grandview, housed in a well maintained, older building just off the main street. Martin Dubek, MD, my host, is a family practice physician and hospital employee. An avid skier, snowboarder and cycler, Dubek is a native Czechoslovakian who completed his residency in Virginia and joined the clinic in 2003 after finding the position online. I thought the interview would take place in Dubek's office located at the back of the clinic, but, after getting permission from the mother, he asked that I join him during a well-visit examination of a nine-month old child.

Dubek used his wireless laptop to populate the child's medical records during the examination, while simultaneously speaking with the mother. The data he entered was transferred over the wireless network to the clinic's server where the medical records of the baby were stored. He was using the technology as intended and appeared to be productive because of it. In his office afterward, Dubek gave me his perspective on the state of rural clinic health care.

The Grandview Birch Street clinic is a designated Rural Health Clinic by the U.S. Center for Medicare and Medicaid Services (CMS). CMS provides financial support to Rural Health Clinics because it needs to guarantee access to care for its patients in rural areas. In exchange for cost based reimbursement, the clinic agrees to maintain certain minimum staffing levels, provide commonly furnished services and basic laboratory services, and have emergency care services and drugs

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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 had the good fortune to attend two health care conferences in April.

The first was the Washington State Healthcare Human Resources Association (www.wshhra.org) and the second was the combined conference of the Washington State Medical Group Management Association (www.wsmgma.org) and the Oregon Medical Group Management Association (www.omgma.com). Both conferences were well organized with excellent presentations from well known speakers.

In these difficult financial times companies look to cut costs and, unfortunately, conference expenses are usually one of the first under the knife. However, there are least two good reasons to keep your conference budget intact:

- **Employee morale and retention:** Excellent health care leaders are hard to find and retain. Support of attendance at conferences shows an organization's commitment to the employee beyond just the paycheck.
- **Ideas to improve business operations.** Most of the topics presented at both conferences were related to making a business more efficient and effective. The conference environment allows the attendee to focus on the subject at hand without the constant interruptions they face in the workplace.

Employee morale and retention and improving business operations are foremost in all successful businesses. Support for employee attendance at association conferences goes a long way to get there.

David Peel, Publisher and Editor

Washington Healthcare News 2008 Editorial Calendar

Month and Year	Theme of Edition	Space Reservation	Distribution Date
January 2008	Healthcare Public Policy	December 3, 2007	December 21, 2007
February 2008	Urban Medical Clinics	January 7, 2008	January 25, 2008
March 2008	Rural Hospitals	February 4, 2008	February 22, 2008
April 2008	Insurance Carriers	March 3, 2008	March 21, 2008
May 2008	Healthcare IT	April 7, 2008	April 25, 2008
June 2008	Rural Medical Clinics	May 5, 2008	May 23, 2008
July 2008	Healthcare Facilities	June 2, 2008	June 22, 2008
August 2008	Healthcare Human Resources	July 7, 2008	July 25, 2008
September 2008	Community Health Centers	August 4, 2008	August 22, 2008
October 2008	Third Party Administrators	September 8, 2008	September 26, 2008
November 2008	Insurance Brokers and Agents	October 6, 2008	October 24, 2008
December 2008	Urban Hospitals	November 3, 2008	November 21, 2008

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available. Policies and procedures for patient care must be in writing and kept up to date, as well as maintenance of a basic patient health record system guided by written policies and procedures.

We talked about the issues involved with the Rural Health Clinic designation. Certainly the reimbursement was favorable. Were the conditions imposed by CMS fair and necessary? Were there incentives for physicians to be efficient?

I asked about the Rural Health Clinic requirement for a Nurse Practitioner, Physician Assistant or Certified Nurse Midwife to be on-site and available to see patients 50% of the time the clinic is open. It seemed like it made more sense to say the physician should be available to see patients 50% of the time. Dubek said, "I don't know why they would implement that [Nurse Practitioner, et al] as a rule. It's been our experience that they're easier to recruit. That may have something to do with it."

Martin Dubek, MD

The topic turned to reimbursement and I noted that Rural Health Clinics get paid by governmental programs at higher rates than urban clinics. He asserted, "It's easy to get complacent as far as a push to be more efficient. I think we could do better at incenting providers to see more patients. When the clinics receive cost-based reimbursement there's no incentive to be more

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efficient." I was told later by Smiley that the hospital has an incentive program in place for physicians, physician assistant clinicians and advanced registered nurse practitioners based on productivity.

What about access? Is it difficult for a rural patient to find the type of physician they need? Dubek stated, "In fact, it's almost impossible to recruit an OB physician. It's not the compensation or the cost of malpractice. Many obstetricians just aren't comfortable practicing in a rural area."

Specialists are a different matter. "Specialists, they're available. Patients just have to travel a little further. But most of us that live here are accustomed to traveling forty or fifty miles to Yakima or Tri-Cities for shopping - or going to specialists."

I told him I was impressed to see him using the laptop during an examination. Dubek said, "It's easy to purchase an electronic medical records system. They're relatively inexpensive. What's not easy is getting them all to interface with each other. We use the Inland Northwest Health Services sponsored product called Centricity®. However, in Yakima, many of the specialists use a different system called ChartConnect. The two systems don't talk to each other because of the high cost to interface. It would be great if all the data from all the providers were available in one database but that's not going to happen unless the federal government steps in."

"I do like using the laptop. The biggest problem is that sometimes it gets interrupted and that can get frustrating. It's getting better but there are still hiccups. If I'm with an older patient with a lot of issues, like exchanging medications, and the system isn't working, it can be extremely frustrating. We have our people working to improve it all the time."

Dubek showed me a report on the number of patients he saw in a recent month. There were no patient names on the list. The list included the insurance covering the patient. The clinic accepts most types of insurance and is one of the few that takes Tri-Care, the Department of Defense's health care program for members of the uniformed services, their families and survivors. He said a number of people that work in the Tri-Cities area come to the Birch Street clinic because they can't find local providers that accept Tri-Care. Dubek noted, "Tri-Care pays well but there are so many administrative requirements the providers don't want to work with them."

I asked Dubek about the uninsured. He told me he didn't have a lot of uninsured patients because of the structure of Washington State's entitlement programs. He explained, "In Washington State we are very giving. It's fairly easy for patients to get signed up for State programs. The State provides the patient with an open 'coupon' from Medicaid when they don't have other coverage. This allows the patient to get care and the provider to be paid."

Rural clinic health care, at least in the clinics owned by Sunnyside Community Hospital, is well funded and systems are in place to allow those without coverage to get the services they need. There are only a couple of aspects that are troubling.

1. The inability to recruit OB physicians for the area. Recruiting difficulties, according to Dubek, aren't confined to Sunnyside but appear to be regional – and not due to compensation or malpractice costs.

2. The reimbursement system in place for Rural Health Clinics. Cost-based reimbursement doesn't appear to provide incentives for a clinic to become more efficient unless they implement their own system like Sunnyside has done.

However, those two issues are largely outside of the hospital system's control. In the meantime, Grandview's Birch Street clinic provides much-needed services to its rural community while at the same time maintaining its financial footing. Dr. Dubek, his fellow physicians, and the management of Sunnyside Community Hospital deserve full praise for their accomplishments.

Medical Facility: Cure Thyself. Look for the Symptoms of Employment Discrimination

By Kathryn L. Feldman
Partner
Labor and Employment Group
Ater Wynne LLP

As health care providers, medical facilities (rural clinics and others) are focused primarily on the care of their patients. However, medical facilities are also employers. As such, they should routinely examine the health of their employment practices.

Discrimination complaints are a common area for concern. Discrimination claims can result when a medical facility employer:

- Passes over a job candidate for a receptionist job on the basis of disability, "because dealing with a disabled person might make our patients uncomfortable."
- Fails to promote a qualified person to an open position, "because she has four kids and won't be able to focus on the added responsibilities of the job."
- Terminates an employee who wears a headscarf and/or asks for permission to pray each day at prescribed times, "because she looks like a terrorist and/or the rest of us can't be expected to pick up the slack."

> ***"Employment discrimination is not limited to hiring and firing decisions; it also includes decisions on promotions, raises, segregation, work assignments and harassment."***
>
> Kathryn L. Feldman, Partner
> Labor and Employment Group
> Ater Wynne LLP

Discrimination takes place when an otherwise qualified employee (or class of employee) is treated less favorably in the workplace simply because he or she possesses a legally protected attribute like race, sex or gender, national origin, religion, age, disability – or even pregnancy.

Individuals in some protected classes are entitled to not only equal treatment, but also reasonable accommodations by the medical facility employer. Failure to provide reasonable accommodations also constitutes a form of employment discrimination.

Employment discrimination is not limited to hiring and firing decisions; it also includes decisions on promotions, raises, segregation, work assignments and harassment.

Race discrimination: By now, employers know that it is unlawful under state and federal law to discriminate against an otherwise qualified employee on the basis of race. What many do not know is that this also applies to color within racial groups. For example, it is illegal to favor – on the basis of skin color alone -- a lighter skinned individual over a person of the same racial group who has darker skin.

Sex or gender discrimination: An employer cannot discriminate in treatment of an otherwise qualified candidate or employee on the basis of sex or gender. Discrimination can take place both ways -- as a preference for or against women, or for or against men.

Sexual harassment lawsuits also fall under the heading of discrimination based on sex or gender. There are two types:

- *Quid pro quo* sexual harassment refers to situations where an employee must submit to sexual advances to get, advance in or keep a job. The employer is automatically liable.

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- *Hostile environment* sexual harassment refers to a sexually-charged atmosphere that is so pervasive that it interferes with the working environment or creates an intimidating, offensive work setting.

National origin discrimination: As immigration increases, and there are more immigrants than ever before in the work force (especially in the healthcare industry), there are a growing number of claims based on national origin discrimination. In a post 9/11 environment, such claims increasingly overlap with religious discrimination.

Religious discrimination: To support a religious discrimination claim, an employee must prove that he or she has a *bona fide* religious belief, that the employer was informed of the belief, and that the employee was threatened with or subject to discriminatory treatment because of this belief. An employer is required to consider a request for and provide religious accommodation – where reasonable.

Age discrimination: The law protects those age 40 and older from age discrimination in the workplace. As the baby boomers age and want to keep working (out of either desire or necessity), employers are likely to see an increase in lawsuits based on age discrimination.

Disability discrimination: State and federal laws protect the rights of qualified disabled employees who can perform the essential function of their jobs – with or without reasonable accommodation – unless

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Know the Underwriting Factors When Designing Your Reinsurance Program

By Robin Brown
Healthcare Reinsurance Consultant
MedRisk, LLC

A newborn infant with a birth defect spends nearly 300 days in the hospital, primarily in neonatal intensive care. Total cost: $2,549,000.

A 54-year-old woman spends only 35 days in the hospital, but requires nearly 2,000 units of blood coagulation Factor VII. Total cost: $2,364,000.

Each of these cases single-handedly affected the financial results of the health plan. The good news is that these plans had an excellent reinsurance program in place to minimize the impact.

Fifteen years ago, plans often selected the lowest rate with little regard given to coverage. However, after large claims occurred and coverage limitations provided inadequate protection, reinsurance was reevaluated. Today the mission of a health plan is to service its members by providing high-quality, affordable health care coverage—and a large claim should not interrupt this service. A well-designed reinsurance program is one of the best tools a company can use to minimize the adverse financial effects of large claims and create predictability from year to year.

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> Healthcare Reinsurance Consultant
> MedRisk, LLC

Reinsurance, by definition, is insurance purchased by an insurer to protect itself from fluctuations in claims loss and to protect against catastrophes. When choosing reinsurance, health plans balance risk, reimbursement, and of course, cost for the optimum program.

Knowing some of the factors considered by underwriters is crucial to understanding how rates are calculated and what adjustments might be best for the plan. Most underwriters consider these top five factors:

1. **Specific Deductible**
2. **Aggregating Specific Deductible**
3. **Claims Experience**
4. **Underlying Contract**
5. **Provider Contracts and Fee Schedules**

The **specific deductible** is applied on a per-member basis, and is the amount the health plan retains. Over the years, the market has seen an increase in deductibles as buyers find the right comfort level of risk assumption. Of course, the higher the deductible, the lower the rate.

Aggregating specific deductibles, once popular primarily with stop-loss policies offered to self-funded employers, are quickly moving into the world of provider excess, HMO reinsurance, and medical excess. Some claim they are nothing more than smoke and mirrors, used as a tool to sell a lower rate. Yes, it is true that premium dollars are saved ("hard dollar savings"), but more risk is assumed (potential increase in "soft dollar liability"). If there are no, or few, excess claims, you will realize savings. Be sure to evaluate and understand the subsequent risk and its impact on your reinsurance coverage.

Keep in mind that if your organization has multiple years of

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claims experience, and you have a sizeable group, the underwriter will take this into account instead of relying solely on manual underwriting. This approach often works in your favor because claims experience unique to your group will be the focus instead of the statistics featured in a national underwriting manual.

During the underwriting process, the **underlying contract** will be evaluated. The underwriter will look for benefits covered and risk assumed. Know that the more risk you have in your contract, the more risk you are passing on to the reinsurer. The more risk your reinsurer takes on, the higher your rate.

The **provider contracts** and **fee schedules** followed with your first dollar claim payments are always viewed by an underwriter because they will indicate the risk that may eventually come their way. Hospital contracts that include case rates or per diems instead of percentage of billed charges will always work in your favor.

It seems reinsurance was simpler in the past. Today, it takes time and energy to create the best reinsurance program for your health plan. Once a large claim is experienced, the effort you dedicate to putting the reinsurance program together will be considered time well spent. Confirming that you have the best possible coverage should always be your focus.

Robin Brown is a Healthcare Reinsurance Consultant with MedRisk, LLC. She has over twenty years experience in the health care and reinsurance industry. The company website is www.MedRiskLLC.com.

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doing so would result in an "undue hardship" for the employer.

Reasonable accommodation can include physical accessibility; job structuring; flexible work schedules; reassignment to another position; modification of examinations, training materials or policies; provision of qualified readers or interpreters and similar accommodations; and/or provision for unpaid leave for necessary treatment.

To prevent potentially costly claims of discrimination, a medical facility employer should create and implement the necessary policies, procedures and practices. This includes educating your employees on how to complain about potential discrimination so the employer can promptly investigate workplace disputes – before they become lawsuits.

In addition, a medical facility employer should pay close attention to the documents kept in an employee's personnel files – or elsewhere. Stick with objective statements; subjective remarks made about an employee can prove dangerous in litigation.

Employers must assume that all email is a permanent record that may be discoverable in the event of a lawsuit. When used as a formal method of documenting employee performance, email should be carefully reviewed prior to sending -- as if it will be seen by a judge or jury. Forensic computer experts can locate email on computer backup files.

Finally, a medical facility employer should be aware that employees who report discrimination in the workplace are legally protected against retaliation. Even something as simple as the "cold shoulder" from a passing doctor has been interpreted by the courts as retaliation.

Medical facility employers should be absolutely clear about what constitutes employment discrimination under state and federal laws. If not, they should consult with an attorney.

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

Rural Clinics Reap Cheap Benefits of Technology

By Crystal Nolan, MHA, FACMPA
Principal
Derry, Nolan & Associates

Frequently a sea of paper charts, cluttered work areas and staff that appear to be anxious (probably because they are unable to find a patient's chart, lab results or any number of other documents) awaits me in the majority of medical clinics I encounter as a medical practice consultant. Recently, two rural health clinics, however, pleasantly surprised me with the *sounds of silence* as I approached their reception areas. Both clinics had adopted technology tools, such as Electronic Health Records (EHR), to streamline their work flow, decrease errors and promote operational efficiency. The staff at these clinics appeared calm, composed and professional, because they were not frantically searching for elusive documents.

According to the Centers for Disease Control & Prevention (CDC), the nation has seen notable progress toward the goal of EHR implementation. Between 2005 and 2006, the percentage of office-based medical practices using any form of EHR increased by 42%. The same article states that physicians in the West (42.3%) were more likely to use EHRs than those in the Northeast (23.5%), Midwest (29.3%) and South (24.2%). Physicians in metropolitan areas (30.3%) were more likely to use EHRs than were those in non-metropolitan statistical areas (20.2%).[1] So

> ***"Both (rural) clinic sites are excellent examples of 'patient-centered' care in action."***
>
> Crystal Nolan, MHA, FACMPA
> Principal
> Derry, Nolan & Associates

while finding this type of technology in areas like Seattle or Tacoma would be expected, to find early adopters (one clinic implemented EHR in 1998) in two rural areas of our state is laudable. Both clinic sites are excellent examples of "patient-centered" care models in action. They devoted considerable monetary resources, not only on an EHR, but also on professionally designed websites that are easy to navigate, interactive and informative.

The medical practice assessments Derry, Nolan & Associates performed for these clients showed EHR adoption and using the internet as a patient resource has proven truly beneficial to the clinics. The physicians at both sites were not only at or above the 75th percentile in productivity (benchmarked against Medical Group Management Association data), but also had excellent accounts receivable (A/R) and days in A/R ratios. The fact that these two rural health clinics offered appointments, office policies, patient education, payment mechanisms, prescription refills and registration through their websites added to the success of their internal operations and financial viability.

Both clinics also had overhead and staffing ratios that were very favorable thanks to the efficiencies resulting from the EHR and the internal communication systems in place. Bottlenecks at the front desks were nearly unheard of because patients pre-registered and completed health questionnaires before arrival. Electronic telephone messages were prioritized by colored flags, numbers and cues, especially if the message was time sensitive. The clinical teams used the EHR to generate prescription forms, radiology and lab requests; often the clinical visit was documented before the next patient was roomed.

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At a time when many clinics are experiencing decreasing revenues, rising expenses (primarily associated with labor resources and supplies), these two rural health clinics are thriving primarily as a result of their adoption of technology. And, their staff appear happy to come to work; positive team dynamics and high employee morale permeate both office environments. Isn't this the type of environment that every clinic administrator dreams of managing?

Generally, to reach such a goal involves planning and promoting a vision, usually requiring a physician champion to overcome the apprehension associated with capital

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Medicare Advantage Marketing: Be Competitive in a 90 Day Window

By Dean Barnhart
President and CEO
Pathway2Design

Companies offering Medicare Advantage plans are operating in a rapidly growing market. According to the U.S. Census Bureau, the baby boomers comprise 78.2 million of the U.S. population. This group is made up of men and women born between 1946 and 1964; they begin turning 65 in 2011. This market is on the fast track and it is imperative that companies selling Medicare Advantage plans effectively prepare to market and sell their plans in the 90 day window allotted by watchdog agency CMS, the Centers for Medicare and Medicaid Services.

The Obstacle Course

In 2008, Medicare Advantage marketing permits companies to market their plans from October 1 through November 14. Between November 15 and December 31, plan providers can submit applications for new sales to Medicare-eligible seniors. This is called the enrollment period. After that, seniors are given until March 31 to change their minds and switch to a similar plan offered by another provider.

> ***"Make sure you have the Major 3 in your budget:***
> ***• New customer sales campaign***
> ***• Existing customer sales campaign***
> ***• Retention campaign"***
>
> Dean Barnhart
> President and CEO
> Pathway2Design

The reason for this period is due to the potential for buyer's remorse. It gives seniors the opportunity to change their minds without consequences if they feel they have been pressured into a purchase or they didn't have enough time to evaluate all of their plan choices. Encouraging seniors to switch plans is much harder as members can only change between like plans and most have just enrolled in a plan and are reluctant to change so quickly.

In 2005, Medicare changed the open marketing window for Medicare Advantage plans in order to keep seniors free from a constant barrage of phone calls, direct mail, and pressure from sales people trying to get them to enroll. Currently, there is a black out of media and sales in the nine months prior to October 1. On that day, the media blitz begins and seniors are inundated by campaigns that push them to seminars, phone numbers, websites, and more. The goal; get them to make a decision knowingly and quickly.

Be Prepared to Pounce

So what are companies doing to prepare in the first nine months of the year? Smart companies start preparing early to ensure they are ready to fully launch a 90 day marketing campaign by October 1. This is such a small window of opportunity; any delay can cost potential members. Those who want to be successful create a professional, well thought out marketing plan that effectively communicates their value propositions. It should focus on 3 major initiatives:

- New customer sales campaign
- Existing customer sales campaign
- Retention campaign

An effective plan includes a variety of channels and media choices. For example, direct marketing through television ads, post cards,

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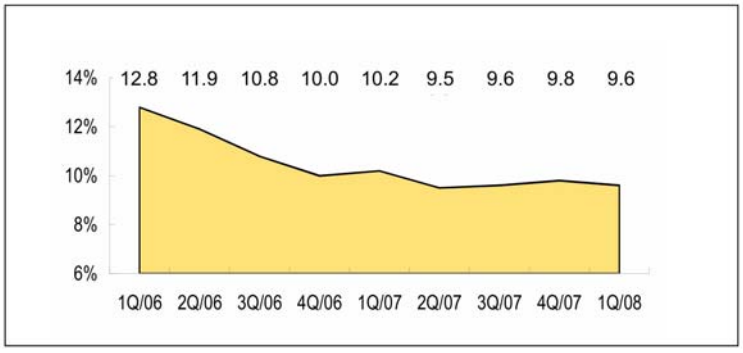
Rents Plateau: Market Holds Its Breath

By Charlie Hampton III
Vice President
Grubb & Ellis

Vacancy rates in the Puget Sound office market dipped during the first quarter, to 9.6 percent, reflecting a resilient regional economy and the continued excess of demand over supply. The Seattle Central Business District (CBD) led with a sharp drop from 8.9 to 8.5 percent vacancy on approximately 200,000 square feet of positive net absorption. The Eastside market followed suit, with declining vacancies lifting rental rates in most submarkets.

These positive figures have been driven by continued tenant demand-largely a function of the local economy.

Nationwide, the economy has lurched between crises since the New Year, with market participants still uncertain of the depth of the current financial turmoil. National employment figures look bleak with 232,000 jobs lost during the first quarter. The Puget Sound economy, however, has a habit of marching to its own tune, a trend which appears to be holding so far in 2008. Washington State, the fourth largest exporter in the nation, has benefited tremendously from the declining dollar which makes American exports relatively less expensive in the global market. The Puget Sound Economic Forecaster estimates 35.3 percent and 20.7 percent growth of real exports during 2006 and 2007, respectively. Moreover, the region's top employers, including Boeing, Microsoft, Russell Investments and Paccar act as a veritable firewall against serious downturn.



Office Vacancy Rate*
** All Classes of Space*

Construction starts have slowed to a trickle - a casualty of the credit crunch. The financing pool has become a puddle as lenders impose higher standards. Work continues, however, on a substantial 2.8 million square feet of office projects in Seattle and over 3 million square feet on the Eastside. The "pig in the python" is scheduled to hit the market beginning this summer in the Bellevue CBD with the City Center Plaza, Tower 333 and the second installment of the Bravern Office Commons.

The Forecast

The long-term outlook for Seattle's office market depends on many factors: the health of the residential housing market, the duration of the credit crunch, population trends and new construction. All indicators currently suggest the region will experience a softening in vacancy rates and decreasing asking rates before the end of the year.

However, until then, average weighted asking rates will continue to creep upward, especially in the Seattle and Eastside Central Business Districts where new construction completions drive submarket pricing higher. The cost of capital will also become an issue for small businesses, which often lack the resources and credit ratings needed to obtain fair loans.

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outlay, address the learning curve impacts and mitigate the fear of choosing the wrong EHR, knowing such an error could impact the physician's practice patterns for some time.

An EHR and an interactive website are long-term investments connecting the clinical and business side of operations. When these physicians made the decision to use technology to improve their outcomes and internal operations, they were confident they would be able to demonstrate the value of the changes. Both rural clinics related to me that they felt the successful implementation of the EHRs was due to taking the time to anticipate changes, such as the initial data input required, and including other physicians and staff in the selection and implementation process.

When technology is fully functioning to the satisfaction of physicians, staff and patients, any clinic undertaking this investment should anticipate having similar outcomes—seeing more patients with less staff, enhanced internal and external communications, reduced errors in managing patient care and maybe even getting home on time for dinner!

Crystal Nolan is a Principal with the healthcare consulting firm Derry, Nolan & Associates, LLC. (www.derrynolan.com) The company is a healthcare consulting firm that specializes in business improvement strategies for large and small private physician groups, hospitals, and integrated health systems. Ms. Nolan can be reached at Crystal@derrynolan.com.

[1]Centers for Disease Control, Advance Data, Vital and Health Statistics, Number 393, October 26, 2007.

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newspaper ads, flyers, billboards, and bus ads are essential pieces of the puzzle. But the process of creating these pieces is a time-consuming one. A successful post card mailing, for instance, relies on an appealing design, relatable images, compelling copy, key messages, and a swift call to action. Additionally, there must be time for CMS approval, printing, and mailing to ensure the post cards arrive at precisely the right time to the targeted recipients. Sound overwhelming? It can be. It is also important to market to current members. In addition to providing excellent customer service, companies should take advantage of referral marketing opportunities. This can be accomplished through referral cards, referral brochures, bring a friend campaigns, event invitations, referral letters from providers, provider office posters, and front office brochure kiosks. In a provider's office, you have the opportunity to reach your target market with little effort and for the minimal cost of creating the collateral.

Recommendations for Success

This shortened window of opportunity for sales success seems to level the playing field between large and small companies when it comes to access to seniors. Everyone is competing at the same time for the attention of the same group of people. Your marketing efforts must illustrate a sense of urgency and provide your potential customer with all of the information they require to make an informed decision. Start planning your strategy in the first quarter of each year. Determine the bandwidth and expertise of current personnel. Are they up to the task at hand? If not, enlist help. Prepare your materials early even if you feel edits will need to be made before going to press. Make sure your printer is prepared and has all of the information needed to meet the October 1 deadline. Remember, that date is just around the corner.

Dean Barnhart is President and CEO of Pathway2Design (www.Pathway2Design). The Company is a full-service creative design group serving both national and international clients since 2004. Mr. Barnhart can be reached by phone at 888-923-3954 or by e-mail at dean.barnhart@pathway2design.com

RECRUITING

Over 4,600 health care leaders in the Northwest receive the Washington Healthcare News each month. As a health care organization, doesn't it make sense to target recruiting to the people qualified to fill your jobs?

To learn about ways the Washington Healthcare News can help recruit your new leaders contact David Peel at dpeel@wahcnews.com or 425-577-1334.

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The Mystery of Decreasing Frequency in Medical Professional Liability Insurance

By Mary-Lou Misrahy, ARM
President and CEO
Physicians Insurance A Mutual Company

The two principal drivers of rates in medical professional liability insurance are claim severity and claim frequency. Claim severity refers to the size or amount paid for settlement on each claim, and claim frequency refers to the number of claims in a given period of time. As expected, in recent years claim severity has increased along with medical inflation, with the cost of settlements driven by medical costs. However, an unexpected *decrease* in claim frequency has us looking at what the legal system, physicians, patients, insurers, patient-safety organizations, and other factors have contributed to this favorable trend.

At Physicians Insurance A Mutual Company, we write medical professional liability insurance for physicians and clinics in Washington, Oregon, and Idaho. For purposes of this article, we will discuss only information about claim trends in Washington. At our company and across the country, the increasing trends in severity and frequency drove rates up during the late 1990s and early 2000s. But in the last few years, frequency levels have dipped below anything we have seen in the recent past. In 2001, our company's claim frequency in Washington was 8.5 claims per 100 insureds. In 2007, claim frequency was only 5.4 claims per 100 insureds.

> ***"Washington now requires a physician's certification of merit for each lawsuit. Additionally, attorneys must verify that a lawsuit is not frivolous, subject to sanctions. This screening may prevent frivolous lawsuits."***
>
> Mary-Lou Misrahy, ARM
> President & CEO
> Physicians Insurance

What is behind this plunging frequency? Despite a number of theories, no one has an exact answer. In states with tort reform and caps on settlements, one would expect the number of claims to decrease. But why would Washington experience a sharp decrease as well, even though it has no cap on damages and little tort reform? What role, if any, do local physicians, medical societies, insurance companies, and patient-safety organizations play? Here are a few developments that some believe may help explain the trend:

Several years ago some companies stopped underwriting questionable risks. So, on average, the physicians insured by companies that made these tough decisions may present a lower risk of claims.

Washington now requires a physician's certificate of merit for each lawsuit. Additionally, attorneys must certify that a lawsuit is not frivolous, subject to sanctions. This screening may prevent frivolous lawsuits.

The media has educated some members of the public on the impact of litigation on the health care delivery system. Therefore, some patients may choose not to file meritless claims, and juries may be reluctant to award high verdicts.

Recent "I'm sorry" legislation encourages physician-patient communication after a bad outcome. Allowing physicians to express sympathy for what happened may help physicians and patients keep the lines of communication open,

Continued on next page

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which may in turn prevent some claims.

The cost of a plaintiff's malpractice lawsuit is often borne by the attorney, and the costs can be recovered only if the plaintiff wins. Because expert-witness fees can run into the thousands of dollars, plaintiff attorneys may be reluctant to file a case if the chances of winning are not high.

The recent upsurge in the use of electronic medical records means that patient data is available to more doctors on call. This may increase the likelihood that critical data is transmitted quickly to physicians--even physicians who see patients for the first time in an emergency. Therefore, medication errors and misdiagnoses may be less frequent.

Patient-safety initiatives are eliminating system issues that could lead to medical professional liability insurance claims. For example, in an effort to reduce medical errors, Washington recently passed legislation requiring physicians to print or type prescriptions.

Organizations such as Physicians Insurance, the Washington State Medical Association, the Washington Health Foundation, and the Washington Patient Safety Coalition are working to dramatically increase patient safety in our state.

At Physicians Insurance, we work every day to promote patient safety at the legislative level as well as in medical-society meetings, medical publications, and risk management seminars. Many of our cutting-edge risk management programs focus on patient safety. Past seminars have included interactive discussions with physicians—in cities throughout the state—exploring patient safety during labor and delivery, emergency-room procedures, treatment for infectious diseases, and numerous other subjects. Upcoming programs will examine patient-safety issues related to chest pain, radiation treatments, routine patient care, and continuity of care after an adverse event.

Additionally, Physicians Insurance's alliance with the Washington State Medical Association has

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Energy Costs Will Close Your Doors. Unless We Go Nuclear.

By Jerome Delvin
Washington State Senator
Eighth Legislative District

Just talk to your facilities manager. You'll hear about surging energy costs, gas and electric bills going through the roof, and scrambling budgets to cover them.

You'll also hear about fears that Washington's new laws to stem "climate change" will cause energy costs to skyrocket, with severe cap-and-trade requirements for every business.

You better believe it.

Panic over a nonexistent "crisis."

As the lone dissenter on the governor's Climate Advisory Team, I watched as panicked legislators and environmentalists made addressing "global warming" a top legislative priority, even over urgent needs like property tax relief so people can stay in their homes. They are now ready to do anything – make you pay any price, destroy any economy, lose any number of jobs – all in the name of "climate change."

I, on the other hand, believe the state is dangerously overreacting. I can cite many, many scientists, statistics and studies that show climate fluctuations – global warming and cooling – happen naturally on a regular basis and have since the beginning of time. But that's the subject of another editorial.

> ***"Even though Europe is flourishing on nuclear power, Washington State's environmental community is dead set against it."***
>
> Jerome Delvin
> Washington State Senator
> Eighth Legislative District

Let's say, for argument's sake, that we *do* want to reduce CO2 levels. Great, let's do it. But let's not destroy the economy in the process. Let's not regulate people out of their cars and businesses into bankruptcy. Instead, let's see what the free-market can do to make cars and facilities more energy efficient and give us cheap energy.

Regulations are not the answer.

Regulations rarely work. The free market works. Want an example? For years, the state of California and the U.S. government pushed electric and hydrogen cars. People wouldn't buy them. Auto manufacturers found out what people wanted and built it. People wanted hybrids. Last year, for the first time, the Toyota Prius outsold the top-selling Ford Explorer SUV.

If we have a problem – any problem – regulation is not the answer. Creative, free-market ideas win nearly every time.

Now, we have a new problem. Energy costs in Washington will be sent skyrocketing because of panic over climate change. Your hospitals shouldn't have to go bankrupt over this. Instead, you need a cheap source of energy – one that produces no CO2.

Good news. It already exists.

Nuclear energy meets every criterion for safe, cheap, plentiful energy production. In fact, Europe is flourishing on nuclear energy. France gets 78 percent of its electrical energy needs from 58 operating nuclear plants.

Currently, there are 104 operating nuclear power plants in the United States, delivering 19 percent of our energy; 70 percent comes from coal and natural gas.

We all know that both coal and natural gas generate CO2 and nuclear energy does not. But did you

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know that nuclear energy is also cheaper to produce? The Swedish Energy Utility, Vattenfall, produces electricity through nuclear, hydro, coal, gas, solar cell, peat and wind energy.

Vattenfall has measured the total amount of CO2 created by each of these sources. The company found its nuclear plants emit less CO2 than *any* of its other energy production mechanisms. While hydro, wind, solar and biomass produce far less CO2 than coal and gas, nothing beats nuclear.

As for costs, Vattenfall says that modern, third-generation nuclear plants can produce energy at 1.68 cents per KiloWatt-Hour. And nuclear plants pay back the energy required to build them in less than two-months of operation.

As for safety, today's technology allows reuse of nuclear waste until final waste output is minimal. Thanks to glassification and other technologies, nuclear waste can be stored safely and cheaply.

Does Europe know something we don't?

Even though Europe is flourishing on nuclear power, Washington State's environmental community is dead set against it.

Experts estimate that by 2020, Washington will have 1.7 million more people. They will need energy and lots of it. This year, I introduced a bill to simply study the advantages and disadvantages of nuclear energy as a possible answer.

Environmental groups became hysterical and lobbied legislators to vote it down. It didn't pass, but I couldn't help but wonder…what harm is a *study*? Nuclear energy could be a big part of the solution to our energy problems, but if it is, they just don't want to know it.

Oddly, if it isn't the answer, they don't want to know that either.

I'm hoping that the people of Washington see it differently. I'm hoping that business owners, CEOs, facilities managers and administrators will demand this state look for answers everywhere – not just from wind and solar.

In the coming years, your hospitals will survive only if you find a way to get cheap, plentiful energy. Otherwise, you could be taxed into the ground.

Washington is already one of the cleanest energy states in the union.

Like Captain Ahab's blind pursuit of the whale, I fear that legislators will continue to ramrod "climate change" laws through the system ─ no matter how many jobs, businesses and choices we lose in the process.

Jerome Delvin is the Washington State Senator of the Eighth Legislative District. This District is in Southwestern Washington and includes the cities of Kennewick, Richland, Benton City and Prosser.

The Mystery of Decreasing Frequency in Medical Professional Liability Insurance

<Mystery

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resulted in a HIPAA manual and highly attended seminars on care for obese patients and issues related to electronic medical records. Physicians Insurance also works with local medical and specialty societies as well as local patient-safety organizations, including the Washington Physicians Health Program, Washington Health Foundation, Washington Patient Safety Foundation, Washington Patient Safety Coalition, Washington Health Care Risk Management Society, Gilda's Club of Seattle, and iHealth Alliance.

At Physicians Insurance we regularly assess our own claims data and data available from physician-owned professional liability insurers across the country. From January 1985 to June 2007, the Physician Insurers Association of America has compiled data from 244,902 claims from physician-owned insurers nationwide so that companies like Physicians Insurance can address emerging issues early on. As we work directly with health care providers in Washington to increase patient safety, we at Physicians Insurance are doing our part to keep claim frequency at bay.

Mary-Lou Misrahy is the President & CEO of Physicians Insurance a Mutual Company, the largest provider of medical liability insurance in the Northwest, servicing Washington, Oregon and Idaho.

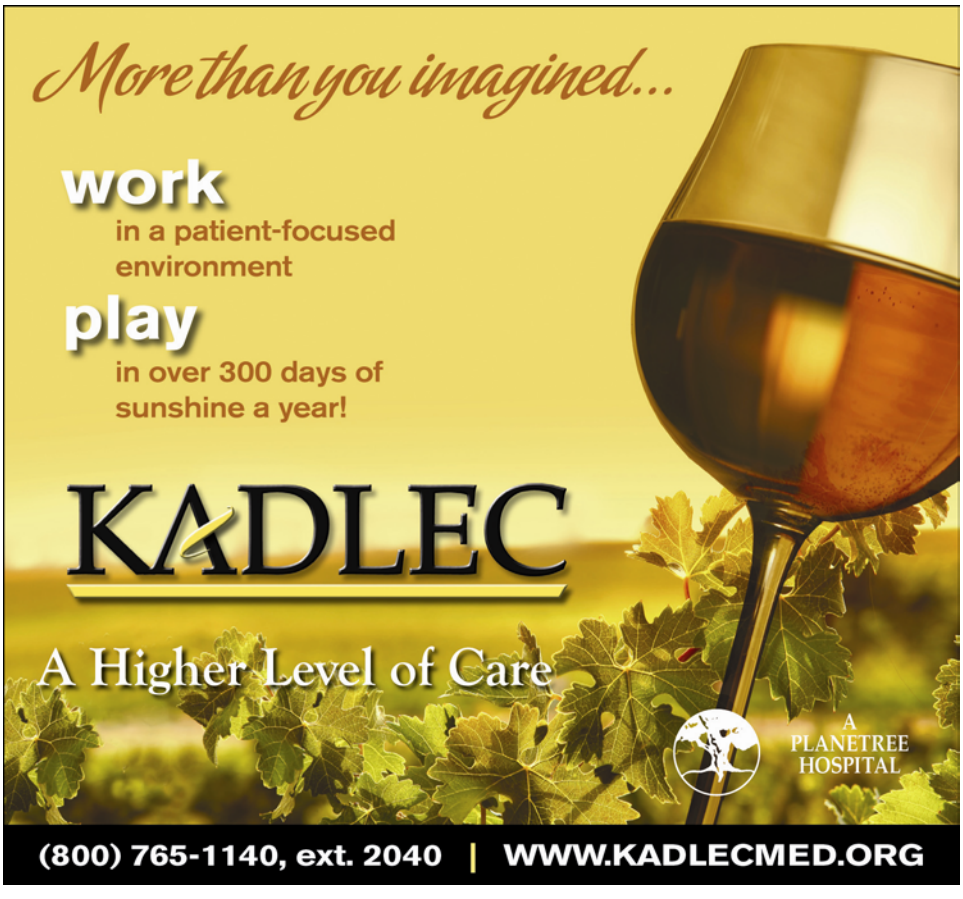
New or Recently Promoted Health Care Leaders

First Name	Middle Name	Last Name	Title	Effective	Organization	New or Promoted Leader
Andrew		Agwunobi MD	CEO, E. Washington Operation	03/08	Providence Health Care	New
Heidi		Anderson RN	Chief Nursing Officer	04/08	Forks Community Hospital	Promoted
Tami		Aschenbrenner	Director of ICU & Step Down Unit	02/08	Capital Medical Center	Promoted
Andrew		Baron MD	Primary Care Medical Director	03/08	MultiCare Medical Group	New
Hillair		Bell	Principal	01/08	Morgan Consulting Resources	Promoted
Brenda		Bruns MD	Executive Medical Director	06/08	Group Health Cooperative	New
Charlie		Button	Chief Executive Officer	03/08	Dayton General Hospital	New
Keith		Cernack	Executive Director	04/08	Community Network Coalition	New
Patty		Cochrell RN MBA	COO/EVP	11/07	Harrison Medical Center	Promoted
Drexel		DeFord	SVP and Chief Information Officer	03/08	Children's Hospital & Reg. Med. Ctr.	New
Philip	M	deMaine	Partner	01/08	Johnson, Graffe, Keay, Moniz & Wick, LLP	Promoted
Dave		Ellis	VP of Sales	01/08	Copytronix-A Xerox Company	New
Marie		Faulring	Controller	01/08	Community Health Plan of WA	New
William		Fisher CPA	Chief Financial Officer	03/08	Cancer Care Northwest	New
Pam		Fowler	Dir. of Mkt & Community Relations	03/08	Valley Medical Center	New
Michael		Fry	SVP, Group Division	03/08	Symetra Group Employee Division	Promoted
Santokh		Gill MHA	Admin. Dir. of Cardiovascular Svcs	04/08	Virginia Mason	New
Mike		Glenn	SVP, Business Development	03/08	Valley Medical Center	New
Grett		Hatch	Admin. Dir. of the Dept. of Medicine	04/08	Virginia Mason	Promoted
Steven		Hurwitz	VP of Human Resources	03/08	Children's Hospital & Reg. Med. Ctr.	New
Cal		Knight	President and COO	03/08	Swedish	Promoted
James		Kublin MD MPH	Director, HIV Vaccine Trials Ntwrk	02/08	Fred Hutchinson Cancer Research Center	Promoted
Julie		Joerns	Director of Surgical Services	04/08	Capital Medical Center	New
Thomas		Jones	Administrator	01/08	Central Washington Medical Group	New
Karen		Lowry PhD MPH	Project Manager	04/08	LabConnect, LLC	New
Jesse		Maier	Controller	03/08	South Sound Neurosurgery	New
Cynthia		May RN MSN	VP Operations/Chief Nursing Officer	04/08	Harrison Medical Center	New
Mary		McWilliams	Executive Director	06/08	Puget Sound Health Alliance	New
Diane		Meredith-Gordon	Director	03/08	The CBO Solution	New
Bill		Mock	Marketing Account Executive	04/08	Retail Lockbox, Inc.	New
Ron		Morris MD	VP Quality/Chief Medical Officer	03/08	Harrison Medical Center	New
Donna	Elam	Mote	Principal	12/07	Morgan Consulting Resources	Promoted
Robert		O'Brien, Jr.	EVP, Health Plan Division	06/08	Group Health Cooperative	New
Rebecca		Parsons	Communications Manager	04/08	Adaptis, Inc.	New
Brian		Pence	Radiation Services Director	01/08	Cancer Care Northwest	New
Beth		Perry	Medicare Agent	04/08	Rapport Benefits Group	New
Shelly		Pricco RN	Director, Patient Care Services	05/08	Enumclaw Regional Hospital	Promoted
Michael		Rask	Senior Vice President	04/08	AON Consulting	Promoted
Jerilyn		Ray	Human Resources Manager	05/08	Enumclaw Regional Hospital	Promoted
Lori		Rice RN CPUR CCM	VP of Workers Comp./Private Svcs	05/08	Qualis Health	Promoted

New or Recently Promoted Health Care Leaders

First Name	Middle Name	Last Name	Title	Effective	Organization	New or Promoted Leader
Cara		Robinson RN BSN	VP of Medicaid Services	05/08	Qualis Health	Promoted
Danielle		Rogers RN	Manager, Women and Infant Services	05/08	Enumclaw Regional Hospital	Promoted
Aaron		Sallade	Applications Manager	04/08	PTSO of Washington	New
Michelle		Sand RN	Asst. Administrator of Pt. Care Svcs.	02/08	Cascade Valley Hospital & Clinics	New
Peter		Schrappen	Fundraising Manager	04/08	Washington Health Foundation	New
Jessica		Shaw	Associate Director of Events	03/08	Virginia Mason Foundation	New
Robert		Siegried	Benefits Account Executive	04/08	Baldwin Resource Group	New
Jeffrey	A.	Sgro	District Sales Manager—NW Region	02/08	Medical Protective	Promoted
Melissa		Stevens	Director of Emergency Services	02/08	Capital Medical Center	New
Peggy		Thiel RN	Manager, Acute Care Services	05/08	Enumclaw Regional Hospital	Promoted
Ingrid		Vimont	Manager Operations	03/08	Swedish Home Care Services	New
Terri		Wallin RN MHA	Executive Director	03/08	Swedish Homecare Services	Promoted
Banks		Warden	ED, Vaccine & Infectious Dis. Inst.	02/08	Fred Hutchinson Cancer Research Center	Promoted
Michelle		Wier, CMPE	Chief Executive Officer	01/08	Valley Medical Center, PLLC (ID)	New
Wes		Wright	VP & Chief Technology Officer	03/08	Children's Hospital & Reg. Med. Ctr.	New
Kathy		Yoler MD	President (OIA) & Med. Dir. (WIS)	02/08	Overlake Imaging Assoc. & WA Imaging Svcs	Promoted
Jane		Zimmerman	Director of Human Resources	03/08	Capital Medical Center	New

Career Opportunities



Washington Healthcare News Expands in Oregon

Over the last two months the Washington Healthcare News has increased it's distribution to northwest health care leaders by 1,200 and now totals 4,600. Much of the growth came from expansion in Oregon where over 600 people now receive the publication.

David Peel, the Publisher of the News notes, "Most of our articles are of regional interest. For instance, we now publish regional financial information on plans and hospitals. We hope our new Oregon readers enjoy the publication as much as our Washington State readers." The News is published monthly in Kirkland, Washington.

Career Opportunities

To advertise call 425-577–1334

Manager – Children's Services

The Manager assumes 24-hour accountability and responsibility for area(s) assigned. This individual is responsible for overall quality of service and for planning, developing, organizing, integrating, and directing programs, staff, and budget in support of the organizational goals and commitments. Bachelor of Science in Nursing or related degree preferred; minimum two years experience in a management or leadership role in an inpatient care setting required.

Controller

Oversees and directs the Accounting, Accounts Payable and Payroll functions. BA in accounting, graduate degree, and CPA preferred. Minimum five years experience in a healthcare setting, previous Federal or NIH Grant experience, five years accounting experience. Shift Hours: 8AM-5PM.

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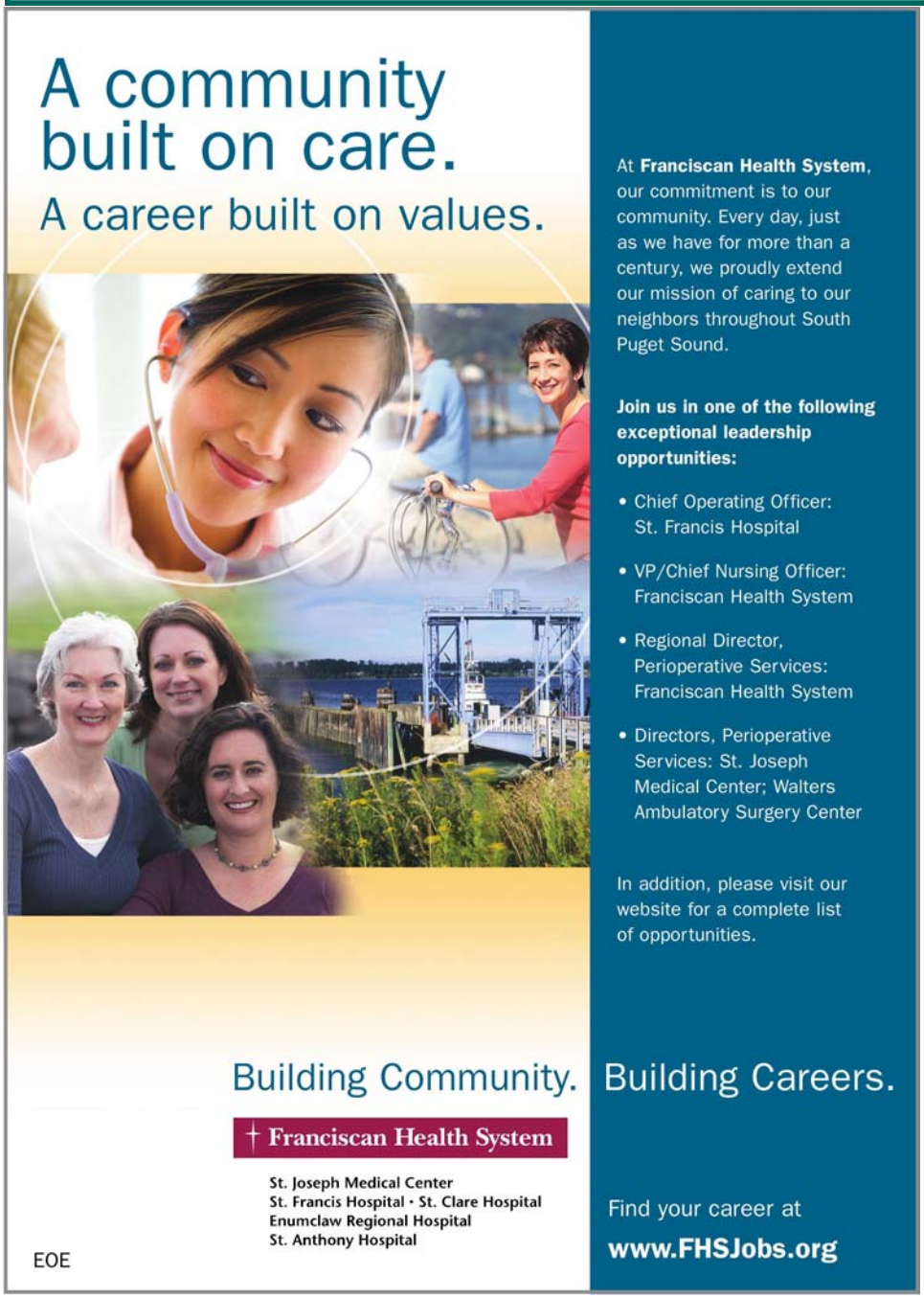

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AA/EEO

Plan and Hospital Financial Information

Financial Results for the 15 Largest Health Plans in the Pacific Northwest (Ranked by Total Revenues)[1]					
Plan Name	**State of Domicile**	**Total Revenues CY 12-31-07**	**Net Income CY 12-31-07**	**Statutory Capital YE 12-31-07**	**Enrollment YE 12-31-07**
Premera Blue Cross	Washington	$2,489,847,796	$105,875,522	$784,031,358	729,843
Regence BCBS of Oregon	Oregon	$2,282,451,997	$20,851,464	$550,950,425	1,106,170
Group Health Cooperative	Washington	$2,242,125,443	$64,174,802	$737,753,731	402,011
Regence BlueShield	Washington	$2,214,886,611	$66,598,417	$925,462,852	884,409
Kaiser Foundation HP of the NW	Oregon	$2,208,389,963	$59,041,115	$494,196,039	472,660
Blue Cross of Idaho Health Service	Idaho	$969,018,397	$31,628,610	$257,546,226	432,089
Providence Health Plan	Oregon	$809,441,167	$58,467,917	$340,519,671	181,162
Molina Healthcare of Washington	Washington	$652,789,860	$45,477,166	$113,621,959	283,485
Community Health Plan of WA	Washington	$521,333,513	$5,548,137	$77,582,754	231,673
Blue Cross Blue Shield of Montana	Montana	$508,998,817	$21,219,793	$144,987,453	236,071
PacifiCare of Washington, Inc.	Washington	$470,823,716	$54,015,908	$228,602,282	51,465
Pacificsource Health Plans	Oregon	$470,038,725	$9,901,134	$124,499,606	149,480
Regence BlueShield of Idaho	Idaho	$423,865,980	($902,403)	$125,570,535	203,274
Health Net Health Plan of Oregon	Oregon	$386,681,642	$12,097,948	$67,435,509	124,806
LifeWise Health Plan of Oregon	Oregon	$320,177,710	($5,273,580)	$69,922,493	115,829

Financial Results for the 15 Largest Hospitals in Washington & Oregon (Ranked by Total Discharges)[2]					
Hospital Name	**State**	**Total Charges CY 12-31-07**	**Total Margin CY 12-31-07**	**Total Discharges CY 12-31-07**	**Total Days CY 12-31-07**
Swedish Medical Center-Seattle	Washington	$2,023,262,137	$101,027,578	34,208	143,492
Providence St. Vincent Medical Center	Oregon	$1,190,848,000	$132,075,000	32,539	144,060
Sacred Heart Medical Center-Spokane	Washington	$1,320,906,441	$69,153,314	29,503	149,640
OHSU Hospital	Oregon	$1,439,008,183	$39,511,642	27,744	144,235
Sacred Heart Medical Center-Eugene	Oregon	$753,619,352	$51,346,157	26,036	114,067
Providence Everett Medical Center	Washington	$1,178,904,174	$30,321,510	24,674	100,545
Providence Portland Medical Center	Oregon	$919,017,000	$61,591,000	22,594	101,599
St. Joseph Medical Center—Tacoma	Washington	$1,438,379,738	$73,744,228	21,802	92,323
Southwest Washington Medical Center	Washington	$974,184,166	$30,890,264	20,886	85,285
Salem Hospital	Oregon	$661,611,020	$19,685,011	20,492	91,132
University of Washington Med Center	Washington	$948,997,861	$31,441,957	19,775	97,450
Legacy Emanuel Hospital & Hlth Ctr	Oregon	$889,675,890	$23,459,988	18,708	107,362
Harborview Medical Center	Washington	$1,156,062,000	$18,045,000	18,662	135,303
Providence St. Peter Hospital	Washington	$898,500,849	$24,444,980	18,162	83,281
Virginia Mason Medical Center	Washington	$1,149,485,689	$18,452,019	17,383	86,009

[1]Source: National Association of Insurance Commissioners. [2]Sources: Washington State Department of Health, Oregon Health Policy & Research.

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