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Molecular & Genetic Testing in Anatomic Pathology

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For more than 100 years pathologists have been using microscopes to look at abnormal tissue and cells to better diagnose disease. Today, we are evolving beyond cellular examination to identify the root cause of these abnormalities within the genetic material of the cell itself. The mapping of the human genome has driven growth in molecular testing, which now allows laboratories to analyze tumor tissue and other specimens to determine likelihood of recurrence, source of disease and the best types of therapies to be used. Increased attention is being paid to "personalized medicine" which targets therapies to individual genetic signatures or profiles. These "targeted therapies" represent the most promising advance in cancer treatment yet. There has been a 30% increase in molecular testing in laboratories across the country in the last few years especially in women's health, infectious diseases, organ transplant testing and oncology and this growth is projected to continue.

What is Molecular & Genetic Testing?

Molecular genetic testing spans the entire spectrum from the characterization of cell biology, protein expression and chromosomal rearrangements to the resolution of single abnormalities in the DNA template. Infectious agents can be identified by virtue of unique DNA/RNA sequences. Molecular testing is used not only in diagnosis, but also in monitoring for the effectiveness of therapy and detection of residual disease in various malignancies. Molecular techniques can also predict the effectiveness of some important medications as well as identify specific targets in individual patients' tumors for new therapeutic modalities ("personalized medicine").

Molecular testing utilizes sensitive

Please see> Pathology, page 3

Inside This Issue

Article	Page
Molecular & Genetic Testing in Anatomic Pathology	1
Healthcare Architecture: Providence Southwest and TGBa Bring New Medical Home to Hawks Prairie	8
Healthcare Law: Attendance Really *Is* Essential: The Ninth Circuit Court Confirms That Hospital Attendance Policies Need Not Be Ignored Under the ADA	10
Healthcare Reform: Health Care After the Supreme Court Decision: Establishing and Operating State Exchanges	12
Healthcare Administration: Swedish Shatters any Vestige of a Glass Ceiling	16
Healthcare Finance: Washington State Hospital Financial Results for CY 2011	18
Career Opportunities	19

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LETTERS TO THE EDITOR

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

Letter from the Publisher and Editor

Dear Reader,

In last month's letter, I spoke of the need for healthcare leaders to allocate extra funds for recruiting costs in their 2013 budgets. Providers must be ready to serve hundreds of thousands of new patients on January 1, 2014 as Medicaid expands and individuals are required to buy health insurance. Trained staff will need to be in place in the fourth quarter of 2013 to serve these patients.

The biggest need, I believe, will be primary care and mid-level providers. As my own doctor told me, "who is going to treat all these new patients?"

Since the supply of primary care and mid-level providers is already tight, budget to pay higher wages. Budget for your providers to work longer hours and expect that to cost more, either in salaries or turnover.

Budget for recruiting staff and be sure to offer competitive compensation because they will also be in great demand. Until next month,

David Peel, Publisher and Editor

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< **Pathology, from page 1**

tools that often confirm ambiguous diagnoses suspected by microscopic evaluation, guide therapeutic decisions and assess. For example, the advent of new treatments for certain breast cancers depends on identification of a gene that is amplified and over-expressed in those cancers; the specific gene that is amplified can only be identified by molecular testing.

Molecular Techniques

Molecular testing has impacted clinical practice quite dramatically. Genetic tests are now available for more than 1,700 diseases, up from 1,250 in 2005.[1] Interpretation of slides under the microscope remains the basis of anatomic pathology. However, an expanding menu of molecular tests now complements traditional pathology methods.

Molecular tests are rapid, sensitive and specific and can be performed on almost all specimen types.

Positive Patient Outcomes

When is molecular testing beneficial? The most obvious benefits are in the targeted treatment of diseases such as the cancers described above and the detection of subclinical (difficult to detect) conditions. Molecular tests can indicate disease risk in pre-symptomatic individuals, assess the risk of recurrence, or determine carrier status and the risk for affected offspring. They may also contribute to more precise diagnosis, refine prognostic categories, connect patients to optimal treatment choices, and monitor treatment efficacy.

CellNetix Molecular Program

Cellnetix started our molecular program in late 2010. This has taken considerable investment and we were only able to undertake this as a relatively large, consolidated group (CellNetix is one of the largest physician owned pathology groups in the country). We will briefly review the common molecular tests (and their applications in Anatomic Pathology) that we currently offer at CellNetix, specifically breast, gastric, colon, lung and melanoma targeted tests.

Breast Carcinoma

The HER2/neu gene is amplified in 18-20% of breast carcinomas, which is tied to overexpression of its protein product and malignant transformation. It is an independent marker for poor clini-

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cal outcome in newly diagnosed patients; however, breast cancer patients with increased expression of HER2/neu have a good therapeutic response to trastuzumab (Herceptin) (Genentech, San Francisco, California), a targeted antibody-based therapy for breast cancer and to paclitaxel. These patients also have relative resistance to endocrine therapies such as tamoxifen and other chemotherapeutic agents. The most commonly used molecular test is fluorescence in situ hybridization (FISH) which allows for the examination of genomic DNA in situ.

Gastric/Gastroesophagealjunction Cancer

Amplification of the HER2/neu gene is observed about as frequently in advanced gastric and esophageal adenocarcinoma as in breast cancer. In October 2010, the FDA approved Herceptin in combination with chemotherapy for HER2/neu-positive metastatic cancer of the stomach or gastroesophageal junction, in men and women who have not received prior treatment for their metastatic disease. The current recommendation for people diagnosed with metastatic stomach cancer is to have the HER2 status of their tumors determined.

Colorectal Carcinoma (CRC)

Mutations of the KRAS (Kirsten ras) gene, found in 30% to 40% of CRCs, are important in the development of cancer. Presence of mutations in this gene can predict lack of response to Panitumumab (Vectibix®, Amgen) and Cetuximab (Erbitux®, Merck Serono) in patients with metastatic colorectal cancer. This illustrates the need for sensitive and accurate KRAS testing for these patients. At CellNetix, we use a sensitive real-time molecular assay to detect the most common KRAS mutations.

This real time method is also used to detect the other mutation in what is called the BRAF oncogene. Mutations in BRAF are also observed in colorectal carcinomas; these mutations are responsible for an additional 12-15% of patients who fail to respond to antibody-based targeted therapies. BRAF mutations appear also to be indicative of poor prognosis and testing for mutations in BRAF is recommended under certain circumstances.

Non-Small Cell Lung Cancer (NSCLC)

The Epidermal Growth Factor

Please see> Pathology, page 6

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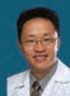
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< **Pathology, from page 5**

Receptor (EGFR) gene encodes a cell membrane receptor; it is a target for signals that set off a cascade of downstream effects and the subsequent development of cancer. Identification of EGFR signaling in cancer has led to the development of anti-cancer therapeutics directed against the EGFR protein, including Gefitinib (Iressa®, AstraZeneca) and Erlotinib (Tarceva®, Roche) for non-small cell lung cancer. Current recommendations are that tumors of all NSCLC patients considered for Gefitinib therapy must be tested for the presence of EGFR mutations before the drug can be prescribed, as Gefitinib is unlikely to be effective in patients without EGFR mutations.

The ALK gene encodes another cell receptor protein involved in the development of NSCLC. Through the use of a FDA-approved protocol, the molecular laboratory in CellNetix routinely performs a quantitative test to detect ALK rearrangements (breaks in the gene) via FISH in NSCLC tissue specimens. This is used to aid in identifying those patients eligible for treatment with XALKORI® (Crizotinib, Pfizer), a drug that is specifically inhibits the activity of the ALK gene in lung tumors.

Melanoma

Melanoma is a complex genetic disease, and multiple genetic alterations have been reported to play a role during disease progression. The BRAF gene is mutated in approximately 8% of human tumors, most frequently in melanoma, where the predominant mutation is observed in approximately 50% of melanomas. Like the mutations referred to above, BRAF mutation is one of the primary drivers of malignancy in the tumor. Zelboraf® (Vemurafenib, Genentech) is an orally available, selective BRAF inhibitor approved by the FDA for patients with unresectable or metastatic melanoma that tests positive for the BRAF mutation.

CellNetix Molecular Pathology Services

Compared to other laboratory tests, molecular-based tests are higher complexity, more expensive, and may have additional ramifications for the patient and his or her biological family members. CellNetix's large anatomic pathology laboratory with diverse molecular and surgical pathology capabilities is well positioned to expand the utilization of molecular testing in pathology practice. Our relative size (45 pathologists/250 employees) gives CellNetix the opportunity to be at the forefront of these new testing protocols.

Our Molecular Pathology department started with our women's health subspecialty, and we brought on High-risk HPV testing, testing for the detection of Neisseria gonorrhoeae (GC) and Chlamydia trachomatis (CT), as well as Vaginosis/Vaginitis testing. We have now also expanded our capabilities in Molecular Oncology. We are up and running with a multitude of FISH and Polymerase Chain Reaction (PCR) -based assays, namely the HER2 FISH for Breast and Gastric Cancer, ALK FISH for Non Small Cell Lung Carcinoma, and Ploidy FISH analysis of Products of Conception. We are also running KRAS mutation assays for Colorectal and Lung Cancer, EGFR mutation for Lung Cancer and BRAF mutation tests for Metastatic Colorectal cancer and Melanoma.

Conclusion

The impact of molecular diagnostics will be felt throughout the entire healthcare system. As the field of genomics gains broader application, clinicians will need to be educated on the proper utilization and interpretation of molecular tests. The pathologist is expected to be a key stakeholder in the future of molecular diagnostics. Pathologists and laboratory professionals need to understand and adopt these new and emerging technologies and their expertise will be critical in this new frontier in medicine. As with many new technologies each day brings more entrepreneurs offering the "latest and best" solutions using molecular technologies to clinicians. Over time and with appropriately controlled studies some of these assays will in fact show their value in improving patient care or reducing waste. However, our experience shows that more often than not extended study rejects the claims of many new tests as delivering on their marketed promises. Clinicians are encouraged to adopt molecular testing technologies when they have been properly reviewed and/or recommended by appropriate professional societies.

Reference:

[1]National Center for Biotechnology Information. GeneTests. Available at: http://www.ncbi.nlm.nih.gov/projects/GeneTests/static/whatsnew/labdirgrowth.shtml.

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Providence Southwest & TGBa Bring New Medical Home to Hawks Prairie

By Nora Haile
Contributing Editor
Washington Healthcare News

The Hawks Prairie area near Lacey, Washington, is fast growing, and Providence Southwest's new medical facility supports the community's evolving health needs.

Taylor, Gregory, Broadway Architects (TGBa) has worked with Providence Medical Group Southwest Washington on a number of outpatient facilities. The latest, a 28,500-square foot medical facility, embodies the medical home concept that Providence promotes. "The Providence Southwest team continues to move services closer to the patients and away from the hospitals," says Kent Gregory, TGBa Principal. "It's a trend that brings medicine to the patient – a customer convenience factor."

Another trend that the medical facility tracks is that of a retail center location. The new Hawks Prairie facility is actually the anchor building in a newly developing retail center, yet maintains distinct, civic-oriented elements. "Designing a medical building that conforms to typical retail center expectations is a recurring challenge," Gregory acknowledges. The TGBa team is familiar with the retail location trend for healthcare facilities, and is adept at addressing the zoning codes usually involved. "It's about finding the fine balance between a location's design being approachable and accessible, yet giving those needing medical care privacy."

Providence Southwest's design objectives meld well with TGBa's methods. Both organizations employ Lean principles, improving quality and removing waste from processes. That efficiency is why the TGBa team applies the 3P (Production Preparation Process) in design. As Gregory explains, "One of the largest waste areas is the intelligence and creativity an organization has within its own staff. We find that working with stakeholders is the most efficient and effective way to design a building. This facility is a good example of its success."

As Gregory describes it, the people who are going to be using the building – physicians, nurses, medical

Providence Medical Group Hawks Prairie

assistants and staff – are brought together and led through a process that provides them with insight to their own processes. Then they create new processes and the space around it to support quality performance. Eventually, it comes down to their creation of the best three design options. Space planning is typically straightforward, he shares, and "Nearly every time, the group evaluates those options and picks out the best, most efficient of the three. They are the authors of their own space – which means they will make sure it's going to work for them and help them perform. That's the magic in the method."

The resultant Hawks Prairie facility not only supports the work of the medical teams that care for the area's residents, it provides a medical home for those residents. Designed to accommodate up to 16 providers, currently the facility houses Hawks Prairie Internal Medicine, Olympia Endocrinology, Hawks Prairie Family Medicine, a full service laboratory and Providence St. Peter Hospital diagnostic imaging services. Beginning this fall, Hawks Prairie anticipates providing Physical Therapy services to their patients with the addition of a full-time Physical Therapist to the facility.

Through the medical home model, patients gain a much more comprehensive form of care, pulling in more wellness activities, as well as collaborative areas. The facility's design features a large central off-stage area that enhances provider collaboration, as well as a shared medical appointment room (SMA). The SMA lets providers have a space to give mini-educational workshops, such as diabetes care, wellness workshops. The providers are able to teach people with similar health challenges together, enhancing a sense of community and creating a near-instant support network for patients.

This medical home model encourages higher quality care, and the setting supports that. The Providence organization is a large, important care provider, and the building, though positioned in a retail center, reflects the scale and character of the care. As Gregory states, "Providence Southwest has been emphatic about the tie-in between the building environment and healing. They wanted a building that was "extroverted" – open, accessible, with serene, natural colors." The aesthetic appeal is apparent in the building's colors and textures, the extensive natural light and the two-story high distinctive mural of cut-steel plate derived from a photograph of trees.

The overall experience between the two organizations, TGBa and Providence Medical Group SWR has been a positive one. According to Judy Backhaus, who's the Physician Services Manager with Providence Medical Group SWR, "TGBa definitely "walks their talk" – sharing how they have applied the LEAN/3P process to their own office. They walked us, step-by-step, through some difficult decision-making along the way. Just last week, a provider now in this new facility, stated his new clinic "turned out really sweet" and he is very happy!"

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Attendance Really *Is* Essential: The Ninth Circuit Confirms That Hospital Attendance Policies Need Not Be Ignored Under the ADA

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Providence St. Vincent Medical Center ("Providence") in Portland, Oregon faced a common dilemma regarding one of the nurses employed in its neo-natal intensive care unit ("NICU"). Year after year, Monika Samper's absences from work greatly surpassed the number of absences allowed under Providence's attendance policy. But Samper, who suffered from fibromyalgia, unquestionably constituted a "qualified individual with a disability" under the Americans with Disabilities Act ("ADA"). Faced with balancing its obligations to provide safe and consistent patient care and its legal obligations to accommodate Samper's disability, Providence spent years attempting to craft a workable solution for Samper's poor attendance. Finally, however, Providence terminated Samper's employment.

Samper subsequently filed suit under the ADA, claiming that Providence's termination decision was improperly based on her disability because her absences stemmed from her fibromyalgia. The Ninth Circuit Court of Appeals' recent decision in the case provides clarification regarding employers' obligations under the ADA. "Just how essential is showing up for work on a predictable basis?" queried the Court. *Samper v. Providence St. Vincent Med. Ctr.*, 675 F.3d 1233, 1235 (9th Cir. 2012). The answer allows healthcare employers to breathe a sigh of relief: "In the case of a neo-natal intensive care nurse, we conclude that attendance really *is* essential." *Id*.

In order to succeed on a disability discrimination claim under the ADA, an employee must prove that he or she is disabled, as defined by the ADA; that he or she is able to perform the essential functions of the position with or without a reasonable accommodation; and that he or she suffered an adverse employment action because of a disability. Samper was able to demonstrate that she was disabled due to her fibromyalgia and that she suffered an adverse employment action – her termination because of her fibromyalgia-induced absences from work. But the Court's conclusion that Samper's attendance was an essential function of her position stopped

her ADA claim in its tracks. As the Court clarified, Samper's demand that she be completely exempted from Providence's attendance policy was *not* a reasonable accommodation request because it would have exempted her from an essential function – something that is not required by the ADA.

Although the *Samper* Court's analysis focused on NICU nurses, its reasoning extends to other employees who provide direct patient care. In analyzing whether regular attendance was an essential function of Samper's position as a NICU nurse, the Court identified a "trinity of requirements that make regular on-site presence necessary for regular performance: teamwork, face-to-face interaction with patients and their families, and working with medical equipment." *Id*. at 1238. These requirements are equally applicable to a large number of healthcare providers and staff.

In addition, the Court emphasized the fact that "NICU nurses must have specialized training, and it is very difficult to find replacements, especially for unscheduled absences." *Id*. Unlike cases in which "workers were basically fungible with one another, so that it did not matter who was doing the [job] on any particular day," in *Samper* the Court recognized that "Samper's regular, predictable presence to perform specialized, life-saving work in a hospital context" was essential. *Id*. The Court further distinguished *Samper*'s circumstances from cases in which on-site presence was not necessary for performance, holding:

> [I]n the context of a neo-natal nurse, it is necessary to *provide* that treatment in the first place. Not only is physical attendance required in the NICU to provide critical care, the hospital needs to populate this difficult-to-staff unit with nurses who can guarantee some regularity in their attendance. *Id*. at 1239.

In addition, the Court acknowledged the critical point that, in a hospital setting, "[u]nderstaffing compromises patient care." *Id*. at 1238.

Samper does not change healthcare providers' duty to avoid attendance discipline for absences due to protected leave such as leave under the Family and Medical Leave Act. When determining accommodation obligations, employers should also check state disability accommodation law, which may differ

Please see> Attendance, page 19

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Health Care After the Supreme Court Decision: Establishing and Operating State Exchanges

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The Supreme Court has ruled on the Affordable Care Act and, although it upheld its constitutionality, it opened the door to giving states more flexibility on the expansion of Medicaid. Consequently, a large number of states appear to be opting out of the expansion program, potentially leaving an estimated three million people uninsured who would have been covered before the ruling, according to the Congressional Budget Office. Participation is no longer a requirement, and states no longer risk losing all their federal funding for Medicaid if they don't participate.

States are now turning their focus to exchanges—health insurance marketplaces in which people who lack affordable coverage through an employer will be able to shop for policies. Anyone can use the exchanges to gain the benefits of comparative insurance shopping, but most customers are expected to be individuals and families with incomes between 133 and 400 percent of the federal poverty level. This segment will be eligible for federal tax subsidies to make insurance affordable.

The Affordable Care Act states that individuals must be able to buy insurance through the new state exchanges by January 1, 2014. But the states must demonstrate to the Department of Health and Human Services by January 1, 2013, that the exchanges will be operational in 2014. If this can't be demonstrated by the deadline, the federal government will establish and op-

erate the exchanges for the states.

So far 10 states and the District of Columbia have enacted legislation to establish state-based exchanges, and three states have established an exchange by executive order. Massachusetts and Utah passed laws in favor of exchanges prior to the enactment of the Affordable Care Act in March 2010. That's a total of 15 states in the "yes" column right now.

To round out the field, three additional states are planning for the establishment of exchanges, a host of others are studying their options, two have decided not to create state-run exchanges, and 15 have exhibited no significant activity or engagement in this area.

The federal government has given the states approximately $1 billion in research, planning, and technology grants to help establish exchanges. Though many are using the funds for that purpose, some have chosen to return them. Nonetheless, the Obama administration is eager to see well-designed and well-run exchanges created around the country, so it's willing to provide additional financing sources that can be used even after the original start-up deadline.

With or without federal funds, establishing a state exchange is complex and challenging—and challenges exist even for those states and insurers that have already invested significant time and money in this endeavor. Among other things, governance and certification procedures must be established; standards for competing

Please see> Exchanges, page 14

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Exchanges, from page 13

plans must be set; new information technologies must be put in place; and small-business health options must be developed and agreed on.

States establishing exchanges also have a number of important questions to ask as well as decisions to make. For instance:

- Will they require health plans to compete on price, list insurance options on an exchange Web site, or ask insurers to place bids?
- Will they have consumer representation on their boards? Who will sit on the boards?
- Will the state allocate funds for the exchange? What if there aren't enough fees collected from participating health plans?
- Will insurance brokers be included in the exchanges?
- Will there be "navigators" who will help educate consumers about the exchanges?

One of the central issues for states is determining how selective an exchange should be. One that involves a limited number of enrollees may have a harder time bargaining with insurers. And an exchange that accepts virtually everybody may help provide reasonable choice for customers.

That said, exchanges must be prepared to confront the consequences of adverse selection, which take hold when there is a disproportionate enrollment of high-risk, high-cost individuals. Indeed, adverse selection can lead to rising premiums and an exodus of lower-risk people and employers, who can take advantage of more affordable options elsewhere. This, in turn, creates a high-risk pool—and even higher premiums.

Despite the challenges of establishing an effective and efficient exchange, the states have been granted a good deal of flexibility by the federal government in this process. For example, they can run an exchange through an existing agency or through a newly created not-for-profit entity. They have the option to open an exchange to all insurers or limit the number of health plans available. They can decide what kind of role agents and brokers can have in selling health plans through an exchange. And they can allow larger employers to participate in an exchange if that makes sense.

Of course, the biggest choice for states is whether their exchange is established and operated by the state itself or by the federal government. In a state-based exchange, the state operates all activities, but it may use the federal government for determining premium tax credits and cost-sharing reductions, exemptions, and risk adjustment and reinsurance programs.

It's unclear, on the other hand, what an exchange that's facilitated by the federal government will really look like. The law says the federal government can operate an exchange either directly or through an agreement with a not-for-profit entity. And the state can decide if it wants to offer a reinsurance program or Medicaid and CHIP eligibility assessment or determination. Another wrinkle here is that an exchange facilitated by the federal government will remain unfunded until people begin purchasing insurance through it.

There are other downsides to having the federal government operate a state exchange:

- There would most likely be fewer health plan offerings for consumers
- Insurers would have to deal with two levels of government
- The federal government would have to get involved with Medicaid eligibility determinations
- The state would have limited influence over policy and the consumer experience

There is a third option, though. In August 2011 HHS proposed an exchange model that would revolve around a partnership between the federal government and states. This state partnership approach would tailor the exchanges to local needs and market conditions, and it would allow a transition to take place so that the states could eventually run their own exchanges. The state would operate the plan management and provide consumer assistance under this model, but it could use the federal government for a reinsurance program and Medicaid and CHIP eligibility assessment or determination.

States aren't the only ones with questions about exchanges right now. Consumers, for example, may know that exchanges will provide a range of health plans with varying levels of benefits, but they

don't know how much plans will actually cost through the exchanges. Another consumer uncertainty: What happens if employers buy health care through the exchanges?

Obviously, many critical details and fundamental specifics still need to be worked out before the exchanges become a reality for our nation. As a result, the next year promises to be intense and fast changing for the entire health care industry. But, in the end, this intricate and sweeping effort should prove worthwhile and beneficial.

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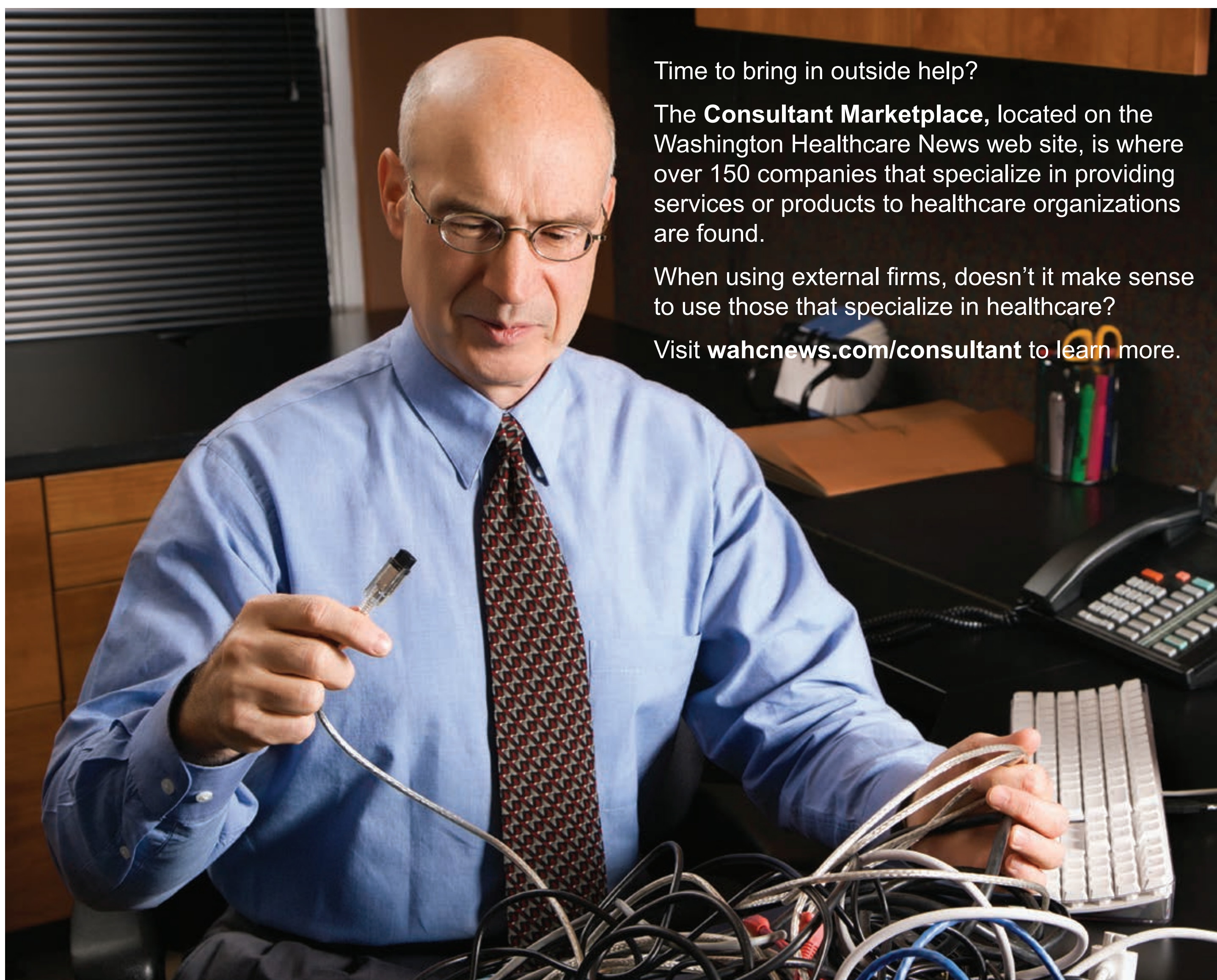

Swedish Shatters any Vestige of a Glass Ceiling

John H. Vassall II, M.D.
Chief Medical Officer
Swedish Medical Center

A glass ceiling for women in medicine has existed throughout history. Lower acceptance rates at medical schools translated into lower graduation rates. Fewer practicing physicians created a smaller pool of eligible women for leadership positions and fewer mentors for women considering a medical career.

There has been considerable progress since the first woman graduated from a U.S. medical school in 1849, with women accounting for 48 percent of medical school graduates in 2011.[1] According to the American Medical Association's Women Physicians Conference, about 30 percent of practicing physicians are now women. Nevertheless, women remain underrepresented in the ranks of senior academic and hospital leadership in many health-care organizations.

At Swedish Medical Center in Seattle, however, the glass ceiling has been shattered. In addition to Nancy Auer, M.D., an emergency-medicine physician serving as chairwoman of the Swedish Board of Directors, Swedish currently has three female chiefs of staff. This is not the first time a woman physician has been elected chief of staff at Swedish, but it is the first time women have filled all three positions at the same time.

Left to right: Michelle J. Sinnett, M.D., chief of staff, Swedish/Edmonds; Lily K. Jung Henson, M.D., chief of staff, Swedish/Issaquah; and Mary B. Weiss, M.D., chief of staff, Swedish/Ballard, Swedish/Cherry Hill and Swedish/First Hill

This unique benchmark has gone largely unnoticed at Swedish – a testament to the medical center's progressive nature and history of being at the forefront of positive change. Swedish – the largest nonprofit health-care organization in Greater Seattle – has a medical staff of nearly 3000 physicians. Established more than 100 years ago, Swedish now comprises five hospitals, two stand-alone emergency room/specialty centers, and a network of more than 100 specialty and primary-care clinics.

Dr. Auer has been a trailblazer at Swedish. Throughout previous tenures as chief of staff and chief medical officer, Dr. Auer was a role model for many women physicians. They were fortunate to witness firsthand her ability to juggle her personal and professional lives, while assuming demand-

ing leadership responsibilities.

Lily Jung Henson, M.D., a neurologist and one of the three current chiefs of staff, acknowledges Dr. Auer as her mentor and role model.

"This very strong and articulate woman took a special interest in me when I first came to Swedish," says Dr. Jung Henson. "She was our pioneer – a tremendous role model for all of us."

Dr. Jung Henson is the first chief of staff at Swedish/Issaquah, which opened in late 2011. Rather than taking the helm of an existing medical staff, she has been responsible for unifying disparate groups. Dr. Jung Henson calls Issaquah a "laboratory" for best practices. She has used her cognitive skills, as well as her passion for patient care, to engage physicians in developing a medical-staff culture that embodies the essence of Issaquah.

In January 2011 – three months after Stevens Hospital in Edmonds, Wash., affiliated with Swedish – Michelle Sinnett, M.D., assumed the chief-of-staff position of the newly created Swedish/Edmonds campus. She knew physicians were supportive of affiliation, but also anxious to retain their independence. It fell on Dr. Sinnett to guide them through the challenges that naturally occur during mergers.

"It was comforting to meet the other Swedish chiefs of staff," says Dr. Sinnett. "I was instantly reassured that we shared a vision to provide exceptional care for our patients."

In addition to being chief of staff, Dr. Sinnett is a full-time surgeon and mother. Although she may feel her parenting skills are in use both at work and at home, it is her surgical time-management skills that keep the pieces of her life in sync.

Dr. Sinnett has never been gender focused, yet she brings to her job some of the best characteristics commonly associated with women – setting clear expectations and consequences, and leading through gentle persuasion and a sense of fairness.

Nancy Auer, M.D.
Chairwoman
Swedish Board of Directors

In Seattle, Mary Weiss, M.D., is completing her second year as chief of staff of the hospitals at Swedish's Ballard, Cherry Hill and First Hill campuses. The collegiality and multispecialty collaborations she relies on and fosters as a family-medicine physician has earned her the confidence of her peers.

"As a practicing physician I wanted things to work better," says Dr. Weiss. "It was a natural step to accept leadership positions, so I could help improve the practice environment and patient care."

Dr. Weiss's leadership style blends outreach to seek input from those most affected by an issue with the desire to keep meetings lively and physicians engaged. Diplomacy and extensive leadership experience have made her an effective change agent.

At Swedish, these four exceptional women have replaced the glass ceiling with a higher bar for all physicians.

[1]Association of American Medical Colleges, *"U.S. Medical School Applicants and Students 1982-83 to 2011-12"*

John Vassall, M.D., is a board-certified internist and chief medical officer for Swedish Medical Center in Seattle, Wash. As such, he serves as liaison between Swedish medical staff at five hospital campuses and multiple ambulatory-care centers and Swedish administration. He oversees patient safety, medical education, medical staff services, clinical effectiveness, regulatory compliance and other medical affairs matters.

Vassall graduated from the University of Washington School of Medicine, and completed residency training at Grady Memorial Hospital and Emory University Affiliated Hospitals in Atlanta.

He is on the boards of trustees for Washington's hospital and medical associations, and authors a monthly patient safety column for the medical association.

Washington State Hospital Financial Results (000's)

Forty Largest Hospitals Sorted by 2011 Operating Revenues[1]

www.wahcnews.com

Hospital Name	Operating Revenues			Operating Margin			Op. Margin/Operating Revenues			Net Non-Operating Gains/Losses			Total Margin		
	YTD 12/11	YTD 12/10	Change	YTD 12/11	YTD 12/10	Change	YTD 12/11	YTD 12/10	Change	YTD 12/11	YTD 12/10	Change	YTD 12/11	YTD 12/10	Change
Swedish First Hill	1,097,132	968,033	129,099	74,098	87,044	-12,946	6.8%	9.0%	-2.2%	6,744	49,987	-43,243	80,842	137,031	-56,189
Virginia Mason Medical Center[2]	902,309	852,752	49,557	33,412	38,891	-5,479	3.7%	4.6%	-0.9%	118	3,908	-3,790	33,530	42,799	-9,269
University of Washington Medical Ctr.[2]	871,116	845,177	25,939	56,260	66,250	-9,990	6.5%	7.8%	-1.3%	-4,229	3,301	-7,530	52,031	69,551	-17,520
Seattle Children's Hospital[2]	859,683	768,221	91,462	59,192	50,835	8,357	6.9%	6.6%	0.3%	-11,328	9,277	-20,605	47,683	60,112	-12,429
Harborview Medical Center[2]	775,949	781,634	-5,685	-3,787	-8,505	4,718	-5.0%	-1.1%	-3.9%	-15,514	-1,058	-14,456	-19,301	-9,563	-9,738
Providence Sacred Heart Medical Center	723,627	715,600	8,027	31,376	40,948	-9,572	4.3%	5.7%	-1.4%	12,089	12,013	76	43,465	52,961	-9,496
MultiCare Tacoma Gen Allnmre Hosp[2]	694,811	655,920	38,891	33,367	52,692	-19,325	4.8%	8.0%	-3.2%	5	-411	416	33,372	52,281	-18,909
St. Joseph Medical Center - Tacoma[2]	635,815	618,491	17,324	78,045	78,153	-108	12.3%	12.6%	-0.4%	-1,005	4,957	-5,962	77,040	83,111	-6,071
PeaceHealth Southwest WA Medical Ctr[2]	570,236	529,650	40,586	14,938	6,455	8,483	2.6%	1.2%	1.4%	-5,388	36,824	-42,212	9,550	43,279	-33,729
Providence Regional Everett Med Center	548,924	527,909	21,015	9,318	32,605	-23,287	1.7%	6.2%	-4.5%	-618	-3,391	2,773	-9,936	29,213	-39,149
Valley Medical Center[2]	474,019	423,110	50,909	12,754	12,801	-47	2.7%	3.0%	-0.3%	18	-2,686	2,704	12,771	10,115	2,656
PeaceHealth St. Joseph Medical Center[2]	434,053	390,044	44,009	47,284	19,609	27,675	10.9%	5.0%	5.9%	34,718	0	34,718	82,002	19,609	62,393
Overlake Hospital Medical Center	421,495	411,981	9,514	21,139	34,359	-13,220	5.0%	8.3%	-3.3%	7,072	6,966	106	28,210	41,324	-13,114
Evergreen Hospital Medical Center[2]	414,977	388,993	25,984	-11,680	526	-12,206	-2.8%	.01%	-2.9%	14,824	15,149	-325	3,145	15,674	-12,529
Providence St. Peter Hospital	403,580	390,766	12,814	9,546	25,851	-16,305	2.4%	6.6%	-4.3%	-424	-1,056	632	9,122	24,795	-15,673
Multicare Good Samaritan Hospital[2]	367,243	323,061	44,182	49,740	60,743	-11,003	13.5%	18.8%	-5.3%	-17,721	17,284	-35,005	32,019	78,027	-46,008
Swedish Cherry Hill	361,037	337,640	23,397	-2,586	20,297	-22,883	-0.7%	6.0%	-6.7%	620	1,361	-741	-1,966	21,658	-23,624
Harrison Medical Center[2]	354,099	360,599	-6,500	6,270	15,586	-9,316	1.8%	4.3%	-2.6%	987	3,161	-2,174	7,257	18,747	-11,490
Yakima Valley Memorial Hospital	337,871	334,047	3,824	-2,893	-3,956	1,063	-0.9%	-1.2%	0.3%	4,963	17,946	-12,983	2,071	13,989	-11,918
Seattle Cancer Care Alliance	335,036	298,222	36,814	16,166	15,525	641	4.8%	5.2%	-0.4%	10,362	2,106	8,256	26,528	17,631	8,897
Kadlec Regional Medical Center[2]	289,550	277,608	11,942	8,778	12,917	-4,139	3.0%	4.7%	-1.6%	1,710	7,040	-5,330	10,488	19,957	-9,469
PeaceHealth St. John Medical Center[2]	263,107	249,362	13,745	8,683	17,421	-8,738	3.3%	7.0%	-3.7%	-35	8,998	-9,033	8,648	26,419	-17,771
Northwest Hospital[2]	259,713	249,830	9,883	-11,707	-9,923	-1,784	-4.0%	-4.5%	0.5%	1,681	495	1,186	-10,026	-9,428	-598
Deaconess Medical Center	254,057	246,881	7,176	-5,414	-2,904	-2,510	-2.1%	-1.2%	-1.0%	3,726	2,384	1,342	-1,688	-520	-1,168
Skagit Valley Hospital[2]	229,321	202,051	27,270	2,293	-121	2,414	1.0%	-0.1%	1.1%	1,087	646	441	3,380	525	2,855
St. Francis Hospital[2]	226,689	224,415	2,274	26,633	33,937	-7,304	11.7%	15.1%	-3.4%	-522	4,999	-5,521	26,111	38,936	-12,825
MultiCare Mary Bridge Children's Hosp[2]	214,285	194,602	19,683	40,544	23,087	17,457	18.9%	11.9%	7.1%	0	-1	1	40,544	23,086	17,458
Legacy Salmon Creek Hospital	203,116	190,834	12,282	3,408	9,766	-6,358	1.7%	5.1%	-3.4%	-1,168	1,836	-3,004	2,240	11,602	-9,362
Providence Holy Family Hospital	191,673	186,791	4,882	1,597	1,981	-384	0.8%	1.1%	-0.2%	531	623	-92	2,128	2,604	-476
Central Washington Hospital[2]	188,764	182,957	5,807	-8,320	967	-9,287	-4.4%	0.5%	-4.9%	463	7,111	-6,648	-7,857	8,079	-15,936
St. Clare Hospital[2]	167,988	163,675	4,313	6,949	9,978	-3,029	4.1%	6.1%	-2.0%	-190	4,498	-4,688	6,759	14,475	-7,716
Grays Harbor Community Hospital	160,466	107,935	52,531	229	-1,043	1,272	0.1%	-1.0%	1.1%	-1,053	1,227	-2,280	-824	184	-1,008
Kennewick General Hospital	147,677	126,366	21,311	1,627	1,767	-140	1.1%	1.4%	-0.3%	643	458	185	3,405	2,225	1,180
Providence Centralia Hospital	144,638	148,715	-4,077	5,061	16,925	-11,864	3.5%	11.4%	-7.9%	49	-203	252	5,110	16,723	-11,613
Olympic Medical Hospital[2]	134,909	130,745	4,164	261	1,380	-1,119	0.2%	1.1%	-0.9%	1,572	1,043	529	1,833	3,130	-1,297
Yakima Regional Medical Center[2]	129,815	119,691	10,124	10,391	10,506	-115	8.0%	8.8%	-0.8%	0	0	0	10,391	10,506	-115
Auburn Regional Medical Center	128,259	137,963	-9,704	-1,161	10,504	-11,665	-0.9%	7.6%	-8.5%	0	0	0	-1,161	10,504	-11,665
Providence St. Mary Medical Center	126,545	126,176	369	6,775	6,007	768	5.4%	4.8%	0.6%	2,337	2,825	-488	9,112	8,833	279
St. Anthony Hospital[2]	118,970	115,199	3,771	7,523	7,318	205	6.3%	6.4%	0.0%	-801	816	-1,617	6,723	8,134	-1,411
Lourdes Medical Center	112,417	90,006	22,411	13,288	1,615	11,673	11.8%	1.8%	10.0%	20	816	-796	13,309	2,430	10,879

[1]Figures from the WA State Department of Health Center for Health (DOH CHS) Statistics web site as of July 31, 2012 unless footnoted with a [2].

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

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

< Attendance, from page 11

from federal law in some cases. In circumstances where healthcare employees are required to provide direct patient care, however, and particularly where such employees receive specialized training that renders them difficult to replace when unscheduled absences arise, the *Samper* case provides clear guidance that the ADA does not require the employer to compromise its reasonable attendance policy. Healthcare employers can now rely on the *Samper* Court's recognition of the critical nature of employee attendance requirements: "An employer need not provide accommodations that compromise performance quality – to require a hospital to do so could, quite literally, be fatal." *Id*. at 1241.

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Director of Health Services

(Oxnard, CA)

Director of Health Services, in collaboration with the Chief Medical Officer, is responsible for strategic direction and management of Utilization Management (UM) programs; strategic direction and management for case management, chronic disease management, health education, and other programs as well as maintaining policies and procedures to meet strategic goals and ensuring regulatory/contractual compliance; collaborating in managing regulatory medical audits and inquiries; assisting Quality Improvement with QI programs; coordinating relationships with clinical and social service agencies; documenting protocols for agency communications and referrals; providing staff support to both internal and external advisory groups and clinical committees; and participating in the grievance process and system as needed.

Education and Experience: Any combination of experience and training that would provide the required knowledge, skills, and abilities would be qualifying. A typical way to obtain the knowledge, skills, and abilities would be: Bachelor's degree from a regionally accredited college or university in an appropriate discipline, e.g., Business, Health Care or Public Administration. A Master's degree in Health/Hospital Administration or Public Health is highly preferred. Five years' of clinical experience, preferably in both inpatient and outpatient care is required. Managed Care experience, particularly managing QM/UM Departments is preferred.

Licenses and Certificates All licenses and certificates must be maintained as a condition of employment. Active, valid and unrestricted state of California RN license required. UM/CM certification preferred. Possession of, or ability to obtain, a valid appropriate California driver's license. Maintain a satisfactory driving record.

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