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RAC Attack: How Can Hospitals Guard Against Medicare Reimbursement Loss?

By Richard Lewis
Manager, Health Care Group
Moss Adams LLP

One of the biggest high-wire acts for hospital administrators and executives today is ensuring that the clinical documentation supports the services coded and billed. Why is this important? Because, to put it simply, Medicare revenue retention is directly tied to hospitals' clinical documentation quality and coding accuracy.

The permanent Medicare Recovery Audit Contractor (RAC) program was rolled out throughout the nation in January 2010. Since then, most hospitals have experienced automated and complex reviews pertaining to suspected coding and billing errors. In August 2010 three of the four RAC contractors received Centers for Medicare & Medicaid Services (CMS) approval to review as many as 29 Medicare Severity Diagnosis Related Groups (MS-DRGs) for medical necessity.

This is just the beginning. RACs have already received approval to review the coding for over 500 of the 746 MS-DRGs. At this point it's more a question of what the RAC won't be reviewing, not what they are reviewing.

The Medicare RAC demonstration project, conducted between 2005 and 2008, centered around three key states (Florida, New York, and California) and returned over $1 billion to the Medicare Trust Fund. Despite the staggering total, and questions about whether the RACs were overzealous, the key point is that almost two-thirds of the $1 billion in take-backs were for care determined to be not medically necessary or provided in the wrong setting.

During the winter of 2009–2010, CMS raised the maximum number of records RACs could request during each 45-day period. Starting in the early months of 2010, providers braced themselves for an onslaught of RAC requests for medical records to conduct complex coding audits. Much to their surprise, the number of requests

Please see> RAC, P3

Inside This Issue

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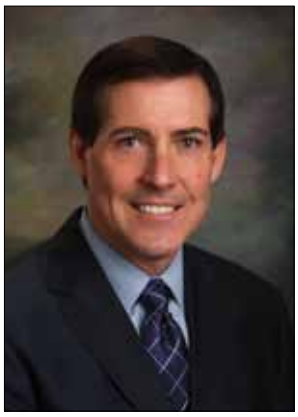
If you have questions or suggestions regarding the News and its contents, please reply to dpeel@cahcnews.com.

Letter from the Publisher and Editor



Dear Reader,

The California Healthcare News maintains a very active Facebook page. We scour the internet and post links to articles of interest to professionals in the California healthcare industry. We also post job openings and articles from the California Healthcare News web site.

Facebook users can "Like" our page and receive updates to their own pages as we make them to ours.

Many people have asked why we're so bullish on Facebook when our reader demographic is a "seasoned" one. After all, aren't Facebook and the other social networks for the young? Absolutely not!

According to iStrategyLabs.com, an organization that has been tracking Facebook growth since October 2007, from 01/04/09 to 01/04/10 more people in the 35-54 age range used Facebook than any other age range. The 29,917,640 U.S. Facebook users in this demographic represented a 328.1% increase over the prior year.

To see our page, visit cahcnews.com and click on the Facebook icon.

Until next month,

David Peel, Publisher and Editor

< RAC, from P1

rarely met the maximums set by CMS and, in many cases, providers didn't receive a request during each 45-day period.

There was a lot of speculation as to reasons for the limited activity from RACs in early 2010. Like most providers, RACs faced challenges when developing new programs and offering new services, including recruiting skilled health care professionals and developing efficient processes and procedures. Instead of incurring inefficient and unnecessary expenses to review only half of the equation (coding), RACs used their time wisely, testing out their data-mining tools and reviewing limited records while seeking CMS approval for the medical necessity audits.

As everyone in the hospital industry knows, these medical necessity determinations can be an excruciatingly complicated process. The margin for error is slim, and mistakes can be extremely expensive. Even minor errors can cost a provider millions of dollars. So it's essential to remember that the key focus of the initial medical necessity reviews is on whether the clinical documentation supports medical necessity for the setting billed.

For example, short stays, primarily one-day stays during which services could have been provided on an outpatient basis (such as observation), will be carefully scrutinized. The most basic elements of the medical record, admission orders, are also being reviewed carefully. Was the physician's admission order properly worded and documented? Without a proper physician order for inpatient admission, the claim isn't qualified to be paid as an inpatient admission. The risks are huge, because the RAC could recoup the entire amount paid to the facility for the inpatient admission.

But even though revenues are absolutely crucial here, the cost of coding and billing (wrong setting) errors extends well beyond dollars and cents. In some cases, honest confusion about certain codes or differing interpretations about the proper setting and coding can lead to wrongful government accusations of fraud and abuse—as well as significant loss of well-deserved reimbursement. Therefore, internal and external audits should be regularly performed to ensure the quality and accuracy of the clinical documentation to support the coding and the medical necessity of the setting billed.

CMS will likely continue to expand the number of MS-DRGs that RACs can review for medical necessity, and hospitals figure to be peppered with a steady stream of government requests for data and records that can explain and justify standard and basic patient care.

In addition to fighting the good fight, hospitals need to continuously improve the quality of their clinical documentation to support inpatient admissions and length of stay. The best defense—and the best way to get rid of RACs—is to code and bill consistent with clinical documentation in the proper setting.

It's important to note that RACs are paid on a contingent fee basis. Simply put, medical necessity validation reviews are where the money is for the RAC. And medical necessity denials are lucrative because, in many cases, the RAC recovers 100 percent of the Medicare payment.

It's well worth considering some of the approaches touched on in this analysis to make sure the government's Medicare reimbursement audits don't eat up precious time, energy, emotion—and revenues.

Rik Lewis, Health Care Consulting Manager and Director of Sales, has more than 28 years of experience specializing in health care coding consulting and project management. He can be contacted at (253) 284-5286 or richard.lewis@mossadams.com.

To learn more about Moss Adams LLP visit their website at www.mossadams.com.

Retirement Plan Management: Another Layer of Disclosure Required for Defined Contribution & Defined Benefit Plans

By William Small
Principal
Highland Capital Advisors

It is no surprise to healthcare employers that the operation of qualified retirement plans have become both more simple, and more complicated. Simplification has come through products, technologies and changes to regulations that support easier design, implementation and maintenance.

More complicated through increased demands on employers, plan sponsors and staff to measure and manage the direct and indirect expenses of the Plan. Some of these changes stem from regulation, some from new legislation and some from changed behaviors in the marketplace by decision makers and vendors.

2009 – Year of the Audit

For many retirement plan sponsors, 2009 was the "year of the audit" as most 403(b) plans with over 100 participants became subject to an annual plan audit and IRS tax filing for the first time. Concurrently, many such plans became subject to the provisions of ERISA, the watershed retirement plan law originally passed in 1974.

2010 – Year of Disclosure

Recently released final regulation under §408(b)(2) from the Department of Labor make 2010 the "year of disclosure" which layers an additional level of obligation upon plan sponsors and their management. The new regulation was released on July 15, 2010, with an effective date that will apply to existing service arrangements as of July 16, 2011. In other words, your current plan compensation must be accounted for beginning next July. The long lead time is reflective of the depth and detail of the new regulation and is intended to accommodate the costs and burden of transition to a new disclosure scheme.

Because the new regulation is interim as well as final, additional requirements may be added prior to the effective date.

The new regulation applies to both defined contribution and defined benefit plans, although some provisions only apply to those which provide participant direction of investment accounts. The new regulation focuses on the disclosure of direct and indirect compensation received by certain service providers that expect to receive at least $1,000 in compensation and that provide:

- Fiduciary or registered investment advisory services;
- Recordkeeping services;
- Brokerage services; or
- Certain other services for which indirect compensation is received.

Disclosure Requirements

Plan service providers are required to provide information in writing to the plan fiduciary (usually the plan sponsor). The rule does not require a written contract delineating the vendor's disclosure obligations, but we think best (or at least adequate) business practices suggest you require it of your providers.

Information that must be disclosed in the vendor's written disclosure includes:

- A description of the services to be provided;
- All direct or indirect compensation to be received by the service provider, its affiliates or subcontractors;
- Detail on "bundled" arrangements where compensation is internal and not explicitly spelled out (as in the case of an insurance company or mutual fund with internal payments to funds, administrators, brokers, etc.);
- Service provider disclosure as to whether they are providing any services as a fiduciary to the plan; and

- Disclosure about plan investments. This obligation is placed upon both fiduciaries and on recordkeepers and brokers who facilitate the investment in plan options through administration platforms or other pooled mechanisms.

Impact & Action

There are significant differences between the New Schedule C to the Form 5500 Annual Report and supporting audit. First, there is no de minimis exemption for plans with fewer than 100 participants; second, the new regulation expands the obligations of plan sponsors dealing with vendor contract provisions and "reasonableness" of such provisions. The primary purpose of the regulation is to ensure that plan fiduciaries are provided with the information they need to prudently select and monitor service providers. This is part of a broader initiative by the DOL to increase the transparency of fee arrangements.

Noncompliance under the regulation may result in a violation of ERISA and an excise tax imposed under IRS code. Brokers, auditors and bundled service providers are scrambling to deal with this new regulation.

Stepping back from the tactical elements of these requirements, the net effect to most sponsors is a disruption of the mud at the bottom of the retirement plan pond. The time has come for every responsible sponsor to understand the nuanced issues surrounding fees, types of investment providers, etc. that have been ignored by many for far too long.

As consultants and advisors, Highland is helping plan sponsor clients deal with the new regulation. Key issues: a) how to gather and collate the required data; b) development of policy and process to determine what is "reasonable" compensation for services provided; and c) implementation procedures to conform with all requirements – driven by both ERISA and IRS regulations and by professional best practices.

For a complimentary analysis of your organization's risk profile and remediation options, give the author a call.

William Small is a principal with Highland Capital Advisors, an SEC-registered consulting and advisory firm serving institutional employers and investors from offices in Seattle, Portland and San Francisco. He can be reached at (800) 717-6180 or bsmall@hcportfolios.com.

Considerations for Acquiring or Affiliating with Another Hospital

By Tanya K. Hahn
Senior Vice President
Lancaster Pollard
and
Mike Johns
Vice President, Finance Practice
Quorum Health Resources

The economic downturn and resulting restricted access to capital have caused many hospitals to consider a partner or other affiliation strategy. Declining volumes and the deteriorating payer mix are further forcing these discussions – as are the seemingly countless opportunities for capital-rich hospitals to acquire struggling, undervalued hospitals.

Recent healthcare reforms may have a further impact on hospital affiliation. In fact, a recent Moody's report predicts that "as governmental auditing and oversight of revenue are tightened, hospitals will be pressured to operate more efficiently, forcing spending cuts and mergers among smaller hospitals after 2014." Affiliating or acquiring may be the right thing to do, but before taking such a step, there are some considerations for both parties.

From the perspective of the hospital needing a partner, the board must consider a continuum of control. At one end of the spectrum is an affiliation that simply calls for cooperation between the hospitals for mutual benefit, and virtually all control is maintained by the hospital seeking a partner. At the other end of the spectrum is the acquisition of one facility by another, and all control is surrendered to the acquiring facility. In between are management agreements, clinical affiliations, lease transactions, and more formal partnerships with legal and financial commitments by each party.

Consideration should also be given to the benefits provided by the other party.

- If capital needs are driving the decision, then the acquiring facility's balance sheet strength should be evaluated. Will they be able to provide the capital needed for the coming years?
- If expanding the hospital's market is the objective, will the partner provide complementary service lines, a desired brand name and reputation, and a different ability to recruit physicians?

Another consideration is whether the acquiring hospital or system has successfully acquired other facilities. Merging two cultures and achieving synergies are not always easy or successful. Facilities with a successful track record of achieving these objectives are more likely to be successful again.

Debt Factors

Most debt structures have broad provisions for mergers and acquisitions, and they often require bondholder or lender approval prior to such a transaction. Reviewing the debt documentation is a key first step in proceeding with any affiliation/merger discussion.

Hospitals must understand what corporate entity is obligated in the outstanding debt of the hospital being brought in, usually known as the Obligated Group. A debt obligation may be supported by both a hospital and its physician practice group. The merger/affiliation, however, may be desired with the hospital only. Understanding the assets or collateral the hospital owns and the debt it can support without the physician practice group is important to knowing how it might be able to refinance or restructure existing debt. In addition, the acquiring hospital/system may have limitations on its ability to restructure its Obligated Group and must understand current refinancing limitations on its own debt before proceeding with the merger/affiliation.

My Debt is Your Debt

A hospital with outstanding letter-of-credit-enhanced debt may see its debt structure improved by affiliating with a partner that brings a stronger financial position or

banking relationship to the table. The LOC may be able to remain in place, saving both hospitals the time and cost of refinancing. Further benefits can be realized if the acquirer has a significant banking relationship with the enhancement provider.

HUD/FHA Section 242 mortgage-insured loans are assumable by acquiring hospitals, with approval from FHA, and they remain non-recourse to the affiliation/acquiring hospital. The current limitations on transfers are not overly burdensome and should not be viewed as a deterrent to the affiliation/merger. FHA-insured loans can be assumed by either nonprofit or for-profit hospitals.

USDA direct loans may be assumable depending on the acquirer or affiliation partner. USDA financing is limited to nonprofit hospitals that are rural and that cannot access other means of capital. If an affiliation changes any of these features, then the USDA financing would most likely have to be refinanced. If the partner is a similar-sized rural nonprofit, then assuming the debt may be negotiable.

If a hospital is considering a new debt instrument and is also considering a future affiliation/merger, it should proactively consider future flexibility. Potential negative implications of a merger/affiliation can be minimized or eliminated through active management of debt covenants and prepayment requirements within the financing documentation.

Lastly, as organizations consider a merger/affiliation, they must evaluate the impacts of such a transaction on the investment portfolios of each as well as any interest rate mitigation contracts such as swaps, caps or collars on the new combined entities. Often these contracts will also include provisions related to mergers/affiliations, which may impact the ultimate decision and/or timing of the transaction. A comprehensive balance sheet analysis needs to occur along with the evaluation of the debt instruments of both parties.

Mike Johns is vice president, Finance Practice, at Quorum Health Resources. For additional information on QHR's consulting solutions, contact vice president Susan Hassell at (866) 371-4669.

Tanya K. Hahn is a senior vice president at Lancaster Pollard. For information on debt financing for acquisitions or other projects, contact Jason Dopoulos or Anthony Taddey at (310) 458-9180 or visit www.lancasterpollard.com.

Time to bring in outside help?

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Visit **cahcnews.com/consultant** to learn more.

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Career Opportunities

Care Center Managers

(Sutter East Bay Medical Foundation)

The Care Center Manager manages the day-to-day operations as well as the employees and workflow to ensure that patient needs are optimally met. This position provides oversight and guidance to staff to maximize efficiency and develops processes that improve the workflow by promoting teamwork with providers and employees to create a cohesive, effective team. The Manager will also assure compliance with state, federal, Sutter and Foundation policies and regulations. One full-time position will be to manage the OB/GYN clinic.

Requirements: Demonstrated knowledge in the following: budgeting process and budget management; office workflow and processes; principles of CQI and problem solving techniques. Ability to: communicate effectively in verbal and written ways; lead; motivate and train adults; recognize trends and monitor and report on them; deal effectively with all customers including physicians and difficult customer service issues; keep information confidential; organize effectively; develop and implement policies/procedures/protocol; develop teamwork among members of a multidisciplinary team; work independently, prioritize work and manage time and workflow to meet deadlines; pay attention to detail. *For OB/GYN position (Berkeley, CA):* Bachelor's degree in business; Master's degree preferred. At least 5 years of direct patient care is preferred, as well as previous management experience in healthcare in an ambulatory setting. Knowledge of anatomy and physiology; an understanding of what constitutes a medical emergency requiring a physician or licensed nurses' attention; knowledge of the scope of practice for Medical Assistants, RNs and Physician Assistants. *For Administrative positions (Antioch and Lafayette, CA):* Associate degree in healthcare or business or equivalent combination of experience and education. 3 years' experience managing employees in an office environment; previous management experience in healthcare is preferred

As one of the nation's leading, not-for-profit networks of community-based healthcare providers, Sutter Health East Bay Region offers all the benefits of a large network but finds its greatest strength in the many talents that our employees share with us and their patients. To see additional requirements, learn more and apply contact Marcos Blanco, Senior Allied Health Recruiter, at **blancom@sutterhealth.org**.

Shift Supervisor

(Long Beach, CA)

Assist in supervising and coordinating activities for Security Officers and PBX staff pertinent to the assigned shift. Assist in the supervising and training, reading, editing and making necessary corrections to reports, logs and inspections. Make written reports for the security supervisor on matters regarding activities on assigned shift. Maintain a rapport with nursing directors and department managers regarding matters pertinent matters. Follow-up on all incidents on an assigned shift and provide back up Security Officers as necessary. Position reports to the Security Supervisor (Captain).

Must have excellent Customer Service skills and telephone etiquette. Knowledge of hospital/departmental emergency procedures for fire, safety, disaster, electrical safety, infection control, MSDS and hazardous/toxic materials. Posses a California State Guard card and other Security and Safety certifications. Ability to collaborate and maintain cooperative working relationships with department staff and hospital personnel.

Ability to communicate in a courteous and professional manner to the medical community and hospital staff. California Driver License, California State Guard card. High School graduate or equivalent. Security supervisory experience and Customer Service.

To apply and learn more visit www.7KH D O O L H Q F H È V D

Career Opportunities

To advertise call 425-457-4316
Visit **cahcnews.com** to see all available jobs.

Valley Health System
A California Local Health Care District

Risk / Compliance Manager
(Hemet, CA)

Valley Health System – a premier healthcare provider and largest employer in the San Jacinto and Menifee Valleys – is comprised of two acute care hospitals and a chemical dependency treatment facility. We seek caring and patient dedicated professionals who embody our spirit of teamwork and mission of working together, making a positive difference in people's lives and healing through excellent, compassionate care.

The following opportunities exist with our 343-bed Hemet Valley Medical Center:

Risk/Compliance Manager

The successful candidate will be the focal point of compliance and risk activities contributing to the fulfillment of the organization's mission and vision by planning, designing, implementing, and maintaining system-wide compliance programs, policies, and procedures.

Qualifications: Associate Degree in Nursing or successful completion of an accredited Registered Nurse Program as evidence by licensure, from a recognized college or university. A valid license to practice as a Registered Nurse in the State of California

Learn more and apply at:
www.valleyhealthsystem.com or email:
District.HumanResources@ValleyHealthSystem.com.

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City of Hope

Clinical Research Associates
(Duarte, CA)

Position:

CLINICAL RESEARCH ASSOCIATES

JOB SPECIFICATIONS:

ASSOCIATE'S DEGREE PLUS 2 YEAR EXPERIENCE WORKING IN A HEALTH CARE SETTING, PREFERABLY IN RESEARCH. CLINICAL TRIALS MANAGEMENT EXPERIENCE MAY SUBSTITUTE FOR MINIMUM EDUCATION REQUIREMENTS. PREFERRED FIELD OR EXPERTISE; MEDICAL RECORDS, HEALTH INFORMATION SYSTEMS, OR RELATED HEALTH FIELD. POSSESS A STRONG INTEREST IN CLINICAL ONCOLOGY RESEARCH PROTOCOLS. DATA COLLECTION

JOB FUNCTIONS:

THE SUCCESSFUL CANDIDATE WILL ALREADY POSSESS WORKING KNOWLEDGE/EXPERIENCE IN: PROTOCOL MANAGEMENT OF ASSIGNED SET OF MULTIPLE RESEARCH PROTOCOLS. COMPILATION, REGISTRATION AND SUBMISSION OF DATA. EFFICIENCY AND REGULATORY COMPLIANCE OF PROTOCOL, ATTEND CLINIC AS NEEDED. MONITORING OF STUDY COMPLIANCE AND DATA FLOW SYSTEMS MAINTENANCE WITH RESEARCH PROTOCOLS.

SALARY:

COMMENSURATE WITH EXPERIENCE
RANGE: $46,580 - $79,420

For immediate consideration or questions, please contact Rosie Armenedariz at 800-732-7150 or apply online at:

www.cityofhope.org/careers EOE

Director, Physician Operations

(Sutter East Bay Medical Foundation)

The Director will direct, supervise and coordinate all SEBMF operations and physician activities for the assigned region of responsibility. This involves either direct or indirect responsibility for staffing, budgeting, fiscal planning, telecommunications and equipment purchases and maintenance, and facility development. This is carried out through daily interaction with physicians, managers, supervisors, and senior administrative personnel.

Requirements: Bachelor's degree in business or equivalent combination of education and related experience; Master's degree in healthcare or business administration is preferred. 5 years' managerial and administrative experience in a medical clinic or group practice setting with an emphasis on clinical operations. General knowledge of the healthcare system, billing processes, clinical procedures, budget preparation, staffing models, employee regulations and previous interaction with physicians in a management role. Current knowledge of group practice management in a clinical setting, medical clinic philosophy, policies and operating procedures; should be up to date on current regulations and policies affecting employees and healthcare. Must possess the following skills: business and analytical; written and verbal; ability to exercise initiative, judgment, problem solving and decision making; ability to develop and maintain effective relationships with staff and physicians; ability to organize work and achieve goals and objectives; ability to research and prepare comprehensive reports.

As one of the nation's leading, not-for-profit networks of community-based healthcare providers, Sutter Health East Bay Region offers all the benefits of a large network but finds its greatest strength in the many talents that our employees share with us and their patients. To see additional requirements, learn more and apply contact:

lobaugr@sutterhealth.org

Sutter Health
Central Valley Region
With You. For Life.

Manager of Marketing and Communications
(Modesto, CA)

The Manager of Marketing and Communications will be responsible for overall management of marketing and communications for the hospital and medical foundation assets in a specified area of the Sutter Health Central Valley Region (CVR). There are three marketing manager positions - one for the medical foundation, one for the hospital assets in Stanislaus/Merced Counties and one for the hospital assets in San Joaquin Counties. These three team-based positions will be based and operate from one central location in Modesto, CA. There are no direct reports to this position, but they will work as a team with other regional support services.

Qualifications: *Required:* Bachelor's Degree in a related discipline. A minimum of 5 years experience as a manager of marketing / communications. Demonstrated experience in development, implementation and measurement of strategic marketing and communications plans. Demonstrated experience in proactive, positive media relationships as a media spokesperson is required. Strong writing skills for both traditional and web/online communication channels are required. Knowledge of graphic design and production, graphic standards/corporate identity management, media relations, government relations, publicity, media spokesperson techniques, publications and special events required. *Preferred:* Preferred degree in marketing or communications. Health care experience strongly preferred. Preferred experience with video shooting, editing, production and uploading. Preferred experience with podcasting or other audio production.

We have a reputation for excellent patient care and a high level of job satisfaction amongst our employees. We offer competitive salaries, comprehensive benefits, good employment incentives and a wonderful quality of life. Please apply online:

www.memorialmedicalcenter.org EOE

PACIFIC HOSPITAL OF LONG BEACH

Security Officer

(Long Beach, CA)

Implement security programs within the hospital to meet the requirements of the hospital, Federal, State, County and local governments. Carries out education, orientation and other training programs for the security of the hospital and its occupants. Performs a wide variety of typing assignments, some of which may be confidential. Demonstrates ability to exercise independent judgment in times of need and emergency situations. Maintains an awareness of customer needs (hospital staff, patients) to ensure customer satisfaction. Observes security deficiencies and report observations promptly during current shift. Obtains accurate and detailed description of person in question. Fills out required documents properly, completely and legibly. Approaches person in a firm but courteous manner. Performs other duties as assigned. Reports to the Lead Security Officer and to the Director of Security, Safety & Communications.

QUALIFICATIONS

Must have excellent Customer Service skills and telephone etiquette. Must have the ability to do the job safely, as evidenced by proper body mechanics, and without injury to self or others. Knowledge of hospital/departmental emergency procedures for fire, safety, disaster, electrical safety, infection control, MSDS and hazardous/toxic materials. Posses a California State Guard card and other Security and Safety certifications.

High School graduate or equivalent. Security Officer and Customer Service. Cal. State Guard Card, California Driver License

To apply and learn more visit **www.phlb.org**. EOE

CHILDREN'S HOSPITAL & RESEARCH CENTER OAKLAND

Vice President, Human Resources
(Oakland, CA)

At **Children's Hospital & Research Center Oakland**, the only independent children's hospital in Northern California, we are currently seeking someone with your multiple capabilities and wealth of experience to fill this key position. We are a facility with 190 licensed beds, 2,800 employees and 6 collaborative bargaining contracts.

In this role, you will formulate and recommend HR strategies and compensation/benefits programs as well as directing the ongoing integration of information technology to enhance their implementation. You will also lead our negotiating team for collective bargaining contracts and identify legal requirements and government regulations affecting HR functions (e.g. EEO, ERISA, ADA, OSHA, Joint Commission Accreditation, Wage Compliance). Along with these and other related tasks, you will also direct management orientation, training, development, performance, recruitment and diversity programs.

Requirements include an undergraduate degree (Master's in Healthcare Administration, Human Resources or related field preferred) plus a minimum of 10 years in an HR leadership role and 5 years in a unionized work environment. Five years in a healthcare or health related environment is ideal.

To view all our opportunities and apply online, please visit our website: **www.childrenshospitaloakland.org**
EOE

Career Opportunities

Administrator
Olympic Peninsula Kidney Center
(Bremerton, WA)

HISTORY AND BACKGROUND

Olympic Peninsula Kidney Center (OPKC) is a community based, 501(c)3 non-profit dialysis organization established in 1980. Our mission is to provide high quality dialysis care for kidney patients in Kitsap and Jefferson counties on the Olympic Peninsula of Washington State.

POSITION OVERVIEW

The Administrator is responsible for ensuring the effective management of the OPKC facilities and provision of all dialysis services with twenty-four hour responsibility and accountability for dialysis operations. This responsibility includes oversight of staffing, scheduling, personnel performance appraisal and discipline, development and administration of fiscal budget, coordination and implementation of all patient care policies, safety and security of the building, grounds and equipment, support to Board of Directors and on-going collaboration with Medical Directors and medical staff.

QUALIFICATIONS

Education - BS or BA degree in healthcare related field. Masters degree in Business Administration, Health Care Administration or related fields preferred. May substitute relevant experience for degree requirement. Organizational management – At least five years of senior management experience. Dialysis experience preferred. Nonprofit experience a plus. Experience reporting to and working with Boards and committees. Demonstrated experience in dialysis operations management. Communication skills – verbal and written. Facility with Microsoft Office products, email and Internet usage.

APPLICATION PROCESS

To apply, please submit your resume and cover letter describing your interest and qualifications to **katrina.russell@dcgseattle.com**. You may send a hardcopy resume to Olympic Peninsula Kidney Center, attn: Katrina Russell, 2613 Wheaton Way Bremerton WA, 98310. All applications will be kept in strict confidence.

CalOptima
Better. Together.

Executive Director, Programs for SPD
(Orange, CA)

CalOptima is a public agency that administers health insurance programs for children, low-income families, seniors, and persons with disabilities in Orange County. CalOptima is Orange County's second largest health insurer overall and largest insurer of children.

This position will lead operations for CalOptima's current programs for SPD and dual eligible members, and develop strategies to take them to the next level of program integration and enhancement. The Executive Director will develop innovative approaches to expand current programs and develop new initiatives to complement them.

Candidates should have 10+ years of related experience, including supervisory experience. Bachelor's degree in a related field is required. Master's degree in Health Administration, Public Health, or other related degree preferred. Candidates should also have extensive experience working at an executive level in a managed care environment, with a successful track record managing home and community based Medicaid (Medi-Cal) services; experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program; and have significant leadership skills, communication skills, strategic thinking and proven ability to build strong interpersonal relationships. Experience in a government or public environment preferred.

Please apply online at: www.caloptima.org

CalOptima is an Equal Opportunity Employer

EK HEALTH

Director over Case Management and Utilization Review
(San Jose, CA)

EK Health Services is currently seeking a Director level employee to oversee the Case Management and Utilization Review departments for the company. A Nurse or other Medical professional with business acumen is welcomed but not required for this position. Workers Comp knowledge & experience preferred, but also not required. Some applicable healthcare experience strongly preferred.

Qualifications: BS degree required; MS / MBA Degree in related field preferred. Valid California Drivers license in good standing. 8-10 years of management experience, exceptional leadership and analytical abilities required. Experience in the insurance, workers compensation or related healthcare required. Strong interpersonal and communication skills; conflict resolution and mediation skills. Ability to foster a collaborative work environment. Must be self-directed and motivated; capable of managing operations independently on a day-to-day basis.

EK Health Services has built a reputation for superior, goal-oriented Workers' Compensation case management and utilization review services. Our emphasis on medical excellence, superior service, impartial reporting and case resolution is the driving force behind our consistent annual growth.

If interested, please submit a resume to Jenna Schrader at **jschrader@ekhealth.com**. Thank you.

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

Clinic Manager

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

Clinic Supervisor

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

RN Supervisor - Nurse Advise

The Vancouver Clinic

We are looking for a customer-service oriented RN with supervisory experience. Will be responsible for the daily supervision of advice nurse staff, assure compliance with all safety and regulatory bodies, train and develop nurse advice staff, and establish, implement, maintain and evaluate/improve patient care and quality service standards.

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

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