The late John Wooden, who will forever be known as the wise man of college basketball, once said that “Teamwork isn’t a preference, it’s a requirement.”

Wooden was talking about hoops, of course, but he easily could have been referring to America’s current healthcare delivery system, which is in desperate need of greater integration and coordination.

Indeed, without collaborative efforts that provide safe, efficient, effective, timely and equitable patient-centered care, the U.S. healthcare crisis will not ease or end – regardless of the actions of our current and future leaders.

This isn’t a new thought. Many healthcare experts have been saying this for years – and a number of healthcare organizations have tried to work in institutional harmony – in an attempt to create greater value for patients in the form of increased quality and lower costs.

Changing the delivery system’s core metric from volume to value is difficult, however, because the fee-for-service model creates often opposing incentives.

So, cost-effective integration is the right concept, and it can take us in a new and improved direction; yet, as we learned during the 1990’s, with the rise of managed care, cost-effective integration has to be flexible to really attract patients, and it also has to empower providers to deliver measurable quality.
Letter from the Publisher and Editor

Dear Reader,

We recently opened an online library of healthcare management articles on the Washington Healthcare News web site. All of our articles published since December 2008 are now available in high resolution PDF files so quality documents can be printed and shared with others.

Our articles are unique and of high interest to manager to “C” level healthcare leaders at hospitals, clinics and health insurance companies. They are also of interest to students and educators.

We encourage you to visit our online library and to have your web master establish a link to our library from your web site. If you find our content to be of value then your web site visitors may as well. The online library URL is http://www.wahcnews.com/library/ and your anchor text should read “Washington Healthcare News Online Library of Healthcare Management Articles.”

Until next month,

David Peel, Publisher and Editor

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outcomes. These complex, and often conflicting, goals can be achieved with Accountable Care Organizations. The recent healthcare legislation included numerous payment reforms penalizing poor quality and rewarding attempts to better coordinate care. The measure also introduces demonstrations for global payments and mandates a pilot ACO program (the Medicare Shared Savings Program).

An ACO brings together a group of healthcare providers – primary care physicians, specialists and hospitals, for example. Then it offers them incentives and rewards for being accountable to a specific population, hitting specific spending targets, and delivering clinical outcome improvements. When an ACO meets or exceeds its goals, it is rewarded with a share of the overall savings. The downside is that there could be penalties if it fails to reach its objectives.

The underlying thinking behind ACOs is that by placing accountability at the provider level we will be able to meaningfully influence and deliver integrated patient-centric healthcare in this country. In other words, what the ACO attempts to do is pay providers to work together and share accountability, avoid supplier-stimulated demand, and deliver the right care at the right place and the right time for the best price for consumers. The ACO concept relies on peer review and peer pressure – plus back-end rewards – to make sure that the best healthcare practices, in terms of cost and outcomes, are identified and implemented.

At this point, participation in an ACO is voluntary and progressive. But providers should understand that in the wake of recent reform legislation, reimbursement will likely soon be tied to this type of healthcare structure. Those not participating will face decreased reimbursement.

All of this may sound great in theory, but an objective assessment of the ACO model raises a number of challenging questions, including:

- What is the appropriate structure for an ACO?
- Who should be allowed to “play”?
- Should ACOs be physician-managed and/or controlled?
- Should the physicians be employees of the ACO or contracted partners? In certain states, employment may violate state law.
- How does an ACO put the necessary financial models and reporting tools and capabilities in place?
- How does an ACO effectively balance provider rewards with requirements and responsibilities?
• How does an ACO make certain that the patient-physician relationship is enhanced and enriched and not adversely affected – especially if penalties for under-performance come into play?
• How does the insurance or at-risk component fit into this equation?
• How do ACOs align seamlessly with Medicare?
• How does an ACO ensure that the population it’s responsible for is sufficiently diversified to mitigate risk?

These tough questions must be answered – and soon – because the ACO model is going to take hold. The good news is that many of the prerequisites are falling into place. We are seeing expanded transparency around healthcare costs and quality; electronic medical records are nearing an important tipping point; and comparative effectiveness and evidence-based pathways are in increasing use.

As the ACO model gains traction, however – and as it becomes an efficient, effective and provider-driven, patient-centric cornerstone of the U.S. healthcare delivery system – we will need a series of major re-education efforts to fully succeed. And this re-education will have to take place on both the provider and consumer sides.

Patients and providers will have to adjust in their relationships. Medical students will have to learn about the nuances of healthcare cooperation and partnership. And the ACOs, themselves, will have to become learning – as well as medical – enterprises that consistently gather, share and employ data to improve the quality and safety of patient care.

The path is difficult, but the direction is clear: If we’re going to truly reform healthcare in America, we must adopt these critical changes. And we have to embrace John Wooden’s wise words, too. Teamwork among providers is an absolute necessity in order to deliver optimal care and protect patient well-being in communities all across our country in the coming decades.

Chris Rivard is a partner and chair of the Moss Adams Health Care Group. He can be reached at 509-834-2456 or chris.rivard@mossadams.com. Chris Pritchard is a partner and leader of the San Francisco office Health Care Group. He can be reached at 415-677-8262 or chris.pritchard@mossadams.com.
Managing the financial risk of high dollar claims is one of the primary challenges of many self-funded medical plans. High dollar claims are an ever increasing percentage of total healthcare claims. At HMA, we recognize that stop-loss to protect against these claims is not a commodity that can be purchased solely based on basic contract provisions and price. There are many aspects of stop-loss coverage that need to be understood to effectively manage risk. It is important to work closely with stop-loss carriers who maintain a philosophy of providing seamless protection and strong relationships with a Third Party Administrator (TPA).

HMA has developed criteria for reviewing carriers, contract terms, and administrative guidelines to ensure the most effective management of high dollar claims risk. Here, we’ve provided a few key contract terms – beyond rates – to carefully consider when selecting and reviewing stop-loss carriers.

Financial Strength

It is essential that the stop-loss carrier be there when they are needed. Continually review their financial viability with a primary focus on ratings from the major rating services.

A carrier with a substantial block of business and tenure in the region is desirable. Carriers that are committed to being in the local market will develop their strategies based on that commitment. They will staff their regional offices accordingly and provide dedicated resources in their home office to provide working relationships with the groups and the TPA. This leads to better administrative efficiency, minimized risk, and competitive rates.

Underwriting Practices

It is important that groups be protected from risk at the time of renewal. If a group has high stop-loss claims volume in one year, the stop-loss carrier may laser a high risk individual (exclude them from future coverage) or propose a large rate increase, neither of which is desirable by the employer providing the self-funded plan. This risk can be mitigated by working with carriers that offer no-new-lasers at renewal provisions and renewal rate increase limits. When the two provisions are combined, they provide significant rate and financial risk protection for the group. Alternatively, carriers that use a pooling approach do not assign all of the high dollar claims experience to a single group, reducing the potential for large rate increases.

Contracts

A risk that is often overlooked is the potential for gaps between the stop-loss contract and the group’s summary plan document. If there are conditions or treatments that are covered by the plan document but excluded in the stop-loss contract, the employer can be at significant financial risk. Work with your TPA partner to assure gaps are eliminated.

Claims Processing

Each carrier has unique claims filing procedures and guidelines. Two examples are: 1) The length of time a claim or an adjustment to a claim may be submitted at the end of the contract period, and 2) policies regarding pre-funding, a process where the carrier pays the claim prior to the group funding the claim. These considerations can impact the group’s risk and cash flow.

Strong relationships between the carrier, the TPA and the group are important in mitigating claim payment disagreements. This can be especially valuable in appeal situations where there are claims that
are denied that are subject to plan language interpretations. It is important to understand how strictly carriers adhere to their administrative guidelines and contract terms as this may significantly impact the outcome of these disputes. Maintaining an open dialog between all three entities is essential to building the relationship.

**Medical Case Management**

Many carriers maintain their own internal case management teams which support and contribute to successful outcomes. A payer’s medical case management department should develop effective working relationships with a carrier. Efficient communication enables the stop-loss carriers to be aware of potentially large claims at an early stage and to work with your payer collaboratively to ensure best care at optimal prices.

Carriers that recognize the quality of work performed by the payer’s medical case management team may decrease their rates. Also, carriers who recognize the potential impact of disease and maternity management programs and discount their rates are well positioned to be long term partners.

**Premium Processing**

In months where cash flow may be tight, it is important to have a carrier with flexible grace periods in the payment of premiums. Will the carrier hold claims if premiums are not received? How will they work with a group to ensure that coverage remains in force? Answering these questions and understanding the carrier’s policy in advance will be critically important to the overall management of the plan.

Financial strength, underwriting practices, contract alignment, claims processing, medical case management, and premium processing are all very important variables that must be understood when considering a stop-loss carrier. HMA carefully evaluates and selects their stop-loss carrier partners to assure the best combination of protection and value for our self-funded customers. To learn more about the importance of having the right stop-loss carrier, contact HMA.

Thomas Beecken is the Senior Product Manager at Healthcare Management Administrators, Inc. (HMA), a third party benefits administrator based in Bellevue, WA. He manages Stop Loss Carrier and Pharmacy Benefits Manager partner relationships. HMA currently administers over 600 benefits plans and offers self-insured employers a full complement of benefit products and services. Contact: 800.869.7093, or proposals@accesstpa.com.

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Employee Engagement Key to Developing Healthier Employees

By Dave Johnson, MD
President
Vivacity

Healthcare expenses continue to rise for employers and employees alike. While healthcare reform attempted to make healthcare more affordable, more than anything it heightened our awareness of just how contentious and important an issue it is to most Americans. As a business or business owner, what tangible opportunities exist to slow or reduce annual healthcare costs?

“Improve your health” is a battle cry heard frequently throughout companies both small and large. Develop healthier employees and by deductive reasoning, related healthcare costs should decline. But how, and more importantly, what, drives successful results? The key is engagement.

Simply offering opportunities for employees to participate in healthy activities, a discount to the local health club or distributing information on healthy choices may produce satisfactory results. However, as we have learned through our own research, there are no simple answers. Above all, engagement is the hidden key to success. The challenge becomes: “can the program generate engagement?”

Develop and support an engaged participant and results point to the difference between an engaged participant and non-participant. Even if a participant had all five biometric readings outside the normal range, their average annual healthcare costs were still lower than a non-participant. Subsequent research revealed that average year-over-year medical costs for engaged employees decreased by 9% or about $300 and participants recorded a significant lowering of their 10 year risk of heart disease.

Vivacity tracked a client’s progress on five key health measurements. Research revealed that healthcare costs for employees engaged in the worksite wellness program averaged more than 30% lower in year one than for those who elected not to participate. The chart measures in real dollars the difference between an engaged participant and non-participant. Even if a participant had all five biometric readings outside the normal range, their average annual healthcare costs were still lower than a non-participant. Subsequent research revealed that average year-over-year medical costs for engaged employees decreased by 9% or about $300 and participants recorded a significant lowering of their 10 year risk of heart disease.

Comprehensive wellness programs have traditionally been available only to large employers. Generally speaking, small to medium-sized businesses do not have the support mechanism in place to offer and sustain a workforce wellness program or the employee base to create economies of scale. While Vivacity can meet the demands of a multi-billion dollar corporation, it recently launched a series of highly innovative products designed exclusively for small to medium-sized businesses. Most importantly, to promote a supportive and ultimately successful program, Workforce Wellness is designed to meet the needs of companies ranging from 25-500 employees and can include professional consultation with a Vivacity wellness professional. This professional advice not only helps clients design a workforce wellness program that meets their specific needs, it also fosters long-term engagement that is critical to success.

Dave Johnson, MD, is President of Vivacity. He has an extensive background working with health plans in disease and health risk management. Learn more about Vivacity and sign up for Johnson’s email communications at www.vivacity.net.
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Data Security Remains Key Risk Management Issue for Insurers and Other Large Holders of PHI

By Anthony R. Miles
Partner
Stoel Rives LLP

With all the discussion about this year’s federal healthcare legislation, HIPAA Security compliance issues may seem like old news. Nonetheless, the list of substantial breach notifications posted on the website of the Department of Health and Human Services (HHS), Office of Civil Rights (OCR), along with developments in HIPAA enforcement and changes to NIST standards, demonstrates that securing protected health information (PHI) remains a worthy focus of risk-management resources for insurance entities, hospitals and health systems. HITECH grants HHS the authority to impose penalties for violations under almost any circumstances, which makes it all the more surprising that many of these reports could have been avoided with better security technology or improvements in policies, procedures and training.

Fortunately for entities with large volumes of PHI, OCR has indicated that it will continue to use enforcement discretion where appropriate. For example, a covered entity can assert an affirmative defense if the violation was not due to willful neglect and was corrected within 30 days of when it was or should have been discovered. HHS also retains the discretion to resolve “indications of noncompliance” by informal means and to enter into “Resolution Agreements” to involve indications of violations. A Resolution Agreement generally includes payment of a resolution amount and incorporates a corrective action plan involving oversight of compliance by HHS including approval of policies and procedures, improved training and other monitoring of implementation and compliance, usually for a period of three years.

HHS takes the position that the resolution amount is not a civil monetary penalty, fine or other penalty, and that its informal processes are not subject oversight by an administrative law judge or other process, so neither is a “get out of jail free” card. An organization entering into a Resolution Agreement must agree to extend the statute of limitations beyond the termination of the Resolution Agreement if it otherwise would expire during that term of the agreement. This effectively leaves the organization vulnerable to penalties for any underlying noncompliance with the Privacy or Security Rules if the organization does not comply with the terms of the Resolution Agreement.

Under these circumstances, the number of breaches involving more than 500 individuals reported to HHS involving laptops and other portable data storage devices is surprising and suggests that employee mobility and remote access continue to be significant security
challenges for organizations that maintain large volumes of health data. Our experience advising clients in data breach scenarios confirms this perspective and suggests other areas in which organizations could further reduce potential exposure to substantial breaches and subsequent enforcement by reviewing their security posture, such as:

- Off-site data storage and data destruction vendors
- Software updates and security patches
- IT Help Desk personnel and procedures
- “Data at rest but in motion”—mobile devices, portable storage media, social networking

Those organizations that have implemented, or are contemplating implementing encryption technology to take advantage of the safe harbor under the Breach Notification Rulevi also should note that some of the algorithms originally approved for compliance with the standards set forth in the HHS 2009 Guidancev no longer will be approved as part of an overall increase in security strength requirements scheduled for 2011.vi Unless HHS issues new guidance overriding the transition schedule for purposes of HIPAA compliance, organizations using encryption modules based on either algorithms with a security strength below 112 bits will need to upgrade their technology prior to January 1, 2011.

Those considering investing in encryption technology should ensure that the products they are considering include technology that will comply with the increased security strength requirements for validation under applicable publications from the National Institute for Standards in Technology (NIST) and Federal Information Processing Standard 140-2. Failure to do so could result in unanticipated interoperability problems with some systems (e.g., community EHRs, ePrescription programs); however, most importantly, interception of a transmission or unauthorized access to data encrypted with these technologies may well be the next wave of unexpected notification and reporting responsibilities, and possibly additional enforcement action by HHS.

Tony Miles is a Partner at Stoel Rives LLP who focuses his healthcare practice at the intersection of healthcare regulation and technology.

Please see> Security, P15
Washington Hospitals Report Solid Results for Calendar Year 2009

By David Peel  
Publisher and Editor  
Washington Healthcare News

Washington State hospitals appear to have weathered the recession, as 36 of the largest 40 hospitals reported positive margins for calendar year 2009. The 2009 figures were similar to 2008, when 33 of the largest 40 hospitals reported positive margins. Included within the key financial information summarization report (page 13), is a comparison between calendar years 2009 and 2008.

Information Sources

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

1. Most hospitals report and are audited on a calendar year basis. However, some large hospitals report on a fiscal year basis making comparisons impossible without adjustments.

2. All hospitals report to the Washington State Department of Health (DOH) on a quarterly basis but the figures are unaudited and there’s no provision to restate prior quarters for adjustments.

3. A few hospitals don’t regularly meet reporting deadlines.

To mitigate the first two reasons, we compiled quarterly figures from the DOH, Center for Health Statistics (CHS) web site and prepared a report similar to the report on page 13. We then sent the report to hospital representatives and asked them to confirm their hospital’s figures. We asked to be provided with correct figures if the figures in the report weren’t correct.

Hospitals with a “2” or “3” to the right of the name provided a reply and confirmed or changed their figures. If a hospital didn’t provide a reply then there is no “2” or “3” to the right of the name and DOH CHS quarterly report web site figures were used.

To mitigate the third reason, we omitted hospitals that did not report quarterly information.

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. This is consistent with the DOH CHS definition of Operating Revenue but is different than the way some external auditors prepare audited financial statements for hospitals.

Thirty-nine of the forty hospitals reported higher 2009 operating revenues than 2008. 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 increased their 2009 operating margin over 2008. When dividing operating margin by operating revenues, several facilities stood out. MultiCare Good Samaritan had the highest percentage at 20.7%, followed by Mary Bridge Children’s Hospital (14.1%), Providence Centralia Hospital (12.1%), St. Please see> Results, P14
### Forty Largest Hospitals Sorted by 2009 Operating Revenues

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Operating Revenues</th>
<th>Net Non-Operating Caseload Costs</th>
<th>Total Margin</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Washington Medical Ctr.</td>
<td>$63,625,924</td>
<td>$28,506,824</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Cantor Children's Hospital</td>
<td>$62,345,524</td>
<td>$27,226,424</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Harborview Medical Ctr.</td>
<td>$61,982,524</td>
<td>$26,863,424</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>St. Joseph Medical Ctr - Tacoma</td>
<td>$60,862,524</td>
<td>$25,743,424</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Evergreen Hospital</td>
<td>$56,651,024</td>
<td>$23,532,924</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Valley Medical Center</td>
<td>$52,477,024</td>
<td>$21,368,924</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Northwest Hospital</td>
<td>$50,323,024</td>
<td>$20,194,924</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Southwestern Washington Medical Ctr.</td>
<td>$48,241,024</td>
<td>$18,067,924</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>St. Joseph Medical Ctr - Tacoma</td>
<td>$47,129,024</td>
<td>$16,958,924</td>
<td>2.5%</td>
<td>0</td>
</tr>
<tr>
<td>Providence Sacred Heart Medical Ctr.</td>
<td>$45,217,024</td>
<td>$14,694,924</td>
<td>2.5%</td>
<td>0</td>
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<tr>
<td>University of Washington Medical Ctr.</td>
<td>$42,006,024</td>
<td>$12,783,924</td>
<td>2.5%</td>
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</tr>
</tbody>
</table>

### Glossary
- Operating Revenues: Revenue from the sale of goods and services related to patient care.
- Non-operating Gains/Losses: Other revenue sources.
- Operating Margin: Profit from operations before taxes.
- Change: Year-over-year percentage change in revenues.

*Figures from the WA State Department of Health Center for Health (DOH CHS) Statistics web site as of June 26, 2010 unless footnoted with a 2 or 3.*
Joseph Medical Center - Tacoma (11.1%) and Tacoma General Allenmore Hospital (11.0%). Three MultiCare facilities were in the top five in this category. Marce Edwards, Media Relations Manager of MultiCare Health System commented, “In addition to the hospitals, MultiCare Health System includes clinics and a vast network of physicians. Our overall operating margin was about 8.9%, in part because we work hard to control our costs.” She continued, “We are providing more charity care, are seeing more patients having trouble financially and are receiving lower reimbursements from government payors. We don’t believe these results will be sustained.”

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 impact of the 2008 stock market meltdown is seen in the report, as is the rebound of 2009. Twenty-six of the forty hospitals reported higher net non-operating gains and losses in 2009 than 2008.

Total Margin
The excess of revenue over expenses and gains over losses generated from all sources is the total margin. Thirty-two of the forty hospitals reported an increase in total margin from 2008.

Cassie Sauer, Vice President, Communications at the Washington State Hospital Association provided context, “It does appear that many hospitals seem to be doing better in 2009, but a number of hospitals are reporting difficulties during the past two quarters with increasing charity and bad debt. Of course, this is in comparison to the 2008 bad baseline year with its problems in total margin (due largely to the drops related to investment income). We also know that a number of hospitals’ increasing margins are due to some pretty significant cuts made in hospitals.”

Final Observations
Washington State hospitals are in good financial shape and have the ability to exert control over both revenues and expenses. However, payers may now believe the scales have tipped too far in the hospital industry’s favor and could demand concessions. On the expense side, as the economy continues to recover, and healthcare reform is implemented, the cuts Sauer noted may need to be reversed and could have an impact on margins.

We’ll continue to report financial information on Washington hospitals as it becomes publicly available.
Like you, we spend a lot of time listening.

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**Clinic Supervisor**

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

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**Manager, Cardiopulmonary/Respiratory Care Services - Vancouver, Washington**

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Chief Nursing Officer (Goldendale, WA)

The C.N.O. position provides clinical and operational leadership in the development of strategic plans to position and maintain the organization as a leading healthcare provider within the community served; maintains accountability for the quality of care and services within the hospital; plans, organizes, directs, monitors, evaluates and acts on quality of appropriateness of care review findings; maintains accountability for quality of care as perceived by patients, families, medical staff, peers and colleagues; maintains accountability for the financial management of nursing services; monitors, evaluates and develops strategies for adding or modifying services as demand changes in relation to facilities, technological advances, and changes in systems or processes that increase productivity, efficiency and satisfaction; develops and coordinates human resources management and development.

Requirements:
- Baccalaureate degree in Nursing from a four-year college or university; Masters preferred. Extensive job knowledge in nursing, patient care services and administrative practice necessary. Previous experience as a C.N.O. preferred. Minimum of five years of relevant clinical experience preferred. Must have current Registered Nurse Licensure in Washington State. Experience in Rural Health Care settings. Experience in labor and management Relations desired.

To apply and learn more visit www.kvhealth.net EOE

Manager of Patient Safety (Seattle, WA)

UWMC has an outstanding opportunity for a MANAGER OF PATIENT SAFETY. The Patient Safety Manager fosters the enhancement of patient safety across the medical center. This individual serves as a leader for patient safety and is a subject matter expert, consultant and resource for patient safety throughout the Medical Center. The Patient Safety Manager possesses expertise in patient safety principals and performance improvement methods. Through consultation and coaching, this individual works collaboratively with UWMC staff and physicians in the identification, planning and evaluation of multidisciplinary process improvements and patient safety projects.

Requirements: Bachelor in Science in a clinical field. Masters level academic preparation or equivalent in clinical or related field (ie,PharmD, MHA, MBA), AND Five (5) years of experience in a clinical setting and at least one year of experience in quality improvement. Certification in Health Care Quality is preferred. Project management experience is preferred. Management level experience is preferred.

To apply please visit www.washington.edu/jobs and enter Req# 61385 in the Req Search field

Family Birth Center Director

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

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

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

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

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

Manager - Leadership Development

Job Summary:
Collaborates with organizational leaders to develop strategic training initiatives to meet organizational goals. Conducts needs analysis and makes recommendations for the delivery of various customized strategies, programs, learning activities and solutions targeted to the development of leadership competencies. Ensures training initiatives align and integrate with strategies, projects and programs for successful implementation and results. Additional areas of emphasis include business critical competency development, consultation with leaders to support their individual succession and talent planning needs, individual development planning, assessments, on-boarding new leaders and emerging leader development support.

Education:
Bachelor’s degree in Human Resources, Education, Business Administration, Training and Development, Organizational Development or related field, and five years of progressively responsible leadership, learning and development and talent management experience in a healthcare or service related business, including three years in a supervisory or management capacity. Master’s degree in a related field preferred. Leadership assessment and development process experience required. An equivalent amount of additional qualifying work experience may be substituted for up to two years of the education requirement.

To apply and learn more visit www.fhshealth.org

Vice President Finance (Boise, ID)

The Vice President of Finance is responsible for development of the association’s position on issues involving financing of healthcare services, including third party payment issues, utilization and data policy. This position also provides leadership on financial issues including analysis and guidance required by the Board of Directors, member hospitals and IHA senior management.

Qualifications:
Requires a baccalaureate degree from accredited college or university in, accounting, finance, business or related field. Five years of hospital financial management experience or equivalent required, including experience with bond issues and financing, FASB and GASB knowledge, and investment/treasury functions. Database management experience and certification in HFMA preferred.

Please send resume and cover letter to dotoole@teamiha.org.
Nursing Director, Medical-Surgical and Critical Care

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

**REQUIREMENTS**

**Required:** BSN. Previous related nursing experience.

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

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

Additional Salary Information: DOE

Apply at www.kvch.com

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**Chief Operating Officer**

(Bellingham, WA)

Interfaith Community Health Center is currently searching for a Chief Operating Officer. This full-time benefitted position will be accountable for continuous improvement in quality of care and service, and efficient use of staff and referral resources to achieve the mission of Interfaith CHC. As a member of the senior management team, they will contribute to the organizational and strategic planning of the organization and be responsible for supervising a staff of 80 or more FTE. The ideal candidate will have at least five years progressive management experience, preferably in a primary care medical group or community health center environment.

If you have the drive and initiative to fill this role, please view the complete job description and application process at www.interfaithchc.org.

We value our employees & offer a competitive wage & benefits package.

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**GroupHealth**

**Clinical Operations Managers**

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

**Responsibilities include:**

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

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

The focus of the Clinical Operations Manager will include:

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

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

- Must have BSN or RN w/ related Bachelor’s degree and current Washington RN license.
- Managerial experience and the ability to lead teams in the development of standard work are essential.
- Competitive salary and excellent benefits.

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

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

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

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Time to bring in outside help?

The Consultant Marketplace, located on the Washington Healthcare News web site, is where over 50 companies that specialize in providing services or products to healthcare organizations are found. Visit wahcnews.com/consultant to learn more.