Performance Audit Report

Three Public Hospital Districts

Valley Medical Center, Evergreen Healthcare, Stevens Hospital

Report No. 1002324

November 12, 2009

Washington State Auditor Brian Sonntag, CGFM

www.sao.wa.gov

Why we did this audit

Public hospitals are funded by property taxes and state, federal and private health insurance providers, who are in turn funded by citizens and employers. Citizens demand cost-effective healthcare services. Our audit was designed to find ways to reduce some of the costs that support these services and to determine ways hospitals can make themselves more accountable and transparent.

Scope

The audit focused on the three largest public hospital districts in the state of Washington. Those districts are:

- King County Public Hospital District 1: Valley Medical Center (Valley)
- King County Public Hospital District 2: Evergreen Healthcare (Evergreen)
- Snohomish County Public Hospital District 2: Stevens Hospital (Stevens)

We reviewed Chief Executive Officer (CEO) compensation and severance arrangements as specified in the employment contracts for fiscal years 2006 through 2008. At Stevens, the former CEO's employment contract also was reviewed since he received severance payments during the period under review.

For other audit areas, we reviewed records from January 1 through December 31, 2007 (2005-2007 for construction), although we also obtained data related to 2008.

The audit cost $1.3 million as of October 30, 2009.

Objectives

The audit objective was to determine if improvement opportunities existed in the following areas of hospital operations for the three hospital districts:

- Transparency and citizen outreach
- Process and procedures used in negotiating and determining CEO compensation and severance
- Nursing and administrative staffing levels
- Procurement and inventory management related to medical supplies
- Construction monitoring and reporting

In addition, the performance audit also addressed the nine elements in Initiative 900. See Appendix A of the report for a cross-reference of those objectives to the report.

Cover photos courtesy of Valley Medical Center, Evergreen Healthcare & Stevens Hopsital

Background

Valley Medical Center has a 303-bed capacity with more than 2,500 clinical and nonclinical employees. It is the oldest and largest public hospital district in Washington. Valley serves more than 400,000 residents with 20 community clinics throughout King County and a hospital in Renton. In addition, Valley is a regional resource with recognized Centers of Excellence in birth, sleep, joint and stroke care and provides specialized treatment in cardiology, oncology, high-risk obstetrics, orthopedics, neonatal, cancer and neurology. Total net patient revenue[1] is approximately $309 million.

Evergreen Healthcare has a 242-bed capacity and employs approximately 2,800 clinical and nonclinical employees. Evergreen serves more than 400,000 people throughout North King and South Snohomish counties with primary care practices, home care, hospice, health education and many other programs and services. Evergreen has more than 800 physicians representing more than 50 specialties and offers clinical services in all major areas, including cardiac care, cancer care, neurosciences, surgery and maternity care. Total net patient revenue is approximately $314 million.

Stevens Hospital is a 217-bed healthcare facility that employs more than 1,300 clinical and nonclinical employees. Stevens Hospital offers a full range of medical and diagnostic services in North King and South Snohomish counties, including a Level IV Trauma Center and emergency medicine, surgery, women's health, birth center, orthopedics, rehabilitation, cardiac care, imaging, laboratory and pathology. Stevens also has the only inpatient mental health acute care facility in Snohomish County and has specialty clinics including pain management, diabetes, eye surgery and pediatric dentistry. Total net patient revenue is approximately $143 million.

1 Net patient service revenue is a hospital's total patient charges minus charity care, debt that is never paid to the hospital and contractual adjustments. Contractual adjustments are the difference between the amount a hospital charges for services less the contractually agreed-upon rate insurance companies pay.

What we found

Transparency and Accountability: Communication with the Public

- Financial, operational and quality information needs to be more available to the public for increased accountability and transparency through Web sites and the use of community advisory programs.
- Undisclosed vendor participation in patient care may unknowingly expose patients to health risks.

CEO Compensation and Severance

Valley

- Because of the unusual practice of paying an annual retention benefit, Valley pays its CEO beyond what a competitive salary would require.
- Valley paid a $1.7 million retirement benefit to a CEO prior to retirement without explanation or public benefit.
- Valley does not tie its incentive pay to all the performance goals for its CEO, increasing the likelihood that the CEO will not meet the goals that do not result in additional compensation.
- Valley Medical Center funded accounts for the CEO's retention and retirement benefits that exceeded Board-authorized amounts by more than $250,000.

Evergreen

- Evergreen has a competitive CEO compensation and severance program. Poorly defined contract expectations may result in disputes or over compensation with regards to incentive pay.

Stevens

- Stevens Hospital has a well structured, competitive CEO compensation program. Stevens does not establish performance goals that are sufficiently challenging.

Operations and Construction Management

Nursing and administrative staffing

- Hospital Districts can increase productivity by improving personnel monitoring and better managing staff costs and staffing levels. Evergreen Healthcare and Stevens Hospital could limit third-party nursing hours (contractors) to 2 percent of productive hours.

Procurement and inventory management related to medical supplies

- Vendors who provide physicians with personal financial benefits may influence the drugs, medical supplies and products selected by physicians, resulting in reduced quality of care.
- Better managing consignment and district owned inventory and limiting access to inventory can reduce potential loss.
- Improved processes and controls can reduce the risk of purchasing unapproved products.

Construction

- Improved monitoring and standardized reporting process will help ensure that projects are completed on time and within budget.
- Better monitoring and standardization over vendor change orders will help ensure change orders are appropriate and minimized.

Cost savings

Accountability and transparency	Potential cost savings and other effects
Communication with the public	• Increased accountability for hospital services and patient care • Increased transparency and reduction in exposure to the risk of litigation • Increased information for the public related to financial and operational performance • Increased public trust and possibly public support for future tax levies
CEO compensation and severance	• At two hospitals, many goals related to the incentive plan do not strongly correlate to incentive payouts and many appear to be related to the CEO's normal duties. • At one hospital district, retention incentives are paid annually, which is not a typical approach and results in annual cash compensation that may exceed the targeted 75th to 90th percentile range of the market. • A retirement payment to one hospital district's CEO did not conform to typical practices. • Valley Medical Center funded accounts for the CEO's retention and retirement benefits that exceeded Board-authorized amounts by more than $250,000.
Operations and construction management	**Potential cost savings and other effects**
Nursing and administrative staffing	• Evergreen has potential cost savings of approximately $5.2 million over five years. • Stevens has potential cost savings of approximately $3.2 million over five years.
Procurement and inventory management related to medical supplies	• Opportunity to reduce costs as well as to reduce risks • Reduction in potential loss of spoiled inventory and risk of expired product being used in the delivery of patient care
Construction	• Reduction of schedule risk, enhanced communication, increased accountability, faster identification of scope gaps or conflicts, more robust and formalized documentation, reduction of legal risk and improvement to overall quality
Total potential cost savings	**Approximately $8.4 million over five years**

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Performance audit report for Public Hospital Districts

October 28, 2009

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October 28, 2009

Dear Mr. Sonntag:

We have completed Phase IV of the performance audit of the public hospital districts. Our engagement was performed in accordance with our Contract No. 1007-C-HD-K18. Our procedures were limited to those described in that letter and its amendments.

Background

In 2005, the voters of Washington state passed Initiative 900 (I-900) authorizing the Washington State Auditor's Office (SAO) to begin conducting performance audits of various Washington state and local government entities. The purpose of these performance audits is to promote accountability and cost-effective uses of public resources through identification of opportunities for potential cost savings.

Scope of our work

The SAO engaged Ernst & Young to complete the public hospital district performance audit in accordance with Generally Accepted Government Auditing Standards. The audit shall address the following objectives from the request for proposal (RFP):

- *Administration* – At the time of this audit, how economical are the public hospital districts' administrative operations, administrative costs, administrative salaries and administrative staffing levels? How efficient are each hospital's administrative operations? If not economical or efficient, determine the impact on costs and services and what can be done to correct those impacts?
- *Communications* – At the time of this audit, how effective and accountable has each hospital been at communicating its operational and service performance to citizens? Are the hospitals working with citizens to determine what they should be reporting so that citizens can assess accountability? How effective and transparent is the hospital at informing the public about its financial condition, financial operating results, budgets, capital projects, increases or decreases in service levels, employee compensation and other financial matters? How effective are the hospitals' efforts at communicating these objectives to the public? If not effective and transparent, what is the impact on citizen awareness, citizen involvement and hospital accountability to the citizens they serve and what can be done to address those impacts?
- *Construction* – Over the past 3 years, have the public hospital districts achieved effective, efficient and economical construction management based on leading practices? And how effective have those hospitals been at planning, designing and managing their construction projects in order to:
  - *Minimize all costs associated with their construction projects, including but not limited to engineering, land acquisition, environmental review, permitting and construction?*
  - *Minimize unnecessary change orders and delays that result in extra costs?*
  - *Obtain* the best quality, timeliness, workmanship and other value?
- *Procurement* – Over the past 3 years, how effectively have the hospitals managed their administrative services performed by contract in order to ensure they obtain competitive contract prices and well defined (quantity and quality) services? If not effective, what is the impact on cost and administrative services received? And what can be done to reduce those costs and improve those services?
- *CEO Compensation and Severance* – Amendment was made to the original contract to include additional procedures in the Statement of Work that needed to be conducted related to compensation and severance issues identified during an accountability audit performed by the State Auditor's Office's local team.

The performance audit shall also address the following I-900 objectives:

- Identifying cost savings.
- Identifying services that can be reduced or eliminated.
- Identifying programs or services that can be transferred to the private sector.
- Analyzing gaps or overlaps in programs or services and recommendations to correct them.
- Assessing the feasibility of pooling the entity's information technology systems.
- Analyzing the roles and functions of the entity and recommendations to change or eliminate roles or functions.
- Recommending statutory or regulatory changes that may be necessary for the entity to properly carry out its functions.
- Analyzing the entity's performance data, performance measures and self-assessment systems.
- Identifying leading practices.

The performance audit is delivered in four phases: diagnose current state, define and design audit plan, execute audit plan and summarize communication and report results.

Results of our work

From March 2008 to April 2009, Ernst & Young executed the audit plan designed for the selected list of risk areas in Phase II of the performance audit. Based on information gathered using data analytics, flow charts, interviews, testing and benchmarking, we identified issues and leveraged our subject matter resources to recommend leading practices and/or to create suggested standard procedures, processes, controls and recommendations to the public hospital districts.

A draft performance audit report was delivered to the SAO on April 20, 2009. An updated report was shared with the public hospital districts on September 23, 2009, which contained our recommendations for the public hospital districts and was the basis for their responses.

Restrictions on the use of our report

Ernst & Young assumes no responsibility to any user of the report other than the Washington State Auditor's Office. Any other persons who choose to rely on our report do so entirely at their own risk.

We appreciate the cooperation and assistance provided to us during the course of our work. If you have any questions, please call Michael Kucha at +1 206 654 7741.

Very truly yours,

Ernst & Young LLP

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Introduction

Background

In November 2005, the voters of Washington State passed Initiative 900 authorizing the State Auditor's Office to begin conducting performance audits of various Washington state and local government entities. The purpose of these performance audits is to promote accountability and cost-effective uses of public resources through identification of opportunities for potential cost savings. These savings can be achieved in a number of ways, such as reduction or elimination of services, use of leading practices, change or elimination of roles and functions and pooling of information technology. In addition to these opportunities, Initiative 900 seeks recommendations for statutory or regulatory changes that may be necessary for the entity to carry out its functions properly.

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Objectives

The objective of this audit was to determine if improvement opportunities existed in the following areas of hospital operations for the three largest public hospital districts in the state of Washington:

- Transparency and citizen outreach
- Process and procedures used in negotiating and determining Chief Executive Officer (CEO) compensation and severance
- Nursing and administrative staffing levels
- Procurement and inventory management related to medical supplies
- Construction monitoring and reporting

The performance audit was also planned and performed to address the nine elements in Initiative 900:

- Identification of cost savings
- Identification of services that can be reduced or eliminated
- Identification of programs or services that can be transferred to the private sector
- Analysis of gaps or overlaps in programs or services and recommendations to correct gaps or overlaps
- Feasibility of pooling information technology systems within the public hospital district
- Analysis of the roles and functions of the public hospital district and recommendations to change or eliminate roles or functions
- Recommendations for statutory or regulatory changes that may be necessary for the public hospital district to properly carry out its functions
- Analysis of public hospital district performance data, performance measures and self-assessment systems
- Identification of leading practices

Methodology

We completed this performance audit in accordance with Generally Accepted Government Auditing Standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained for all segments of the audit provides a reasonable basis for our findings and conclusions based on our audit objectives. We planned and performed the performance audit to review the following:

Chief Executive Officer (CEO) compensation:

In planning our audit of CEO compensation, Ernst & Young developed a multiphased statement of work. The project was conducted in four phases:

- **Phase 1** – Review documentation related to CEO cash compensation and severance arrangements for each public hospital district and identify areas of potential concern or opportunities for improvement.
- **Phase 2** – Develop a work plan for the identified areas of concern or opportunities for improvement identified in Phase 1 to determine issues and recommendations.
- **Phase 3** – Execute the work plan.
- **Phase 4** – Issue the final audit report to the State Auditor's Office and assist that office in presentations to state legislators, legislative committees or public hospital district boards.

Our work included:

- Conducting interviews with hospital executives and representatives from the hospitals' boards.
- Validating our understanding of processes and procedures through discussions with representatives of the hospitals and boards.
- Performing benchmarking analyses to determine competitive levels of cash compensation for CEOs of similarly sized hospitals and competitive severance arrangements in the healthcare industry.

Other audit areas:

In planning the remainder of our audit, Ernst & Young developed a multiphased statement of work. The project was conducted in four phases:

- **Phase 1** – Conduct a performance and risk assessment to identify improvement opportunities in the form of leading practices and/or issues. Identify areas that have the greatest opportunity to reduce costs and improve efficiency.
- **Phase 2** – Develop a work plan for the highest risk areas identified in Phase 1 to determine issues and recommendations.
- **Phase 3** – Execute the work plan.
- **Phase 4** – Issue the final performance audit report to the State Auditor's Office and assist the State Auditor's Office in presentations to state legislators, legislative committees or public hospital district Boards of Commissioners.

Our work included:

- Conducting interviews with managers and staff.
- Validating our understanding of controls by walking through processes and procedures with control owners.
- Performing benchmarking analyses to determine how well the hospitals being reviewed perform relative to peers.
- Testing transactions and records for effectiveness of controls and adherence to policy.

- Reviewing policies and procedures.
- Reviewing hospital reports.
- Surveying employees.
- Analyzing processes to identify potential cost savings or efficiencies.

We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Scope

The performance audit focused on the three largest public hospital districts in the state of Washington. Those districts are:

- King County Public Hospital District 1: Valley Medical Center (Valley)
- King County Public Hospital District 2: Evergreen Healthcare (Evergreen)
- Snohomish County Public Hospital District 2: Stevens Hospital (Stevens)

Ernst & Young reviewed CEO compensation and severance arrangements as specified in the employment contracts for fiscal years 2006 through 2008. The review included processes for negotiating and determining compensation and severance; merit increases; annual incentive payments; the use of competitive benchmark data; other forms of compensation; the performance review process; and adherence to contract terms and conditions. At Stevens, the former CEO's employment contract also was reviewed since he received severance payments during the period under review. Ernst & Young began the CEO compensation and severance audit in February 2009 and completed fieldwork in April 2009. The CEO compensation and severance audit is not intended to provide detailed process improvement plans or compensation and severance plan designs. It is intended to identify potential issues and opportunities for process improvement as well as leading practices.

For other audit areas, Ernst & Young tested data and records mainly related to fiscal year 2007 (2005-2007 for construction), although Ernst & Young also obtained data related to 2008 for certain tests and analysis. All three public hospital districts included in this performance audit have a fiscal year that matches the calendar year (January 1 through December 31). Ernst & Young began the performance audit for the other audit areas in March 2008 and completed fieldwork in June 2008.

Potential cost savings and other effects summary

Accountability and transparency	Potential cost savings and other effects
Communication with the public	▶ Increased accountability for hospital services and patient care ▶ Increased transparency and reduction in exposure to the risk of litigation ▶ Increased information for the public related to financial and operational performance ▶ Increased public trust and possibly public support for future tax levies
CEO compensation and severance	▶ At two hospitals, many goals related to the incentive plan do not strongly correlate to incentive payouts and many appear to be related to the CEO's normal duties ▶ At one hospital district, retention incentives are paid annually which is not a typical approach and results in annual cash compensation that may exceed the targeted 75th to 90th percentile range of the market ▶ A retirement payment to one hospital district's CEO did not conform to typical practices ▶ At one hospital district, accounts for retention and retirement benefits were funded in excess of Board-authorized amounts by over $250,000
Operations and construction management	**Potential cost savings and other effects**
Nursing and administrative staffing	▶ Evergreen has potential cost savings of approximately $5,225,000 over five years ▶ Stevens has potential cost savings of approximately $3,195,000 over five years
Procurement and inventory management related to medical supplies	▶ Opportunity to reduce costs as well as to reduce risks ▶ Reduction in potential loss of spoiled inventory and risk of expired product being used in the delivery of patient care
Construction	▶ Reduction of schedule risk, enhanced communication, increased accountability, faster identification of scope gaps or conflicts, more robust and formalized documentation, reduction of legal risk and improvement to overall quality
Total potential cost savings	**≈ $8,420,000 (over five years)**

Ernst & Young recognizes following the recommendations will require resources. Although this performance audit was not structured to include detailed plans and related expenses, Ernst & Young estimates the public hospital districts have the experience and expertise to develop the specific steps necessary to follow the recommendations and that the cost savings gained through the recommended efficiencies will more than offset the costs. The following pages detail each hospital's individual results.

Public hospital district background

Brief history of public hospital districts

A brief history of all public hospital districts in the state of Washington, as well as more detailed information on each of the three hospitals districts, is included in Appendix B. Each district is governed by a five-member, publicly elected Board of Commissioners. Below is a brief description of each of the three public hospital districts that were included in this audit.

- King County Public Hospital District No. 1 operates as Valley Medical Center and is the oldest and largest public hospital district in Washington State. The district employs more than 2,500 people and is licensed to operate a 303-bed hospital and 20 clinics throughout King County. In addition, Valley is a regional resource with recognized Centers of Excellence in Birth, Sleep, Joint and Stroke care and provides specialized treatment in cardiology, oncology, high-risk obstetrics, orthopedics, neonatal, cancer and neurology. Total patient charges in 2008 were approximately $804 million. After adjustments for contractual discounts, charity care and bad debt, net patient service revenue was approximately $309 million.
- King County Public Hospital District No. 2 was established in 1972 and serves more than 400,000 people in north King and south Snohomish counties. The district operates as Evergreen Healthcare and is licensed to operate a 242-bed hospital and a network of primary and urgent care centers. The district's specialties include a maternity center, a cancer center, hospice and home health care, 24-hour emergency care, a critical care unit, cardiac care and surgical services. The district employs approximately 2,800 people and had total patient charges of approximately $669 million in 2008. Net patient service revenue was approximately $314 million.
- Snohomish County Public Hospital District No. 2 was established in 1962 to operate a hospital and provide healthcare services to the residents of Edmonds and surrounding communities. The district includes Stevens Hospital, an acute-care hospital with 217 beds, two primary care clinics and a retail pharmacy. The hospital is the only hospital in southwest Snohomish County and is one of the largest employers in the area. The district's total patient charges in 2008 were approximately $355 million. Net patient service revenue was approximately $143 million. The district has more than 1,300 employees.

Transparency and accountability

Communication with the public

Background

Public hospital districts are municipal corporations. They operate under all applicable statutory, constitutional and regulatory provisions of the state of Washington. The governing bodies of these districts are publicly elected and accountable to the citizens.

The objectives of this audit include:

- Does the hospital provide regular and consistent financial and operating results to the Board of Commissioners?
- Does the hospital keep the citizens informed of its activities?

Issues and recommendations – communication with the public

Issue 1 – Two hospital districts do not provide easily accessible financial, quality and operations information to citizens

Background and criteria

To help ensure good stewardship over public resources, government entities should make financial, operational and quality information readily available to the public. Monthly financial and operational statements should be readily available on a hospital's website. In addition, explanations should be provided on information that may be difficult for a reader to understand. Quality of patient care data should also be made easily available through the website.

Condition

Neither **Valley** nor **Evergreen** provides access to monthly financial and operational results through their websites. Management at both Valley and Evergreen stated they would provide this kind of information to anyone upon request, but they are cautious about posting it to a website because they believe the reports would be misunderstood or misinterpreted. They both provide limited financial and operating information through newsletters sent to all mailing addresses in the hospital districts. Neither provides any quality of care data on their website. However, the Board of Commissioners at both Valley and Evergreen meet at least monthly in open public meetings where financial and quality information is regularly presented and reviewed.

See commendation below for Stevens.

Cause

Management believes financial and operational reports and information may be misunderstood or misinterpreted and, therefore, does not include them on their website. Valley's management also stated the district had not received any requests for such information from citizens and they developed/designed their website to provide items they had been told by the public they need or is of interest to them.

Effect or potential effect

The financial and operational information is not readily available to the citizens, resulting in decreased transparency and accountability. Also see the ***Potential cost savings and other effects*** below.

Recommendations

Valley and **Evergreen** should develop easy-to-understand financial and quality of care information, such as medication errors and patient falls, to post on their websites (instead of developing financial statistics, they could choose to post their financial statements).

Commendations

Stevens' Board of Commissioners meets in an open public meeting at least monthly. A standing agenda item is Board review of the monthly financial and operational results. Recently, Stevens began posting monthly financial and operational information on its website. These are the same reports presented at monthly Board meetings. Also, the most recent set of audited financial statements is posted on the website, along with internal quality data and links to external websites (Centers for Medicare & Medicaid Services, Joint Commission[1]) that provide information about the quality of care and outcomes.

Issue 2 – Two hospital districts could enhance community outreach efforts by establishing community advisor programs, which allow citizens from the district to participate in the operation of the public hospital district

Background and criteria

Typical community outreach generally includes hosting educational events, sponsoring local events, conducting health screenings, providing flu shots, etc. Other methods to engage the community include supporting an active volunteer program and distributing regular newsletters and updates. **Evergreen** has a leading practice that goes above and beyond typical community outreach and actually engages the community in advising the hospital on important decisions. The program is called Community Advisors. Its board has 36 members who go through an application and screening process. The board meets monthly to review levy fund allocations, current hospital issues, financial and operational results, etc. The Community Advisors then take this information back to the community through their everyday interactions with others in the community.

Condition

Valley and **Stevens** are not using community programs similar to the Community Advisors program at **Evergreen**.

See below for commendation for Evergreen.

Cause

Management has not explored or has deemed ineffective additional programs for promoting community participation like Community Advisors.

Effect or potential effect

Failure to use leading practice community outreach programs may not strengthen ties to the community as effectively or efficiently as possible. Also see the ***Potential cost savings and other effects*** below.

Recommendations

Valley and **Stevens** should consider initiating programs similar to Evergreen to strengthen ties with the community.

[1] The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 15,000 healthcare organizations and programs nationwide. Joint Commission accreditation and certification are recognized as symbols of quality that reflect an organization's commitment to meeting certain performance standards.

Commendations

Evergreen uses the Community Advisors program. See ***Background and criteria*** section for a description of this group.

Issue 3 – Hospital Districts do not notify patients of vendor participation in patient care and track vendor immunizations

Background and criteria

Vendor representatives are often present at and participate in patient care procedures across the nation. In this way, the vendor representatives educate and train physicians on the benefits and use of their products. This is common in healthcare settings and all three public hospital districts follow this practice. Notifying patients about vendor participation in their healthcare procedures is a leading practice.

Condition

Patient consent forms at **Valley**, **Evergreen** and **Stevens** do not notify patients of possible vendor presence and/or participation in patient procedures. Consent forms at Valley and Evergreen do include the presence of observers in procedures; however, they do not clearly state that observers may take a role in the procedure. Evergreen is revising its consent form to disclose potential vendor presence as well as the vendor's role and level of participation. None of the hospitals track vendor immunizations that typically are required of hospital staff.

Cause

Management was unaware of the importance of patient consent forms to address vendor involvement in procedures. In addition, management was unaware of the importance of tracking vendor immunizations.

Effect or potential effect

Control gaps related to vendors participating in patient procedures may expose the hospital to the risk of litigation related to a lack of consent for vendor participation or infection danger from lack of immunizations. Also see the ***Potential cost savings and other effects*** below.

Recommendations

Valley, Evergreen and **Stevens** should update their patient consent forms. The form updates should include patient consent to having vendor representatives or non-hospital staff members present and for their participation in patient procedures. The forms should also disclose financial relationships noted in Issue 14 below. The hospitals should require vendors to provide immunization records if they will be visiting patient care areas and should set stricter standards for vendors who work in sterile areas such as the operating room. **Evergreen's** current patient consent form revision project could be used for guidance at **Valley** and **Stevens**.

Potential cost savings and other effects – communication with the public

Due to the challenges faced when assessing the success of communications (e.g., differences in education level, size and demographics of the audience need to be considered), direct cost savings cannot be estimated based on the above recommendations. However, other potential effects could be experienced by the districts if the above recommendations are followed. They are:

- By providing financial data to the public, the hospital acknowledges that it is a steward of public tax money, leading to increased trust and possibly public support for future tax levies, if needed. Increased tax levies can be used to improve programs, services and facilities (depending on levy purpose), which can result in increased volume and improved financial performance.
- By providing quality data to the public, the hospital demonstrates the type of care it provides, which can lead to increased accountability for hospital services and patient care. This could lead to an enhanced reputation, improved physician recruiting, increased volume and better financial performance.
- By notifying patients that vendors may participate in patient procedures and obtaining patient permission, hospitals increase transparency and may reduce their exposure to the risk of litigation.

*For additional practices that effect transparency at each of the three hospitals, please also see the first issue under the section titled **Procurement and inventory management related to medical supplies** below.*

Chief Executive Officer (CEO) compensation and severance

Background

Based on our work plan, we identified areas of concern and opportunities for improvements. With the help of the State Auditor's Office, we narrowed the scope of our audit to focus on these questions for each district:

- How is the CEO's cash compensation established, including base salary increases and incentive payouts?
- Is the severance opportunity provided to the CEO reasonable and competitive with market standards for similar organizations?
- What process does the board of commissioners follow in reviewing and approving CEO compensation and severance arrangements?

Valley Medical Center

Overall observations

Valley's CEO is paid a base salary of $587,800. The CEO's total compensation is primarily comprised of three elements: base salary, incentive award (if and to the extent granted) and retention payment. Due to the CEO's long tenure, it is expected that he would be paid above competitive market median levels. Valley's compensation philosophy is to target the 75th to 90th percentile (highest paid 10 to 25 percent) of the market for total compensation, where performance warrants. This may be appropriate based upon the CEO's tenure, experience level and performance. We typically see organizations use variable compensation to deliver compensation at or above the 75th percentile.

Although the maximum incentive award of 32 percent of base salary is below competitive levels, the combination of the maximum incentive award and retention benefit (as described in Issue 4) results in annual cash compensation above the 75th percentile of market for similarly sized organizations (note: 90th percentile data was not available). The annual incentive plan appears to set forth a structured methodology for determining the award achieved under such plan. The goals with monetary awards associated are well defined with measurable performance criteria and a minimum level of financial performance which must be achieved prior to any award being earned, which are highly competitive plan design features. In addition, the Board retains an outside third party to annually audit the CEO's performance with regard to each of the measurable incentive goals and determine the total annual incentive award. In determining the CEO's overall compensation levels, the Board conducts competitive benchmarking surveys through an independent consultant.

Issue 4 – The CEO's retention benefit that provides for five years of annual payments equal to a percentage of the CEO's base salary, annual incentive award and benefits is not a typical practice (also see related Issue 6)

Background and criteria

It is a common business practice for companies to adopt a retention program in response to a perceived risk that certain key employees may not remain employed with the company over a defined period of time. Such risk may arise due to a variety of factors (e.g., competitive labor market, internal change or mergers/acquisitions). Companies typically use retention programs that provide key employees with a monetary payment only if the employee remains with the company over a certain period of time. Most companies provide retention payments as a lump sum once the employee has fulfilled this obligation. Annual retention payments over an extended period of time are not a common practice.

Condition

In 2003, the Board adopted the Supplemental Executive Benefit Plan that provides both a retention and retirement benefit. The retention benefit originally was set for five years with annual payments. Although the CEO had significant tenure at the time, the Board felt the need to retain him in light of the "impending need to implement significant facility and program enhancements during the next several years at a time of increased uncertainty in and challenges to the health care industry." The Board has extended this program on multiple occasions with payment of the annual benefit currently extended through 2013. The formula under the current retention provisions of the plan provide the CEO with a yearly retention amount to be paid in each of the fiscal years 2009 through 2013 equal to 102% of the retention amount paid to the CEO in 2007 (defined as 12 months of the CEO's annual base salary plus incentive program awards and benefit compensation). This results in an annual payment equal to approximately 40 percent of his annual base salary. Under the Supplemental Executive Benefit Plan, the CEO agreed to a 12 month non-raiding of employees clause and a two year non-competition provision after employment is terminated.

Cause

The Board of Commissioners' rationale for annual retention payments was the recognition that, while the current CEO was approaching the end of his career, they believed he was an attractive candidate for CEO positions at other public and private hospital systems, which could be substantially larger than Valley and may pay much higher annual compensation. The Board determined that it was necessary to extend the retention incentive over multiple years even though the CEO has a long tenure with the hospital due to the desire to retain the CEO during a time when the new facility improvements would be occupied. The Board also wanted to maintain a stable CEO position due to the recruitment efforts the executive team was experiencing. The Board decided the retention payments should be made annually as opposed to the end of the retention period due to the CEO's age. Furthermore, the Board believed providing for successive annual payments created an immediate and clear inducement to the CEO to postpone retirement beyond the CEO's original expectation of retiring at or about the age of 60.

Effect or potential effect

The addition of the annual retention payment to base salary and maximum annual incentive results in CEO annual cash compensation above the 75th percentile of the market for similarly sized healthcare organizations.

If the Board determines a new CEO is needed within the retention time period, it may still be obligated to pay the remaining retention benefits to the current CEO. This is due to the Supplemental Executive Benefit Plan stating any unpaid retention benefits must be paid to the CEO within 30 days following the CEO's involuntary termination for any reason other than physical disability or conviction of a felony or the CEO's voluntary termination following a material reduction in his decision-making authority or compensation/benefits.

Recommendations

Valley should:

- Given the stated compensation philosophy, affirm that performance warrants annual cash compensation that is above the 75th percentile and reconfirm appropriateness of mix between fixed and variable pay.
- Reevaluate the need for annual and recurring payment of retention benefits.
- Reassess the risk that the CEO will voluntarily leave his position with Valley given his long tenure with the hospital and the current economic environment.
- Since the current benefit runs through 2013, the Board should assess whether the value of the non-competition provision is still commensurate with the consideration being paid under the retention plan.

Issue 5 – Payment of the retirement benefit while the CEO is still actively employed is not a typical practice (also see related Issue 6)

Background and criteria

Companies commonly provide benefits to provide financial support when an individual retires. Such benefits are generally paid no earlier than the employee's actual retirement.

Condition

In 2003, the Board adopted the Supplemental Executive Benefit Plan, which provides a retention and a retirement benefit. Under the retirement provisions of this plan, the Board agreed to pay the CEO a retirement benefit in an amount equal to 24 months of his base salary. Under the terms of the 2003 program, the amount would be payable to the CEO upon retirement, provided that at least one of the following had occurred: he was at least 60 at the time of retirement; he was involuntarily terminated by Valley for any reason other than death, disability or conviction of a felony; or he voluntarily terminated his employment due to a material reduction in his decision-making authority or compensation/benefits.

The original terms of the program also provided that no retirement benefit would be payable to the CEO if he voluntarily resigned. In 2007, the Board amended the program terms to provide that the retirement benefit would be payable to the CEO "after January 1, 2009" (a time at which the CEO had attained age 60) upon the CEO's written request. On January 30, 2009, the CEO requested payment of the retirement benefit. On the same date, the Board received a memo detailing the CEO's contract extension and a copy of Resolution 868 (which addressed the Supplemental Executive Benefit Plan) prior to taking action on the contract extension on February 2, 2009. On February 27, 2009, a retirement benefit of $1,701,537 was paid to the CEO, who is still actively employed at Valley. During the Board meeting on March 16, 2009, the retirement benefit was approved by the Board as part of a lump-sum amount that included all of February's payroll payments.

Cause

The Board of Commissioners decided it was necessary to make a lump-sum retirement benefit payment available since the accrued benefit would become taxable to the CEO after January 1, 2009 when he became fully vested. Without such a payment the CEO would owe taxes without the cash to pay them. Also, the Board determined by not making the payment available before the CEO's actual retirement, they would be incentivizing his retirement at the same time they were paying him a retention incentive. The Board knew and understood that the early payment of retirement benefits was not typical, but they believed there was a good business reason for the decision and that the decision could be understood only when considering the unique circumstances surrounding the current CEO's employment and compensation arrangements.

Effect or potential effect

The current retirement program does provide the CEO with a true benefit payable only upon retirement. The CEO was actively employed with Valley on February 27, 2009, when the full retirement benefit was paid to him; we found no indication this payment was made in anticipation of his retirement. In addition, the Supplemental Executive Benefit Plan provided that the CEO would forfeit any payment of the retirement benefit if he voluntarily resigned from Valley. Because Valley's Board agreed to pay the retirement benefit while the CEO is currently employed, this benefit no longer is subject to forfeiture if he voluntarily resigns.

Recommendations

Valley should:

- Avoid including similar provisions in future contracts.

Issue 6 – Valley Medical Center funded accounts for the CEO's retention and retirement benefits that exceeded Board-authorized amounts by over $250,000

Background and criteria

Under state law, decisions made regarding CEO compensation must be made by the hospital's Board of Commissioners in an open public meeting. These decisions are reflected in Board Resolutions. Resolution 778 authorized the 2003 employment contract and the retention and retirement compensation benefits for the CEO. Resolution 778 also directed the President of the Board to execute an employment contract and the Supplemental Executive Benefit Plan.

Key documents referenced in this finding are as follows:

- Resolution 778 – decision and authorization by the Board of Commissioners authorizing the 2003 employment contract for Valley's CEO and outlining the associated terms for funding the retention and retirement benefit accounts
- 2003 Employment Agreement – actual document executed by the President of the Board with Valley's CEO's outlining the terms of his new contract
- Supplemental Executive Benefit Plan – separate document executed by the President of the Board on the same date as the Resolution and the employment agreement outlining the details of the retention and retirement benefits

The timeline and related facts from July through November 2003 are as follows:

- July 19, 2003 – A draft resolution is created (funding terms match the Supplemental Executive Benefit Plan).
- August 19, 2003 – Preliminary calculations for both the potential retention and retirement benefits prepared by external advisors are contained in VMC District Board Draft Notes (output of calculations match amounts actually funded). The preliminary calculations were based on the language in the July 19th draft resolution, but they contain key differences from the draft resolution including using a larger amount for the base salary.
- September 8, 2003 – A letter is sent by Valley's outside legal counsel to consultants working for Valley which states in part…"The formula for calculation of the Retention [and Retirement] Fund is specified in the Resolution. A draft resolution is attached which is undergoing some revision but materially reflects the current intent." The draft resolution is from July 19th.
- October 29, 2003 – External advisors conducted a market analysis of total CEO compensation. The analysis included "proposed" amounts that represented the retirement and retention payments. The market analysis was sent to Valley's outside legal counsel, who then forwarded it to the Board of Commissioners on October 31st.
- October 31, 2003 – A letter is sent by Valley's outside legal counsel verifying that the proposed Resolution 778 and the proposed contract were in a proper form to meet IRS standards. One of those IRS standards was the proper approval of the compensation arrangement by a governing body.
- October 31, 2003 – Valley's CEO communicates in a memo to the Board that "…All of these documents are basically the same as they were before when we met and decided to move ahead this past summer" in reference to the July 19th draft resolution and August 19th preliminary calculations.
- November 17, 2003
  - Board of Commissioners adopts Resolution 778 which has similar, but not identical provisions, to the July 19th draft resolution regarding the calculation of the CEO's retention and retirement compensation.
  - The President of the Board executes an employment agreement with the CEO. The agreement references Resolution 778 for the terms and conditions of the retention and retirement funds.
  - The President also executes the Supplemental Executive Benefit Plan on this date with funding terms matching the July 19th draft resolution.

- November 25, 2003
  - External advisors indicate in a memo to Valley's CFO that the "District Board has approved the creation of the [Supplemental Executive Benefit Plan]…The [Supplemental Executive Benefit Plan] calls for…the Retention Account…to be funded in the amount of $844,085…[and]…the Retirement Account…in the amount of $1,764,898". Although these amounts are consistent with the August 19th preliminary calculations, they are not consistent with the calculations defined in the Supplemental Executive Benefit Plan, Resolution 778 and the employment agreement.
- November 28, 2003 – Valley funds accounts for both the retention and retirement benefits based on the external advisors' November 25th memo.

The employment agreement signed on November 17th states that it superseded and replaced any prior oral or written understandings. After detailed discussions on this issue, the Attorney General's office stated that "under Washington contract law, surrounding circumstances and evidence extrinsic to the contract are to be used to determine the meaning of specific words and terms used in the contract and not to show an intention independent of the contract or to vary, contradict or modify the written word."

Condition

Resolution 778, the Supplemental Executive Benefit Plan and the preliminary calculations all differ in the terms of how the retention and retirement benefits should be calculated.

Retention Benefit	**Per Resolution 778 & Employment Agreement**	**Per Supplemental Executive Benefit Plan**	**Actual Contributions Based on Preliminary Calculations**
Total Retention Benefit	772,061	763,150	844,085

Retirement Benefit	**Per Resolution 778 & Employment Agreement**	**Per Supplemental Executive Benefit Plan**	**Actual Contributions Based on Preliminary Calculations**
Year 1			
Total Year 1	772,061	786,045	869,408
Year 2			
Total Year 2	780,972	809,626	895,490
Total Year 1 and Year 2	**1,553,033**	**1,595,670**	**1,764,898**

The amounts funded based on the preliminary calculations totaled over $250,000 more than the amounts that would have been funded if calculated under the Resolution or the Supplemental Executive Benefit Plan funding calculation.

Cause

The Board of Commissioners and Valley management were unaware of the differences in language between Resolution 778 (employment agreement references Resolution 778) and the Supplemental Executive Benefit plan regarding how the funding should be calculated for the retention and retirement benefits. They were also unaware that neither the Resolution nor the Supplemental Executive Benefit Plan matched the preliminary calculations.

Effect or potential effect

Valley funded the retention and retirement benefit accounts at amounts greater than those approved by the Board under Resolution 778 or under the Supplement Executive Benefit Plan executed by the President of the Board. Subsequent retention benefits are also impacted because they were based on the $844,085 contribution made on November 28, 2003.

Recommendations

Valley[2] should:

- Review Resolution 778, the employment agreement and the Supplemental Executive Benefit Plan to determine the appropriate funding amounts.
- Conduct a legal analysis to determine whether compensation amounts in excess of the Supplemental Executive Benefit Plan and Resolution 778/the employment agreement should be recovered. Extend the legal analysis to review the appropriateness of the 2008-2013 retention benefits.
- Establish review protocols to avoid future funding mistakes.

Issue 7 – Only half of the annual incentive plan's goals affect the amount of the incentive award and the CEO's performance on those goals has resulted in close to maximum payouts for the last three years

Background and criteria

A leading practice in annual incentive plan design is to identify goals an employee must meet during a specified performance period in order to receive an annual incentive award. Incentive plans in most companies provide for an objective link between achievement of the measurable goals and the amount paid to the employee. Incentive goals with no associated monetary effect generally do not result in focusing the employee's efforts toward achieving those goals. In addition, incentive plans do not consistently pay out at maximum levels for several years.

Condition

The annual incentive plans for 2006 through 2008 identify 10 goals, five of which result in a monetary payout. The incentive goals that have no link to the amount of the annual incentive award include maintaining competitive hospital rates (requiring that rates be no higher than a certain percentage of peer group hospitals); recruiting physicians; expanding accessibility to quality healthcare; and enhancing certain identified programs. The amount of the award is not reduced if these goals are not achieved. In addition, many of the nonmonetary goals appear to reflect typical CEO duties and responsibilities.

The CEO has received annual incentive payouts of 30.21 percent of his salary (based on the preceding year's base salary) from 2006 through 2008 (for performance in 2005 through 2007). The maximum annual incentive award that could be earned under the plan is 32 percent of the base salary. The CEO did not earn an incentive award for 2008.

[2] After Valley management was informed of this issue, the CEO issued a directive to the Treasurer of the District to conduct a full investigation, including obtaining new legal representation other than those involved in 2003.

Cause

The Board of Commissioners sets goals to drive performance and only links goals to the incentive award that are easily measurable. All other goals are used to assess the CEO's overall performance and are considered during decisions regarding merit increases to base salary. Due to an incentive award not being paid out for 2008 and during the late 90's, the Board does not believe the incentive goals tied to the incentive benefit are too low.

Effect or potential effect

The CEO may not focus his efforts as much on the goals that do not have a monetary award associated with them.

Based on the substantially similar goals from year to year, Valley may be paying near maximum payouts for performance that has not significantly increased year over year.

Recommendations

Valley should:

- Reevaluate the necessity of including additional goals that do not result in an incentive reward and annually review the goals with monetary awards associated to ascertain if they support the key objectives of the hospital.
- Review the relationship between performance and payout under the annual incentive plan on an annual basis to confirm the goals are set at a level to drive performance levels that warrant maximum payouts.

Evergreen Healthcare

Overall observations

Evergreen's CEO is paid a base salary of $559,600. It has a competitive CEO compensation and severance program. Compensation levels are targeted at the median of the competitive market. The District completes a benchmark compensation study annually to determine the market median compensation level. The study reflects common benchmarking methodologies using data from nationally recognized sources. The base salary is increased annually based on the competitive market data and the CEO's overall performance. The annual incentive target of 40 percent of the CEO's base salary reflects competitive practices in the healthcare industry. The CEO severance program is well-designed with a minimum payout of 18 months of base salary and an additional month provided for every year of service up to a maximum of 24 months. By increasing the severance based on years of service, Evergreen has limited its exposure to possibly paying a significant severance for limited tenure. The severance is paid only if the CEO is involuntarily terminated other than "for cause" or his contract is not renewed.

As described in the employment agreement (Resolution No. 803-07), the CEO's flexible benefit program, retirement (pension and nonqualified supplemental retirement benefit), vacation and disability insurance appear to reflect competitive practices.

Issue 8 – The incentive plan is very subjective with numerous performance goals related to the incentive payout appearing to be part of a CEO's normal job duties

Background and criteria

Incentive plans are designed to encourage employees to achieve goals above and beyond normal job responsibilities and duties. Leading practices in incentive plan design for executives involve setting goals based on three to five financial performance or strategic objectives in order to focus the participants. The objectives should be measurable and monetary rewards should be associated with each.

Condition

The CEO develops incentive goals annually for review and approval by the Board of Commissioners. The goals tend to be similar from year to year. Many of the goals reflect ordinary, expected job duties for a CEO, such as planning and conducting the annual Board Leadership Planning Retreat and holding fundraisers. The 2009 incentive plan contains 48 goals and objectives, significantly more than the typical three to five found in an annual incentive plan. The Board evaluates the CEO's performance against these objectives throughout the year and determines the final incentive payout. Since none of the objectives are linked directly to monetary awards, the Board used its discretion to determine the incentive payout of $274,200.

Cause

The Board of Commissioners historically has approved numerous annual performance goals for the CEO that represent expected CEO job duties as opposed to goals that would reflect performance above what is expected because the Board uses the goal-setting process to drive the CEO's day-to-day behavior. The large number of goals is due to the Board wanting to link all of the CEO's goals to the District's strategic plan.

Effect or potential effect

By not linking measurable goals to monetary awards, the plan allows the Board to exercise complete discretion in determining the incentive payout, which could result in over or underpaying in comparison to actual performance.

Recommendations

Evergreen should redesign the annual incentive plan to include:

- Fewer performance goals.
- Each goal should have objective, measurable results identified.
- The results should be linked to monetary rewards.

Issue 9 – The CEO's employment contract and the incentive plan do not specifically address incentive payments upon termination, including resignation, death, disability or retirement

Background and criteria

It is common practice for executive employment contracts and incentive plans to address what will be paid due to voluntary termination, involuntary termination (for cause and not for cause), disability, retirement and death. These events should be formally addressed so that all parties understand the obligations and benefits under the incentive plan for each scenario.

Condition

Evergreen's current CEO employment contract and the incentive plan documentation do not specify what payments the CEO is entitled to receive under the incentive plan in the event that he is terminated.

Cause

In negotiating the CEO's employment contract, Evergreen's Board of Commissioners failed to include common provisions to address termination payouts. Neither the Board nor the CEO was immediately aware that the contract did not address these common provisions.

Effect or potential effect

Without the specific termination events and the related incentive payout defined, uncertainty could arise regarding the obligations of Evergreen and the benefits to the CEO if he leaves his employment. The annual incentive plan lacks clarity as to what will be paid if the CEO terminates his employment, which could result in a dispute between the two parties. This lack of clarity was an oversight by the Board.

Recommendations

Evergreen should consider:

- Modifying the CEO employment contract or the annual incentive plan to define payouts when the CEO leaves the hospital's employment.

Stevens Hospital

Overall observations

Stevens' CEO is paid a base salary of $383,900. Overall, Stevens has a well-structured, competitive CEO compensation program. Stevens targets the median (or slightly below) of the competitive market for its CEO's base salary. The Board uses independent consultants to provide benchmarking data and advice on competitive market trends annually or biannually. The Board also uses an outside consultant to facilitate the discussion of the CEO's performance review. The maximum annual incentive award of 30 percent of the base salary is slightly below market practices but still within the competitive range. The annual incentive plan is also well-structured with defined, measurable performance goals with weightings to emphasize the level of importance.

Due to the former CEO's severance arrangement that resulted in more than $1.1 million in severance payments over a multi-year period when the CEO was terminated, Stevens' Board developed a formal process for benchmarking severance and negotiating with the new CEO. When the current CEO was hired, the Board negotiated an 18-month severance benefit, which is at the low end of the competitive range.

In addition, the CEO's relocation benefit under his employment contract provided for a maximum number of employer-paid trips between his former and current residences up to a maximum dollar value. Based on documentation provided, Stevens paid $9,922 more than the maximum dollar value ($22,000) for the specified number of trips in his contract. However, once the error was discovered, the CEO reimbursed Stevens for the excess amount as shown in documentation provided during the audit, and the issue has been resolved. Stevens also instituted ongoing monitoring processes of the CEO's expenses to avoid any future occurrences similar to this instance.

Issue 10 – Several of the annual incentive plan performance measures were exceeded during the prior year or significantly exceeded in the current year, indicating that the goal-setting process may result in goals that are not sufficiently challenging to warrant additional compensation

Background and criteria

A leading practice in annual incentive plan design is to identify goals that must be met during a specified performance period in order for the employee to receive an annual incentive award. Incentive plans in most companies provide an objective link between achievement of the measurable goals and the amount of the award paid to the employee. Organizations should balance the relationship between performance levels and awards so that award amounts reflect the degree of difficulty in achieving the goals. Generally, incentive plans do not consistently pay out at minimum or maximum levels for several consecutive years.

Condition

Maximum performance levels for seven of the eight goals in 2008 were exceeded, resulting in a payout of 90 percent of the maximum award. In addition, we noted that the 2009 maximum performance level for the days cash on hand was established using the 2008 goal even though this goal had already been achieved in 2008.

Cause

In response to the near maximum payout for 2008, the Board of Commissioners redistributed the weighting given to each goal to focus improved performance on patient satisfaction as opposed to financial performance. The financial goals for 2009 were set based on 2008 levels due to the expectation that a down financial market would greatly impact hospital financial performance.

Effect or potential effect

Stevens' current goal-setting process may result in goals that are not sufficiently challenging to warrant additional compensation. Stevens may be making near maximum payouts for performance that is not truly challenging.

Recommendations

Stevens should:

- Review the relationship between performance and payout under the annual incentive plan on an annual basis.
- Review goals from year to year to assess the increase in the degree of difficulty in attaining the various performance levels.

Commendation

Stevens' annual incentive plan is well-structured with defined performance metrics and goals. Each metric is objective and measurable with weightings assigned to emphasize importance. It also appears that the performance goals can change annually in order to reflect the hospital's evolving priorities.

Operations and construction management

Nursing and administrative staffing

Background

As part of our risk-based approach, we reviewed hospital administration, including how many staff reported to each manager (i.e., span of control) and employee turnover. We also looked at how the hospitals manage staff, measure staff productivity and how they use technology to enable staff management. We noted that some hospital technology systems provided real-time information (continuously updated with the latest information) and other technology systems are updated overnight. Real-time systems allow the hospital to see and act on issues immediately by providing more timely information.

Based on our work plan for the high-risk areas and with the help of the State Auditor's Office, we narrowed the scope of our audit to focus on the following questions related to the following leading practices in staffing performance measurement:

- Given the hour-by-hour changes to the number of patients served, unscheduled procedures and unexpected emergency department visit fluctuations, does the hospital track staffing changes daily?
- Has the hospital established staffing guidelines for every department based on specific workload measures to predict and control staffing?
- Are those guidelines used in combination with an automated time-keeping system?

The following issues and accompanying recommendations all relate to the above questions concerning staffing performance measurements.

Issues and recommendations – nursing and administrative staffing

Issue 11 – Ineffectively managing hospital personnel leads to overstaffing and underutilization, creating additional costs

Background and criteria

Workloads in a hospital vary by department and fluctuate over time. Leading practices recommend daily monitoring of workload against staffing levels and employee productivity to ensure employees are used in the most efficient and effective manner. By monitoring workload, management can shift employees to departments where they are most needed or adjust work schedules to reduce unproductive employee time.

Condition

Evergreen and **Stevens** have financial analysts or accountants assigned to each department within the hospital to assist department managers with the budget process, but these individuals are not used consistently to help manage employee staffing or to analyze productivity. Department managers at **Evergreen** and **Stevens** do not have standard reports and tracking tools to manage employees and measure their productivity on a daily basis.

See commendation below for Valley.

Cause

At **Evergreen**, the relationship between the financial analysts and department managers is varied due to management not requiring standing meetings or official sign-offs from the financial analysts regarding their interactions, review or analysis. At **Stevens**, the role of the accountants assigned to each department is limited and focused more on accounting matters and monthly budget review than proactive staffing and productivity monitoring.

In general, productivity software is either not used or not fully implemented at both **Evergreen** and **Stevens**. Lastly, some departments not specifically tied to patient care have not been viewed as variable in terms of staffing by **Evergreen** (meaning the same amount of employees always work in the department no matter the workload), so productivity metrics have not been defined for those departments, which also works against a standardized, facility-wide approach to managing staffing and productivity.

Effect or potential effect

The lack of standardized reports for staffing and productivity at both **Evergreen** and **Stevens** leads to the inability of management to easily compare a department's productivity and staffing because the quality and format of the information presented by department varies. This may result in overstaffing and underutilization of hospital personnel. Although some departments monitor productivity daily, no standardized tools or processes are in place for management to monitor productivity daily, and without that, it is extremely difficult to identify reasons for variances after a week or more and thus difficult to correct staffing problems.

For those departments at **Evergreen** that do not have any productivity metrics, department managers have little incentive to manage staffing as efficiently as possible. Management also does not have a way to measure productivity other than comparing the department to its budget. Managing strictly against budget may not be an accurate method because the budget is primarily based on the previous year's expenses that were measured against budget. If the budget is not set properly, then the department is constantly being measured against a flawed metric.

Recommendations

Evergreen should define the financial analysts' roles with department managers to:

- Assist in daily monitoring of productivity, including dual accountability with department managers.
- Assist in monitoring costs.
- Assist in analyzing and identifying root causes related to productivity management (e.g., scheduling imbalances, ineffective use of overtime).
- Include in the monitoring process target salary and nonsalary costs per unit of service as an additional measure to evaluate departmental management effectiveness.
- Schedule joint meetings with managers and members of senior leadership to review productivity and expenses.

Evergreen should also establish:

- An employee monitoring system for productivity and staffing that is standard across all departments and has the ability to report information daily with initial focus on nursing and other clinical departments, but adding all departments in a progressive manner.
- Training so managers and senior leadership can effectively use the monitoring system and standard reporting processes to review productivity measures.
- Productivity metrics for all departments based upon budgetary needs of the hospital (all departments should be viewed as variable in terms of staffing even though some departments may not vary staff on a consistent, daily basis).

Stevens should:

- Determine if accountants assigned to departments are capable of analyzing staffing and productivity; if not, develop tools and training to provide the accountants with that capability.
- Establish expectations that the accountants support daily department analysis of trends in overtime, agency use, problem solving with the manager (e.g., is the manager scheduling equitably from day to day?) and help the managers analyze costs.
- Perform a cost-benefit analysis and select one of the following:
  - Re-establish the DPMS tool.
  - Upgrade Kronos to include Visionware (which is no longer sold as an add-on product, but is integrated into a package).
  - Leverage the data available from Kronos and develop tools internally to use that data.

Departments with greater variable workloads (e.g., nursing, clinical services, dietary, transport) should be the initial focus.

In the short term, **Stevens** should perform the following:

- Determine which currently available Kronos reports are most valuable to managers in managing and understanding their labor costs.
- Provide these reports to managers along with training on how to use and access them.
- Senior leadership should follow up with managers regarding their use of reports and solicit feedback.

Commendations

Valley assigns individuals from its Finance Department to all other departments to assist managers in the budget process and in the daily managing of staffing and productivity. This relationship is formalized by having these personnel from Finance attend weekly or biweekly meetings with both managers and senior leadership where the managers are held accountable for productivity and budget variances.

The daily management of staffing and productivity is possible because **Valley** uses the Kronos Visionware system for daily productivity tracking (in departments where productivity data is compiled on a daily basis), with the process standardized through Finance. Kronos Visionware is a labor analytics system designed to assist managers in optimizing the number of worked hours and the cost of those hours in situations where work volume fluctuates unpredictably over time. Existing reports from Visionware are consistently reviewed by Finance against the productivity metrics that have been defined for all departments and those reports are discussed weekly or biweekly with managers and senior leadership.

Potential cost savings and other effects

Potential cost savings for all issues in the nursing and administrative staffing area have been grouped together and discussed below.

Issue 12 – The hospital districts' monthly budget review processes lack precision and discipline to allow management to make timely, fact-based decisions regarding staffing costs

Background and criteria

The annual budget-setting process results in an annual operating budget for each department that rolls up into a hospital-wide budget. Leading practice, based on our professional experience, suggests actual performance for each department should be compared to the annual budget on at least a monthly basis. The review should be conducted through the use of consistent, standard templates so the process is thorough and organized consistently for all departments. Standard templates provide each department

with a format to organize budget data in an identical way to the other departments, which facilitates an efficient review by upper management across all departments. Variances from budget should be investigated and reported to departmental management and confirmed by upper management. This type of internal control, if performed monthly, helps to detect potential issues before they become too large.

Condition

Evergreen and **Stevens** both compare monthly operating activity to the monthly budget. However, they don't have a standard template or process for documenting and reporting their reviews. A standard template would provide a common format for each department to organize their budget data and variance analysis. Using a common format would also help upper management efficiently review budget analysis across the entire district. Also, if actual performance varies 3 percent or greater from the budget at Evergreen, department managers are required to meet with their respective vice president to review the variance. In general, productivity and staffing are not regularly reported unless in relation to a variance explanation.

See commendation below for Valley.

Cause

Management has not prioritized the use of a standard process across all departments for analyzing, documenting and communicating operating performance compared to budgeted performance.

Effect or potential effect

Without standardized processes and templates for analyzing, documenting and communicating actual-to-budget performance, the quality and type of information communicated to management may vary widely and management may have difficulty comparing department results and making timely, fact-based decisions.

Recommendations

Evergreen and **Stevens** should use consistent budget analysis templates district-wide. The Finance department and division vice presidents should provide input on the format and content. The districts should consider the following elements:

- Number of patients treated and revenue compared to budget
- Hours per unit of service
- Salaries per unit of service
- Non-labor costs per unit of service
- Variance explanations
- Plans for correction

Commendations

Valley uses established measures to determine how well and how productively the hospital is run. For example, staff-hours-per-patient day is monitored in the weekly or biweekly meetings with department managers and senior leadership. Monthly budget reports, when available, are also incorporated into these meetings. Finance has created salary and nonsalary costs per unit of service as an additional metric to monitor costs. The budget review process has been defined by each vice president and it is consistently followed for their departments.

Potential cost savings and other effects

Potential cost savings for all issues in the nursing and administrative staffing area have been grouped together and discussed below.

Issue 13 – Lack of position control at Stevens allows departments to potentially hire in excess of budget, resulting in additional costs

Background and criteria

Position control is where every employee represents a position number based on budgeted full-time equivalents (FTEs)[3] for a department. Position control is an important component of staffing because it links all positions back to the budget and is designed to prevent hiring in excess of budget.

Condition

Stevens does not have a formal position control tied to the number of budgeted FTEs by department. However, as vacancies occur, the need for the position is reviewed by the appropriate vice president.

See commendations below for Evergreen and Valley.

Cause

Stevens' management has not recognized position control as a priority.

Effect or potential effect

Without position control, departments may be able to hire individuals in excess of budget, which can lead to departments being overstaffed and over budget. Although it could not be determined whether **Stevens** is overstaffed due to the lack of position control, the risk of overstaffing is apparent.

Recommendations

Stevens should:

- Create a formal position control based on the budgeted FTEs by department.
- Ensure Human Resources conducts a review of the budgeted position control listing prior to posting a position, and the department manager and the appropriate vice president should review the need of the requested position based on the departmental volume and workload.

Commendations

Valley's formal position control system has vacant positions reviewed by the respective financial analyst assigned to each department as a check for a position control number and need before posting.

Evergreen's formal position control system is run by Human Resources (after vice president review), validating a position matches a position control number before posting. New positions, and the associated business case, are reviewed by a senior leadership team called the Position Requisition Review Team.

[3] Full-time equivalent, or FTE, is a common term used in the healthcare industry to describe staffing numbers. An FTE of 1.0 means a position is the equivalent of a full-time worker, whereas an FTE of 0.5 signifies a half-time worker.

Potential cost savings and other effects – nursing and administrative staffing

To assess the potential for opportunity at the three public hospital districts, Ernst & Young performed a benchmark exercise (see Appendix E) that could potentially be used to identify areas of cost savings. In reviewing this appendix, users of this report should know we did not modify the benchmarks to remove variation based on the unique operating environments at each hospital. The additional work required to fine-tune the benchmarks to provide an equitable comparison across all three hospitals was not included in the scope of this audit. The results of the unaudited benchmark exercise are included in Appendix E.

One of the areas contained in Appendix E includes hospital nursing staffing levels. As part of our audit we examined each hospital district's reliance on agency nurses and other temporary staff. As Valley exhibited the strongest controls with regard to monitoring its staffing levels, we examined Valley's reliance on agency nurses and other temporary staff as a potential benchmark. We noted Valley's reliance on agency nurses and other temporary staff was limited to 2 percent of total productive hours (productive hours are hours spent directly or indirectly on patient care; examples of nonproductive time include training and paid time off), whereas Stevens and Evergreen totaled 2.4 percent.

Based on the above findings for Evergreen and Stevens, opportunity exists to reduce labor costs through improved management of staffing and productivity. Due to agency nurses receiving a higher hourly rate than staffed nurses (often more than double), agency nurses should be the first to have their hours reduced when staffing management improves. Many hospitals have even begun to eliminate all agency costs. Evidence of the success of these efforts has been broadly reported across the nation. Some examples include Charleston Area Medical Center (85 percent reduction in agency dollars[4]), Norton Healthcare (99 percent reduction in agency hours[5]) and TriHealth ($1.5 million in annual savings[6]). Based on Ernst & Young's professional experience, we estimate by following the above recommendations the hospitals could achieve potential cost savings[7] related to a reduction in FTEs via a reduction in agency hours down to the benchmark set by Valley. This reduction represents the following cost savings:

- **Evergreen** could experience cost savings around $5,225,000 over a five-year period by reducing agency hours to 2.0 percent of productive hours, assuming the staffing mix and wage rates remain relatively stable.
- **Stevens** could experience cost savings around $3,195,000 over a five-year period by reducing agency hours down to 2.0 percent of productive hours, assuming the staffing mix and wage rates remain relatively stable.

Ernst & Young recommends Valley and Stevens both review the hourly rates they are currently paying for agency usage. Data analysis shows Evergreen currently pays on average $60 per hour for agency staff, while Valley and Stevens average $82 and $75 per hour, respectively. Nursing and administrative staff compensation was not included in the scope of this audit so the reasons for the differential are unknown, but additional cost savings could potentially be achieved by reviewing these compensation rates.

Each hospital may be able to use Appendix E to identify other possible areas of potential cost savings.

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[4] Kronos case study available at http://www.kronos.com/AssetInfo.aspx?id=1279.

[5] American Hospital Directory case study available at http://www.ahd.com/LaborStudy050721.pdf.

[6] Kronos case study available at http://www.kronos.com/AssetInfo.aspx?id=2806.

[7] The recommendations for Issues 11 and 12 refer to better management and utilization of current staffing and the unaudited benchmarking exercise in Appendix E points to potential overstaffing at both Evergreen and Stevens. Therefore, the agency usage reduction should not require hiring additional staff. However, if the reduced agency hours needed to be replaced with full-time staff, the potential cost savings would be less. The cost savings over five years would be approximately $2,415,000 for Evergreen and $1,855,000 for Stevens.

Procurement and inventory management related to medical supplies

Background

As part of our risk-based approach, Ernst & Young conducted a high-level review of each public hospital district's medical supplies procurement process, from the initiation of a purchase requisition to payment of an invoice, including contracting, product selection, vendor management, order placement, receipt and inventory management. The hospitals' purchasing departments use purchase requisitions to initiate medical supplies purchases. Management expects the majority of items to be purchased using requisitions. Use of a well-controlled requisition function reduces costs by limiting orders to items and quantities in accordance with the policies of the hospital.

Entering into vendor contracts and purchasing medical supplies are essential to delivering high-quality care to the patients of the hospital. These two processes work hand-in-hand to ensure that products selected provide high-quality care and are purchased at a reasonable cost. Valley and Evergreen have annual expenditures of medical supplies in excess of $35 million while Stevens' annual expenditures are around $16.5 million.

Vendor management processes have to do with the credentialing of vendors to do business with a public hospital district, managing the influence of vendors over clinical decision-making and handling the participation of vendor representatives in the delivery of healthcare. It is important that this participation is presented to the patient in advance and that patient consent is obtained for vendor representative participation in any procedure. In addition, any financial incentives of an individual provider should be disclosed prior to a procedure.

Order placement and receipt are managed by procurement personnel who are responsible for ordering and receiving medical supplies. The primary purpose of these departments is to review orders for accuracy and reasonableness prior to placement, as well as to verify that the goods ordered were received in good condition and in quantities ordered. Finally, inventory management is responsible for the safe, efficient storage of goods and their delivery to end-users in all departments of the hospital.

The payment process takes place in the accounts payable department. Processing invoices can be done in the previously described procurement process; a separate but similar process for capital items (e.g., equipment, buildings or building improvements); or a direct request for payment to a vendor. Each type of payment should be subject to approval at various levels of the organization depending on the dollar amount, department and criteria which may be defined by the individual hospital.

Based on our work plan for the high-risk areas and with the help of the State Auditor's Office, we narrowed the scope of our audit to focus on the following question related to the general control environment and to procurement:

- Are the procurement and inventory management controls related to medical supplies in line with leading practices?

Issues and recommendations – procurement and inventory management

Issue 14 –The hospital districts lack policies requiring physician disclosure of outside compensation and financial relationships on an ongoing basis, which can potentially affect the selection and cost of medical supplies.

Background and criteria

Relationships between doctors and vendors may have an influence on what products and services doctors choose to offer their patients. Doctors' decisions may be influenced by gifts or other financial incentives such as royalties related to product development or payments for speaking, training or travel. For municipal officers[8] these arrangements are covered by the Revised Code of Washington (RCW) 42.23.030 (Interest in contracts prohibited — Exceptions) and RCW 42.23.070 (Prohibited Acts), which both prohibit a municipal officer from receiving benefits related to contracts or related to the officer's services as such officer, respectively. Even though most, if not all, physicians would not be considered a municipal officer, hospitals should make sure these relationships are disclosed and do not adversely impact patient care. To further control vendor representatives, a credentialing process should be in place that requires formal registration of vendor representatives doing business at each entity, including a business associate agreement.[9] The state of Massachusetts has passed a law to promote cost containment, transparency and efficiency in the delivery of quality healthcare that addresses some of the issues noted here (see Massachusetts Chapter 268C of Senate Bill Number 411).

Condition

All three public hospital districts lack policies requiring the disclosure of outside compensation and financial relationships on an ongoing basis. No violations of the RCWs mentioned above were noted nor did we specifically test for any. However, we did note Stevens' policy bans all gifts and is thus in compliance with the RCWs mentioned previously, while Evergreen's and Valley's policies set explicit limits on vendors' gifts and samples and thus would not be in compliance with the RCWs mentioned above in relation to municipal officers. Even though the policies are in place, the vendor visit logs at all three facilities do not track gifts and/or samples given or the value of the same. Therefore, it was not possible to test for compliance with applicable dollar limits (where they have been established).

Cause

Hospital management has not prioritized the institution of processes and controls to monitor vendor/doctor relationships and in some cases has not set limits on gifts and compensation from vendors to employees. In addition, the majority of medical staff at all three hospitals are private physicians not employed by the districts and the Washington Legislature has not limited gifts or compensation from vendors to practicing physicians.

Effect or potential effect

Doctors may knowingly or unknowingly be biased to a vendor's products and services because of financial benefit to themselves. This may put the hospital at financial risk due to increased medical

[8] According to RCW 42.23.020, "'Municipal officer' and 'officer' shall each include all elected and appointed officers of a municipality, together with all deputies and assistants of such an officer, and all persons exercising or undertaking to exercise any of the powers or functions of a municipal officer." In the case of public hospital districts, it is most likely this definition would not apply to any physicians practicing medicine within the confines of the public hospital district.

[9] Any hospital is required to have a business associate agreement with any organization whose activity involves the use or disclosure of the covered entity's protected medical information to comply with the regulations of the Health Insurance Portability and Accountability Act.

supplies costs and patient lawsuits. As a result, the quality, cost and transparency around patient care may suffer.

Recommendations

Valley, Evergreen and **Stevens** should require that vendors log their visits, including:

- Date of visit,
- Vendor and representative information,
- Destination department,
- Person visiting,
- Gifts and/or samples, and
- Value of gifts and/or samples given.

All three public hospital districts should develop policies requiring the disclosure of outside compensation and financial relationships on an ongoing basis for hospital employees. Additionally, hospitals should set policy to explicitly limit gifts and/or samples and require all employed physicians and staff to complete an annual confirmation that they have complied with applicable policies. The confirmation should also require disclosure of outside compensation, which may create a real or perceived conflict of interest (e.g., physician speaking or consulting fees, travel, royalty payments). All three hospitals should either update or create policies explicitly prohibiting the acceptance of any gift, compensation, gratuity or reward by anyone who could be considered a municipal officer according to RCW 42.23.020.

We recommend the Washington Legislature amend state law to explicitly limit gifts and compensation to physicians from vendor representatives; Massachusetts Chapter 268C of Senate Bill Number 411 could provide some guidance.

Potential cost savings and other effects

Potential cost savings for all issues in the procurement and inventory management area have been grouped together and discussed below.

Issue 15 – Hospitals are not completely limiting the use of products not approved for purchase to contain costs

Background and criteria

New products and improvements to existing products are constantly being developed and put on the market for purchase (recent examples at Valley are the review of repositionable electrodes and new glucose monitoring products). These products need to be reviewed in relation to their impact on patient care/satisfaction versus their cost. These products also need to be contracted by the hospital prior to use in order to negotiate the best price and avoid unknown costs to the patients. Contractually limiting payments to vendors for products not approved is a leading practice used by hospitals to encourage vendors to comply with hospital policy. Leading practice is also to not allow hospital personnel to purchase products from the vendor that have not been approved for purchase. Product approval and contracting processes, commonly referred to as value analysis in healthcare settings, are designed to review all new products prior to their initial use.

Condition

The programs at **Valley** and **Evergreen** are well-defined, but both value analysis programs demonstrated the potential to be bypassed during our testing and walk-through. Goods purchased prior to approval by the value analysis team were noted, leading to concern about its overall effectiveness. However, it should be noted that when products go through the defined value analysis process at Valley, the results are acceptable related to rate of approvals and denials. Although Evergreen's value analysis procedures are better defined than Valley, Evergreen does not contractually limit payments for products that bypass the

process and are used prior to approval, while Valley has added contract riders for unapproved products. **Stevens'** value analysis process is relatively new, has been slow to get off the ground and could be strengthened significantly.

Cause

Valley and **Evergreen** have developed well-defined value analysis teams, but their processes can be bypassed. Valley and Evergreen were unaware of the potential for their processes to be bypassed. The value analysis process at **Stevens** was not a point of focus previously and a team was not in place.

Effect or potential effect

Products and services that bypass established value analysis processes create a risk to the hospital for both higher costs above negotiated contract rates for similar products and off-label use. Off-label use is when a drug or medical device is used to treat a disease or condition not listed on its label, or used in such a way that's not outlined in the label. However, it should be noted that off-label use of products was not reviewed as part of this performance audit, nor was it observed. Higher costs are typically passed on to the patient and/or the insurance company through higher charges for these products.

Recommendations

Valley and **Evergreen** should strengthen their existing value analysis processes to prevent them from being bypassed. Evergreen should contractually limit payments for products that are not approved prior to use to discourage the vendors from attempting to bypass the value analysis process.

Stevens should continue to develop its value analysis process and monitor its effectiveness once it is fully operational. This development could be aided by collaboration with Evergreen and Valley to learn from their processes, especially relative to the timeliness of review.

Potential cost savings and other effects

Potential cost savings for all issues in the procurement and inventory management area have been grouped together and discussed below.

Issue 16 – Certain hospital districts do not properly manage consigned inventory to prevent unnecessary costs

Background and criteria

Managing consigned inventory[10] presents an increasing challenge as many healthcare providers convert high-cost supplies to consigned rather than owned inventory. Consigned inventory is stored at the hospital, but it is still owned by the vendor until it is actually used. Consignment inventory is typically counted by vendors, and any missing items that have not been billed to the healthcare provider are charged at the end of a set time period, generally quarterly. Properly managed consigned inventory levels should match vendor records upon audit unless the vendor's records are not up to date. In such cases, the hospital should be able to prove such updates are needed through correspondence or patient records. The management of consignment inventory is very important because inventory on consignment generally includes high-cost, implantable devices, such as pacemakers.

Condition

Valley and **Stevens** do not have adequate internal controls over consigned inventory.

See commendation below for Evergreen.

[10] Consignment inventory is inventory in the possession of the hospital, but it is still owned by the vendor. The hospital purchases the inventory only after the item has been consumed, typically through a patient procedure. Consignment inventory generally includes high-dollar implantable items, such as pacemakers.

Cause

Valley management has not established internal controls over consigned inventory.

Stevens does not have policies and procedures in place for consigned inventory.

Effect or potential effect

Inadequate consignment inventory records do not allow districts to dispute varying consignment inventory amounts with vendors.

Recommendations

Valley and **Stevens** should:

- Adopt a consistent policy for managing consigned inventory.
- The policy should include a formal process for tracking inventory movements and should tie items directly to a patient's medical record as a requirement for payment.
- Categorize items in their consignment inventory and document any changes to agreed inventory levels in writing with vendor representatives.
- Periodically reconcile consigned inventory records to actual inventory and follow up on any discrepancies.

Commendations

Evergreen demonstrates the strongest program of the three hospital districts for managing consignment inventory. As a result of our testing, a vendor updated its records to reflect an agreed upon inventory level change. This discrepancy between actual inventory and vendor records was the only exception found at Evergreen and was resolved as a vendor error.

Potential cost savings and other effects

Potential cost savings for all issues in the procurement and inventory management area have been grouped together and discussed below.

Issue 17 – The hospital districts have not established appropriate approval levels over the purchase of medical supplies

Background and criteria

Medical supply purchase orders are orders for items used in the day-to-day business of a hospital. Medical supply purchases are typically high-volume, low-dollar transactions. This is where the bulk of the annual purchasing activity occurs. Valley and Evergreen have annual expenditures of medical supplies in excess of $35,000,000 while Stevens' annual expenditures are around $26,000,000, most of which are bought using purchase orders. Medical supply purchase orders generally require approval prior to issuance, but the level of approval is much less than that required for capital purchases (capital purchases are long-term items such as equipment, buildings, land, etc.).

Condition

Valley and **Stevens** do not currently have documented approval levels for requisitions or purchase orders for all departments. Valley was in process of creating such levels for all departments during field work but they were not able to be tested. **Evergreen** has established approval levels; however, approvals are defined by a dollar threshold for all purchasers (as opposed to individual or departmental thresholds) and testing showed that those levels were inconsistently applied.

At **Stevens,** we noted a segregation of duties issue related to purchase transactions in the Lawson application. The treasurer/senior accountant has both administrative Information Technology (IT) access

to the Lawson application and a job role in the accounting department. As a result, this person can set up vendors, authorize payments and alter the transaction record after the fact.

Cause

Valley and **Stevens** have not prioritized the establishment of purchasing approval levels. **Evergreen** was unaware that its purchasing approval levels were being bypassed. Inconsistent adherence to approval levels is not currently being reviewed regularly at **Evergreen**.

Stevens' management had not realized the potential impact of the segregation of duties issue.

Effect or potential effect

Lack of adequate purchasing controls may lead to unrestricted purchasing activity. Unrestricted purchasing activity through the use of purchase orders can lead to a legal requirement to purchase unwanted or unneeded goods that are not competitively priced.

Recommendations

Valley, Evergreen and **Stevens** should develop an approval matrix that covers both electronic and paper purchases. As different departments and individuals will have varying needs for spending authorities (e.g., a requester in the operating room will require different thresholds than someone in a clerical function), these limits should be established on an individual or departmental basis rather than a blanket, dollar-based approach. This matrix should be enforced electronically wherever possible, and manually prior to the creation of a purchase order where it is not. Exception reports should be reviewed regularly.

Stevens should immediately correct the segregation of duties issue mentioned above by eliminating the treasurer/senior accountant's administrative IT access to the Lawson application.

Potential cost savings and other effects

Potential cost savings for all issues in the procurement and inventory management area have been grouped together and discussed below.

Issue 18 – The Hospital Districts' inventories are not managed effectively

Background and criteria

Hospitals must manage their inventory levels to keep enough supplies on hand to service patients' needs, but without having too much inventory. Excess inventory requires unnecessary storage space either in a central location or in the patient care setting. Excess inventory can also lead to spoilage, theft or mismanagement of resources.

Condition

All three public hospital districts showed room for improvement in inventory management during the walk-through observations. The walk-through observations were conducted by taking a tour of each hospital and walking through the various areas where supplies are kept. The observations below generally relate to physical security of items, unnecessarily high inventory levels and inconsistent policies.

Valley demonstrated a lack of control related to the storage of items that were either high cost, high risk or potentially contained sensitive patient information in a digital format. Physical security was also identified as an issue in several areas. Inventory levels in the pharmacy are potentially higher than necessary and similar excess was observed with some supplies in the operating room. Signature policies for in-house deliveries were not consistent from department to department, varying based on the destination of a delivery within the hospital.

Evergreen's inventory management program showed room for improvement. Specific issues were noted with respect to physical security of a small number of inventory locations and inventory levels for some items are potentially higher than necessary. Based on our observations during the walk-through, opportunity exists for Evergreen to more aggressively manage its purchases through vendor consolidation, purchasing methods and contract terms.

Stevens demonstrated few issues with respect to physical security of its inventory locations. Inventory control, however, could be improved, especially in nursing units relative to the storage of pharmaceuticals in medication rooms and drug dispensing machines.

Cause

Management has not created robust processes and procedures for tracking, securing, analyzing and replenishing inventory items.

Effect or potential effect

Ineffective inventory management may lead to theft, misuse and spoilage of inventory. Unsecure sensitive patient information could be compromised.

Recommendations

Valley should focus on improving the physical security of inventory, especially inventory containing potentially sensitive and/or valuable products or information. Inventory levels should be aggressively monitored using a report that highlights inventory that is not used or used infrequently, where possible. Signature policies should be uniform for all deliveries.

Evergreen should review its physical security policies, procedures and practices hospital-wide. In addition, a review of specific item placement and the number of varieties of similar products should be performed to further reduce risk and supply expenses.

Stevens should focus on inventory and control procedures in nursing units and the physical security of inventory items.

Potential cost savings and other effects – procurement and inventory management

Based on the above issues for all three public hospital districts, opportunity exists to reduce costs as well as to reduce risks that have the potential to create additional cost. Issues related to inventory management, especially those related to excess inventory, have implications in both potential loss and risk of expired product being used in the delivery of patient care.

In considering all of the issues above, Ernst & Young subject matter professionals determined the recommendations cannot be directly tied to any specific cost savings. However, a high-level analysis does indicate all three public hospital districts show room for improvement in managing their supply expenses. A 2008 supply chain study conducted by the Healthcare Financial Management Association (HFMA) reported hospitals performing at the top 25th percentile spent $180 on supplies per adjusted patient day.[11] By following the above recommendations, each of the hospitals should be able to narrow the gap between their spending level and the HFMA benchmark. As a point of reference, supply spending at each hospital was calculated as shown below:

- Valley's annual medical supply expense of $36 million calculates to approximately $190 per adjusted patient day.
- Evergreen's annual medical supply expense of $35 million calculates to approximately $245 per adjusted patient day.
- Stevens' annual medical supply expense of $16.5 million calculates to approximately $228 per adjusted patient day.

[11] Supply expense per adjusted patient day is a common industry benchmark. Patient days need to be adjusted to account for a hospital's Case Mix Index (CMI) and inpatient/outpatient split. CMI is a relative measure of the costliness of the patients treated by a hospital and needs to be considered because more acute patients generally require more supply spend per day than average patients. Inpatient/outpatient split is accounted for because patient days measures inpatient usage, but supply spend represents usage by both inpatients and outpatients.

Construction

Background

Effective monitoring and reporting are important elements of any capital construction program. Monitoring enables assessment of the contractor's performance with regard to scope, schedule, cost and quality, and facilitates identification of risks, opportunities, gaps and variances that require attention. Construction reporting summarizes data gathered during monitoring activities and communicates the appropriate information to various groups involved with the project. Performed properly, monitoring and reporting of construction projects provide sufficient information to enable timely understanding of critical issues and allow adequate time for establishing necessary preventive or corrective measures to mitigate risks such as schedule delays, cost overruns, scope gaps or quality deficiencies. Our audit focused on the effectiveness of overall monitoring processes but not the impact of inadequate controls over individual construction projects.

Valley and **Evergreen** had construction projects of approximately $150 million and $130 million, respectively, from 2005 through 2007. By comparison, **Stevens'** construction program was approximately $3 million during the same period.

Ernst & Young's professional experience shows a strong correlation between the following leading practices and completing construction projects on time and within budget. These practices include:

- Carefully tracking performance of construction projects against the approved budget and schedule.
- Providing timely, accurate reports to senior leadership that summarize key project data.
- Reviewing cost summary reports that include the committed, invoiced, paid to date and estimated cost at completion.
- Reviewing and tracking change orders that include description, dates, amounts and approval status.
- Reviewing and tracking critical issues (including claims and disputes) that could impact the project budget, schedule or scope.

Based on our work plan for the high-risk areas and with the help of the State Auditor's Office, we narrowed the scope of our audit to focus on the following questions related to construction performance, monitoring and reporting:

- Does the hospital's construction (or facilities) department carefully track performance of construction projects against the approved budget, baseline schedule and agreed-upon scope of work?
- Does the construction department provide timely, accurate reports to senior management that summarize key project data, including a contract cost summary (committed, invoiced, paid to date and estimated cost at completion), change orders (description, dates, amounts and approval status) and critical issues (including claims and disputes) that could impact the project budget, schedule, scope or quality?

Issues and recommendations – construction

Issue 19 – The hospital districts' monitoring and reporting processes could be improved to enhance project management and improve project performance

Background and criteria

As noted above, carefully tracking the performance of construction projects against the approved budget and schedule and providing timely, accurate reports to senior leadership that summarize key project data allows management to identify and resolve issues as they arise.

Condition

Valley actively monitors construction sites, such as the emergency tower under construction during the audit, but does not have robust documentation or reporting processes. With the exception of meeting minutes, Valley's project managers do not publish formal project status reports for internal use or for reporting to hospital administration or the Board of Commissioners. Instead, the project managers rely primarily on informal means of reporting and communication, including weekly meetings with and e-mails to the Vice President (VP) of Facilities that include updates on project status and significant issues. During the monthly Building Committee Meeting, the VP of Facilities publishes an agenda, but not a formal status report. The VP of Facilities instead relies on a collection of handwritten notes, photos, change order summary information, etc., to update members of the Committee.

However, Valley uses a team effort to monitor construction quality and progress in the field. Valley's project managers perform site visits several times per week to review progress and issues. The VP of Facilities visits project sites multiple times per day and also conducts a special walk-through of all active, on-site projects with a member of the Board of Commissioners every Wednesday. Valley's plant engineers also conduct site visits to review the status of engineered systems under construction. In addition, Valley's architectural/engineering consultants typically perform site visits at least twice per week and document any nonconforming items or quality issues in their field observation reports.

Stevens' management acknowledges the processes for monitoring and reporting on construction projects before calendar year 2008 were insufficient. Stevens is working to document existing practices and develop more formalized processes for monitoring and reporting of construction projects. In the past few months, Stevens has developed more formalized processes around change order approval, scope management and capital approval for projects. The construction projects typically undertaken by Stevens are small works[12] projects with total values below $200,000. These projects are relatively simple to track due to their small size and limited, straightforward scope. The construction manager develops a weekly project report to summarize cost and schedule performance for all active projects in the form of a bullet-point list. This report is generally adequate for small projects of this nature.

See commendation below for Evergreen.

Cause

Valley's VP of Facilities believes due to the small size and interactive nature of the Facilities department that additional documentation requirements would be an unnecessary burden.

Stevens has not undertaken many large construction projects in the recent past, so construction management has not been an item of focus for upper management.

Effect or potential effect

Inadequate monitoring and documentation may lead to an inability to quickly and accurately communicate a project's status to stakeholders, an inability to defend against contractor claims due to inadequate project documentation and overall loss of accountability of project managers. It may also lead to scope creep, budget overruns, schedule delays and other quality issues.

Recommendations

Valley should develop a more comprehensive approach to documentation and reporting by the project managers, including more detailed, formalized reports to document critical issues, budget status, change orders and schedule performance weekly. The VP of Facilities should also use a more formalized, standardized report to capture financial status, schedule status, change orders and critical project issues.

Stevens should continue developing more formalized processes around construction monitoring and reporting. Stevens should also enhance its reporting by using a more robust, yet streamlined, summary report for each project that captures key budget data, schedule information, change orders and critical

[12] Small works projects are any projects estimated to cost less than $200,000.

issues. This type of reporting will become more important as Stevens takes on larger, more complex projects.

Commendation

Evergreen monitors construction project costs weekly through the Weekly Activity Report. These reports are reviewed and discussed weekly in a department-wide meeting that is open to architects, contractors and end-users. The Weekly Activity Report includes costs incurred, estimate to complete (ETC), estimate at completion (EAC) and the expected variance with budgeted costs. The positive impacts of this type of weekly monitoring include the ability to forecast the project costs at completion, the ability to provide for timely insight into project cost overruns and to take proactive corrective action and to provide for accurate communications/reporting to project stakeholders.

Potential cost savings and other effects

Potential cost savings for all issues in the construction area have been grouped together and discussed below.

Issue 20 – Hospital contractors are not required to use specific software programs for schedule and progress reporting, resulting in less effective oversight

Background and criteria

A leading practice is for public works owners to use effective project management software and to require their contractors to use compatible software so that projects can be adequately monitored.

Primavera is the most widely used software program in the construction industry for critical-path-method scheduling for large construction projects. Primavera is used at the beginning of the project to develop the baseline schedule, and then it is used throughout the project to update the schedule to reflect actual progress and modifications to critical-path activities and milestones. Prolog is a commonly used software program in the construction industry for construction project management. Prolog is primarily a database used to track and record key project information (change orders, meeting minutes, requests for information, etc.) and to enable rapid communication of data between project stakeholders (owner, architect/engineer, contractor, subcontractors, etc.). Microsoft Project software is used for project scheduling and, while not specifically developed for construction projects, is well suited for developing and maintaining schedules for small construction projects of limited complexity.

Condition

Valley's project managers have found that using Prolog software enhances project communications, increases efficiency and reduces time frames for review/turnaround of change orders, requests for information, etc.; however, while Valley's contractors often voluntarily use Prolog software, use of Prolog is not contractually required of contractors. Valley's project managers also do not have the ability to electronically review project schedules submitted in a Primavera format.

Evergreen's Construction Management department runs Microsoft Project software and has invested significantly in Microsoft Project training for its small works coordinators. However, Evergreen does not require its contractors, by contract, to submit schedules in a Microsoft Project format on smaller projects. On larger projects, such as the Emergency Department and the Inpatient Facility project, Evergreen requires the contractor to submit schedules both electronically and in hard copy formats. The contractor develops schedules using Primavera software for these projects, which Evergreen does not own. However, Evergreen's outsourced construction manager (Turner Construction) does own the software and has the ability to read and review Primavera schedules electronically.

Stevens uses Microsoft Project software to develop internal project schedules, which currently do not require a significant number of activities; but Stevens does not require contractors to submit schedules in Microsoft Project for smaller projects. For larger projects, Stevens' construction manager has an older

version of Primavera on his computer, so he can read certain electronic Primavera schedules, but he would not be able to read electronic schedules prepared using the latest version of Primavera.

Cause

For most projects, contractors are not contractually obligated to provide the hospitals progress and schedule reports in predefined formats. **Stevens** and **Evergreen** have not wanted to place this burden on some of their smaller contractors.

In addition, **Valley, Evergreen** and **Stevens** also decided not to invest in the latest version of Primavera due to its high cost.

Effect or potential effect

The inability to receive reports and information in a consistent file format across all construction jobs may lead to inefficiencies, suboptimal or illogical sequencing of schedules, undetected issues and missed deadlines.

Recommendations

All three hospitals should contractually require their contractors to submit electronic reports in formats readable using the hospitals' project management software. This common communication platform will allow critical information to be shared more broadly and efficiently. It will also help the hospitals perform a more detailed analysis of schedules, including sequencing, duration and float,[13] for all major activities.

Valley's recommendations include contractually requiring contractors to use Prolog to derive the benefits described by project managers consistently across projects. Valley should also consider implementing Primavera software on at least one workstation to facilitate more detailed analysis of schedules for all major activities.

Evergreen and **Stevens** should contractually require their contractors to submit schedules in a Microsoft Project format on small works projects. If Evergreen plans to stop outsourcing the construction management function on larger projects in the future, then it should consider investing in Primavera software so that its project coordinators can learn to review and analyze Primavera schedules electronically to verify logic, sequencing, durations, etc. Although Stevens currently has minor capital activity, its future activity is anticipated to increase significantly.

Potential cost savings and other effects

Potential cost savings for all issues in the construction area have been grouped together and discussed below.

Issue 21 – The hospital districts do not analyze the root cause of change orders, which may result in recurring budget/cost overruns on construction projects

Background and criteria

During the course of a construction project, changes to the agreed-upon scope, cost and/or schedule frequently arise. Change orders represent formal changes to a construction contract that typically modify the contract value and may impact the project schedule. Change orders may be initiated by an owner or a construction contractor. On large projects, change orders may constitute substantial dollar amounts and need to be closely monitored to make sure they are valid, properly classified (e.g., hospital-requested change, design error or omission or unforeseen condition) and to identify trends to improve project management. As it is common for change orders to total up to 10 percent of total project costs, sound processes around the monitoring and approval of change orders are important.

[13] Duration is the scheduled length of time an activity should take to complete. Float refers to the time built into the schedule beyond the scheduled duration that, if used, would not delay the start of a succeeding activity.

Condition

Valley does not maintain a formal change classification system to identify the root cause and party responsible for each change order on every project (the Surgery Project did have a formal change classification system for change orders). Valley's project managers do not maintain their own formal logs of change orders on construction projects. Instead, they rely upon the change order logs prepared by the contractor and architect. Valley's contractors develop Potential Change Order (PCO) logs that Valley can access via the internet when Prolog software is used on the project. The architect's change order summary appears to be primarily intended for contingency management purposes.

Evergreen's change classification system does not allow analysis of change orders by root cause on individual projects and across all projects. During project execution, Evergreen relies heavily on architects to develop estimates for change order work or evaluate the contractor's proposed change order pricing. Evergreen maintains a change classification system to identify the root cause and party responsible for each change order. The root cause of change orders is identified during Change Order Review Committee meetings or on Request for Information forms.

Stevens has incurred project change orders, cost growth and schedule delays due to insufficient scope definition and inadequate project monitoring against the original scope. Stevens defines project scope in the Capital Request Form, but it is developing additional controls to better define scope early in the project life cycle and to monitor the project against the original scope. Specifically, Stevens added the requirement for the end-user to fill out an additional Capital Request Form for any significant scope changes to an ongoing project.

Cause

Hospitals have not put effective monitoring processes in place to adequately classify, review and approve (or reject) change orders.

Effect or potential effect

Failing to understand the drivers behind change orders may lead to loss of accountability, recurring budget/cost overruns and the inability to improve estimating, design and construction practices.

Recommendations

Valley should establish a formal change order classification system that is standard across all projects and can be easily accessed by all members of its project teams. The log should track change order number, brief description, amount, contingency source (owner or contractor), total value of changes, dates (submitted/approved/rejected), status (approved/approved with changes/rejected), time impact (days), delay to critical path (days), responsible parties and the root cause of the change. Valley's project managers should maintain their own formal logs of change orders for all projects in a standard format that includes all the elements mentioned previously.

Evergreen should continue to improve monitoring of smaller projects by developing additional processes and training programs focused on management of small projects. Evergreen should also enhance its change classification system to allow for analysis of root cause and owner versus contractor-initiated changes across all projects.

Stevens should continue to develop controls to better define the scope early in the project life cycle and to prevent scope creep during construction.

Potential cost savings and other effects

Potential cost savings for all issues in the construction area have been grouped together and discussed below.

Issue 22 – One hospital district does not require timely updates to construction schedules, which may result in an inability to identify project delays and related costs

Background and criteria

Large construction projects may span multiple years. Regular schedule updates (monthly at minimum) allow management to monitor actual progress against the baseline schedule and anticipate delays to critical-path activities and milestones. Leading practices are such that the public works owner requires such schedules.

Condition

Stevens' contracts do not require contractors to submit their schedules both electronically and in hard copy format. However, the small projects undertaken by Stevens often have total durations less than one month. Although Stevens currently has minor capital activity, its future activity is anticipated to increase significantly and these reports will assist in monitoring.

See commendation below for Valley and Evergreen.

Cause

Monthly schedule updates and status reports are not required as part of the standard project contract.

Effect or potential effect

Failing to require monthly schedule updates on larger projects may lead to an inability to monitor/forecast progress in a timely manner, an inability to identify the project's critical path, unanticipated delays and associated cost impacts, an inability to perform time impact analyses to link root cause impacts with days of delay and inaccurate reporting on schedule performance. A lack of monthly status reports can lead to loss of accountability by contractors due to the lack of formalized reporting and insufficient documentation of cost status, change orders, schedule status and critical issues.

Recommendations

Stevens should add language to its standard contract to require full schedule updates monthly as it undertakes larger-scale projects in the future.

Commendations

Valley and **Evergreen** require contractors, by contract, to submit full schedule updates monthly through the pay application process, which is the process contractors need to go through in order to be paid for their work. The process is designed to verify the contractor has met certain benchmarks required in the contract before being paid.

Potential cost savings and other impacts – construction

Based on Ernst & Young's previous experience working with numerous clients in both the healthcare industry and other industries, we have found that implementing process improvement recommendations to address risks and gaps in construction management processes can yield cost savings. However, the scope of the audit was limited to monitoring and reporting processes and even though the above recommendations could yield savings in construction costs, the recommendations cannot be directly tied to any specific cost savings and are more directly related to risk mitigation. A detailed analysis of potential cost savings on a project-by-project basis would be necessary to calculate any specific savings, but it is outside the scope of this performance audit.

It should be noted that even greater cost savings can be generated through proper selection of the project delivery method (e.g., design/build versus design-bid-build) and contracting strategy, prequalification and competitive bidding and detailed review/development of construction contract terms and conditions at the outset of projects prior to commencement of construction. Additional cost savings also may be available once the project begins, through improvement of other key construction management processes in areas such as scope management, value engineering and cost management.

In addition to potential cost savings, other positive impacts from improvements to construction monitoring and reporting activities include reduction of schedule risk, enhanced communication, increased accountability, faster identification of scope gaps or conflicts, more robust and formalized documentation, reduction of legal risk and improvement in overall quality.

Appendix A

I-900 Elements

Appendix A provides a chart showing each I-900 element and where each is addressed in the performance audit findings.

	I-900 Element	Communications with the public	CEO compensation and severance	Nursing and administrative staffing	Procurement and inventory management related to medical supplies	Construction
1	Identification of cost savings (or potential cost savings)			■	■	
2	Identification of services that can be reduced or eliminated			■		
3	Identification of programs or services that can be transferred to the private sector					
4	Analysis of gaps or overlaps in programs or services and recommendations to correct gaps or overlaps		■	■	■	■
5	Feasibility of pooling the entity's information technology systems			■		■
6	Analysis of the roles and functions of the entity, and recommendations to change or eliminate roles or functions	■	■	■	■	■
7	Recommendations for statutory or regulatory changes that may be necessary for the entity to properly carry out its functions				■	
8	Analysis of the entity's performance data, performance measures and self-assessment systems	■		■	■	■
9	Identification of leading practices	■	■	■	■	■

Appendix B

History of public hospital districts

Public hospital districts were first authorized in 1945 when the Washington State Legislature passed Revised Code of Washington (RCW) 70.44. Under RCW 70.44, public hospital districts can be formed at any time through election or petition by a group of citizens in Washington who live in the same area as long as those citizens are willing to take on the financial burden. The financial burden comes in the form of a tax levy, which must be approved by district voters. The tax levy provides the funding to construct and maintain healthcare facilities or to provide healthcare services. Once a levy is passed by a newly formed public hospital district, the levy amount is added to each district resident's property tax bill. The law limits public hospital district property tax levies to a maximum total of 75 cents per $1,000 of assessed value. Property tax assessment is the responsibility of the county assessor, and the county treasurer receives payments and distributes all levy fund portions to the appropriate public hospital district.

In return for the ability to collect public funds, public hospital districts operate under a different environment than private and nonprofit healthcare organizations. As a government entity, public hospital districts are limited by statutory, constitutional and regulatory provisions, meaning they are prohibited from engaging in any activity that is not specifically authorized or cannot be necessarily or fairly implied to be authorized. Lending public credit and owning stock are two examples of activities not allowed at public hospital districts. However, public hospital districts do have the authority to condemn property, hold elections and join forces with other government entities in cooperative ventures.

Washington law enforces the need for using public hospital district profits to enhance community service through the election of board members and restricts use of funds to certain purposes. Public hospital districts are required to be governed by a group of elected officials referred to as the board of commissioners. Per RCW 70.44.040, public hospital districts have the option to have a three-, five- or seven-member board. In order to seek election to any public hospital district's board of commissioners, a candidate must be at least 18, a citizen of the United States and a resident of the district for a minimum of 30 days prior to the election. Once elected, board members serve a six-year term and are not limited in the number of times they can be reelected. Public hospital district documents and proceedings are subject to the state's open meetings and public records laws.

Public hospital districts are classified as special-purpose districts, which are government entities created by legislative authority to carry out certain limited functions that meet a certain need for the citizens of the district. Other common special-purpose districts include fire protection and school districts. Although all public hospital districts are formed by the same process, the level of service varies by district. The current breakdown is as follows:

- 56 public hospital districts
- Two public hospital districts do not directly provide healthcare services
- 54 public hospital districts provide healthcare services

Public hospital districts not providing healthcare services

Although it is not common, two public hospital districts in Washington collect taxes but do not directly provide any healthcare services. Jefferson County Public Hospital District 1 levies taxes and gives those revenues to neighboring Clallam County Public Hospital District 1 to defray costs associated with delivering healthcare services to Jefferson County's residents. Pend Oreille Public Hospital District 2 also levies taxes and transfers those funds to Pend Oreille Fire Protection District 2 to support emergency medical services for Pend Oreille County residents.

Public hospital districts providing healthcare services

Much more common are public hospital districts that levy taxes to help pay for the cost of delivering healthcare services. Of the 54 public hospital districts currently providing healthcare services, 12 do not have a hospital, but deliver services through clinics, emergency medical services, skilled nursing facilities

and/or assisted living facilities. The remaining 42 public hospital districts maintain a hospital to provide healthcare services, and 32 of the 42 are classified as Critical Access Hospitals. The Critical Access Hospital Program was created by the 1997 federal Balanced Budget Act to serve Medicare patients in rural areas that have limited access to healthcare services. In Washington State, the Critical Access Hospital Program is administered by the Department of Health through the Office of Community and Rural Health and the Office of Facility and Services Licensing in close collaboration with the Washington State Hospital Association. In order to be classified as a Critical Access Hospital, a hospital needs to meet certain requirements on items such as size, location and length of stay. Six of the 42 are also located in rural areas, but they are not considered Critical Access Hospitals. The remaining four of the 42 are all located in urban/suburban areas, including all three public hospital districts selected for this performance audit.

King County Public Hospital District 1 – Valley Medical Center background

In 1947, Public Hospital District 1 of King County was the first public hospital district created in the state. Renton Hospital was constructed in 1947 as a 100-bed facility and operated for over 20 years. In 1967, plans for a new hospital were conceived and a $7,000,000 general obligation bond was approved to fund construction in a new location. On October 4, 1969, Valley Medical Center (Valley) opened to the public. From 1977 to 1983, the hospital spent $23,000,000 to add a new Emergency Treatment Center, Surgicenter and the Children's Wing. In 2006 and 2007, Valley finished construction on a new Birth Center and Neonatal Intensive Care Unit and opened a new lobby and Surgery Center. Valley broke ground during September 2007 on a new Emergency Services Tower, which will include a Level III Trauma Center, a 30-bed Intensive Care Unit, three additional floors of patient rooms and two levels of underground parking. Today, Valley has a 303-bed capacity with over 2,500 clinical and nonclinical employees and is the largest public hospital district in Washington State. Valley serves more than 400,000 residents with 20 clinics throughout King County and the central hospital in Renton. In addition, Valley is a regional resource with recognized Centers of Excellence in Birth, Sleep, Joint and Stroke care and provides specialized treatment in cardiology, oncology, high-risk obstetrics, orthopedics, neonatal, cancer and neurology.

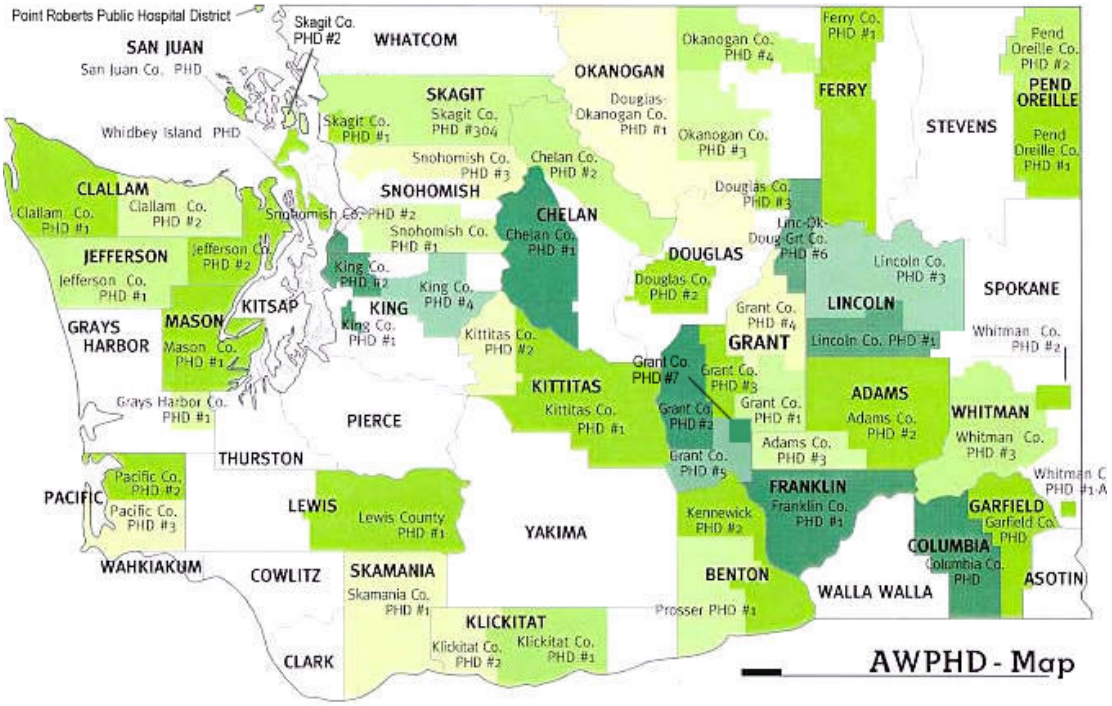
King County Public Hospital District 2 – Evergreen Healthcare background

In 1967, voters in the northeast suburbs of Seattle formed King County Public Hospital District 2. Tax-supported bonds funded the construction of a new hospital, and on March 9, 1972, Evergreen General Hospital opened to the public as a 76-bed facility on 35 acres near the intersection of Kirkland, Bothell and Redmond. Over the years, Evergreen Healthcare (Evergreen) has grown significantly. A third and fourth floor were added to the original building in 1982 and 1984, respectively. The north wing opened in 1986 with a new Emergency Department and Critical Care Unit. The early 1990s saw the opening of the Hospice Center, the east wing and the Professional Center. The east wing doubled the size of the existing hospital. In 2002, the Evergreen Surgery and Physicians Center opened adjacent to the hospital. Lastly, in May 2007, the new Emergency Department and Silver Tower opened to the public. The Silver Tower will provide as many as 192 patient care beds in the future, although half of the Tower is unoccupied awaiting future development. Today, Evergreen Hospital Medical Center has a 242-bed capacity and employs approximately 2,800 clinical and nonclinical personnel. Evergreen serves more than 400,000 people throughout northern King and southern Snohomish counties with primary care practices, home care, hospice, health education and a wealth of other programs and services. Evergreen has more than 800 physicians, representing over 50 specialties, and offers clinical service in all major areas, including cardiac care, cancer care, neurosciences, surgery and maternity care.

Snohomish County Public Hospital District 2 – Stevens Hospital background

In 1962, voters of Snohomish County approved an initiative establishing Snohomish County Public Hospital District 2. The movement to establish a public hospital district started in 1958 when a group of citizens realized the rapidly growing area needed a local, accessible hospital. Completed in January of 1964, Stevens Memorial Hospital cost $2,000,000 and had a 110-bed capacity. In 1989, voters passed another initiative of $25,000,000 for physical improvements. Today, Stevens Hospital is licensed for 217 beds and has a staff of more than 1,300 employees and a medical staff of approximately 450 primary care physicians, specialists, and allied health professionals. Stevens offers a full range of medical and diagnostic services in its service area of North King and South Snohomish County, including a Level IV Trauma Center, emergency medicine, surgery, women's health, birth center, orthopedics, rehabilitation, cardiac care, imaging, laboratory and pathology. The Stevens emergency room handles over 42,000 visits per year. Stevens also has the only inpatient mental health acute care facility in Snohomish County.

Exhibit B-1: Washington State public hospital district map[14]



[14] Washington State Public Hospital District map from the Association of Washington Public Hospital Districts' website: http://www.awphd.org/members_map.asp.

Appendix C

Competitive market data – compensation

Ernst & Young maintains an extensive library of published salary surveys. The surveys contain information on competitive pay levels and practices across all industries. In benchmarking the compensation levels for the three hospital CEOs in this report, we used the following scope parameters:

Position match	CEO
Geography	National*
Industry	Healthcare (for profit and not-for-profit organizations)
Revenue size**	Valley = $309.3 million
	Evergreen = $313.7 million
	Stevens = $143.5 million
Full-time equivalents	Valley = 2,050
	Evergreen = 2,750
	Stevens = 1,300

**The hospitals indicated that they would recruit from across the U.S. for the CEO position.*
***Revenue sizes are based on 2008 audited financial statements and represent net patient service revenue.*

Data was collected for both freestanding hospitals and hospital systems. All data was aged to a common date of April 1, 2009, using an aging factor of 4.2 percent based on the projected 2009 salary increases as reported in the *WorldatWork Salary Budget Survey.*

The chart below shows the competitive compensation at the 25th percentile, 50th percentile and 75th percentile of the market. The percentiles are defined as follows:

- 25th percentile: when the data points are arrayed from high to low, the point at which 25 percent of the individual data points fall below and 75 percent of the data points are above
- 50th percentile (median): when the data points are arrayed from high to low, the point exactly in the middle at which 50 percent of the individual data points fall below and 50 percent of the data points are above
- 75th percentile: when the data points are arrayed from high to low, the point at which 75 percent of the individual data points fall below and 25 percent of the data points are above

The compensation elements are defined as follows:

- Base salary: the standard pay that a person receives for doing a job
- Annual incentive: an additional payment made to a person for achieving certain performance goals outside of the normal job duties
- Total cash compensation: the sum of the base salary plus an annual incentive

STATE OF WASHINGTON - PUBLIC HOSPITAL DISTRICT REVIEW

Published Survey Competitive Market Analysis

(Dollars stated in 000s)

Position	2009 Compensation (4)	25TH PERCENTILE Market Consensus	25TH PERCENTILE Competitive Range (1)	50TH PERCENTILE Market Consensus	50TH PERCENTILE Competitive Range (1)	75TH PERCENTILE Market Consensus	75TH PERCENTILE Competitive Range (1)	Overall Competitiveness (2) 25th Percentile	50th Percentile	75th Percentile
Hospital System CEO										
CEO - Evergreen ($313.7M) Systems										
Base Salary	$559.6	$464.0	$394.4 - $533.7	$538.1	$457.4 - $618.9	$605.5	$514.7 - $696.3	120.6%	104.0%	92.4%
Actual Annual Incentive as a % of Base	49.0%	32.5%		30.1%		31.9%				
Actual Annual Incentive	$274.2	$151.0		$162.2		$193.0				
Total Cash Compensation (3)	$833.8	$615.0	$522.7 - $707.2	$700.3	$595.3 - $805.4	$798.5	$678.7 - $918.3	135.6%	119.1%	104.4%
CEO - Stevens ($143.5M) Systems										
Base Salary	$383.9	$367.0	$311.9 - $422.0	$418.6	$355.8 - $481.4	$478.1	$406.4 - $549.8	104.6%	91.7%	80.3%
Actual Annual Incentive as a % of Base	27.0%	30.6%		30.2%		29.8%				
Actual Annual Incentive	$103.7	$112.2		$126.4		$142.6				
Total Cash Compensation (3)	$487.6	$479.2	$407.3 - $551.0	$545.0	$463.3 - $626.8	$620.8	$527.7 - $713.9	101.8%	89.5%	78.6%
CEO - Valley ($309.3M) Systems										
Base Salary	$587.8	$454.2	$386.0 - $522.3	$518.1	$440.4 - $595.8	$591.9	$503.1 - $680.6	129.4%	113.5%	99.3%
Actual Annual Incentive as a % of Base	0.0%	31.6%		31.2%		30.9%				
Actual Annual Incentive	$0.0	$143.5		$161.9		$182.9				
Total Cash Compensation (3,5)	$587.8	$597.7	$508.0 - $687.3	$680.0	$578.0 - $782.0	$774.8	$658.6 - $891.0	98.4%	86.4%	75.9%
Freestanding Hospital CEO										
CEO - Evergreen ($313.7M) Hospital										
Base Salary	$559.6	$388.6	$330.3 - $446.9	$477.3	$405.7 - $548.9	$586.2	$498.2 - $674.1	144.0%	117.2%	95.5%
Actual Annual Incentive as a % of Base	49.0%	34.8%		36.3%		37.7%				
Actual Annual Incentive	$274.2	$135.3		$173.2		$220.8				
Total Cash Compensation (3)	$833.8	$523.9	$445.3 - $602.5	$650.5	$552.9 - $748.1	$807.0	$685.9 - $928.0	159.2%	128.2%	103.3%
CEO - Stevens ($143.5M) Hospital										
Base Salary	$383.9	$316.7	$269.2 - $364.2	$389.9	$331.4 - $448.4	$480.0	$408.0 - $552.0	121.2%	98.5%	80.0%
Actual Annual Incentive as a % of Base	27.0%	25.2%		26.1%		26.9%				
Actual Annual Incentive	$103.7	$79.8		$101.8		$129.4				
Total Cash Compensation (3)	$487.6	$396.5	$337.0 - $456.0	$491.7	$418.0 - $565.5	$609.4	$518.0 - $700.8	123.0%	99.2%	80.0%
CEO - Valley ($309.3M) Hospital										
Base Salary	$587.8	$387.1	$329.0 - $445.1	$475.4	$404.1 - $546.7	$583.9	$496.3 - $671.5	151.9%	123.7%	100.7%
Actual Annual Incentive as a % of Base	0.0%	31.7%		32.9%		34.0%				
Actual Annual Incentive	$0.0	$122.5		$156.2		$198.3				
Total Cash Compensation (3,5)	$587.8	$509.6	$433.1 - $586.0	$631.6	$536.8 - $726.3	$782.2	$664.9 - $899.6	115.4%	93.1%	75.1%

(1) Generally, a level of pay that is between 85% to 115% of the market consensus is considered competitive. This assumes that the incumbent has a moderate level of experience and is performing as expected.
(2) Incumbent actual compensation compared to market consensus
(3) Total Cash Compensation = Market Consensus Base Salary + Market Consensus Annual Incentive (Actual)
(4) Compensation reflects current base salary and annual incentive paid in 2009 for performance in 2008
(5) Valley Medical Center's CEO did not receive an annual incentive for 2008 performance. If an award had been earned at levels similar to historical payouts, total cash compensation would have been in the 75th percentile range.

SCOPE FACTORS

Industry: Healthcare - Hospital Systems, Independent Hospitals
Revenue Cuts: $313.7M, $143.5M, $309.3M
Geographic: National Data
Trend Factor: 4.2% to April 1, 2009

SURVEY SOURCES

Economic Research Institute: *Executive Compensation Assessor 2009*
Watson Wyatt Compensation Survey: *HC Executive Compensation 2008-2009*
Sullivan Cotter & Associates: *Hospitals & Health Systems Manager & Executive Survey 2008*
Mercer HR Consulting: *US Executive Survey Report 2008*

Ernst & Young defines competitiveness as follows:

Incumbent pay vs. market consensus	Degree of competitiveness
115% +	Highly competitive
85% to 114.9%	**Competitive**
75% to 84.9%	Less than competitive
Less than 75%	Significantly less than competitive

Ernst & Young recommends benchmarking executive compensation on an annual basis.

Appendix D

Competitive market data – severance

Ernst & Young conducts a special survey of compensation and severance practices in the healthcare industry on an annual basis. The survey includes freestanding hospitals and hospital systems from across the country. The results of the 2008 survey show the following severance practices:

Position	Range of severance policy	Most common policy
CEO (hospital system)	18 to 36 months of base salary	24 months of base salary
Other hospital system executives	12 to 24 months of base salary	18 months of base salary
Hospital president	12 to 24 months of base salary	12 months of base salary

In addition to the cash severance, most executive severance agreements contain provisions for the following:

- Noncompete/nonsolicitation: the executive is prohibited from competing against the hospital and/or soliciting employees for a defined period of time
- Confidentiality: the executive agrees not to disclose any proprietary information

Appendix E

Nursing and administrative staffing audit area benchmarking reports – unaudited

As a part of effective productivity monitoring, periodic benchmarking should be done to evaluate the effectiveness of the public hospital districts' efforts in maintaining efficient staffing levels for the patient population served, the services provided and the limitations of the physical plant. As a part of the benchmarking process, Ernst & Young established a "template" for the three public hospital districts to use and included benchmarks for key clinical and diagnostics areas. Although Ernst & Young did not attempt to benchmark all administrative and support areas, an area was benchmarked if the hospital could provide the workload information and the administrative/support functions were clearly defined. When reviewing the reports, please note the following:

- Lines in white (non-highlighted) have appropriate benchmarks and show a staffing variance based on current workload. Benchmarks are not normalized since Ernst & Young did not conduct specific departmental reviews.
- A positive variance indicates overstaffing, while a negative number indicates understaffing. In many cases, due to the organization of these cost centers, positive full-time equivalent (FTE) variances are cancelled out by negative variances in related departments (e.g., cafeteria and nutritional services).
- Benchmarks used were obtained from Ernst & Young's database of client hospitals and third-party proprietary firms.
- Many departments at Evergreen and Valley use Relative Value Units (RVUs) and Resource-Based Relative Value Scale (RBRVS) data for workload. Ernst & Young believes this is a good practice as it enables automation of monitoring and will show an impact of changes in service acuity. However, a standard value of 1.0 hours per RVU was used since Ernst & Young does not know the weighting factors involved, realizing in many departments that the weighting factor is something other than 1.0.

All variances in the following reports should be viewed as a starting point for the clinical and diagnostic areas. Hospital administration should consider targeting the areas with the highest positive variances and confirm the appropriateness of the benchmark used. The template or something similar should be used on an annual basis to evaluate the public hospital districts' effectiveness in staffing efficiency as compared to other similar hospitals.

Valley Hospital
Payroll Data: May 17, 2008 YTD (Annualized)
Workload Statistics: May 31, 2008 YTD (Annualized)

Department Description	Worked FTEs	FTEs needed at Max Benchmark	Minimum Staffing Variance
NURSING AND INPATIENT SERVICES			
6011 - CRITICAL CARE UNIT	47.58	43.30	4.28
6015 - CARDIAC/PCU	32.25	23.97	8.27
6020 - GEN SURG/GYN	52.70	44.24	8.45
6050 - GENERAL MEDICINE	56.14	46.06	10.08
6060 - RESPIRATORY/RENAL	29.78	24.30	5.48
6072 - 3 NORTH	20.61	15.81	4.80
6100 - BARIATRICS	21.13	16.26	4.87
6150 - NWB Neuroscience	25.03	17.51	7.51
6172 - NICU	27.07	21.32	5.75
7000 - BIRTH CENTER	96.72	100.80	(4.09)
7015 - FETAL MONITORING	6.50	7.78	(1.27)
SURGICAL SERVICES			
7020 - SURGERY	47.78	52.72	(4.94)
7025 - ENDOSCOPY	8.50	6.29	2.21
7030 - RECOVERY	33.47	26.40	7.08
7035 - DAY SURGERY	11.02	9.80	1.22
7040 - ANESTHESIOLOGY	11.37	10.70	0.67
7111 - CARDIOLOGY	2.82	4.66	(1.85)
7113 - EEG	2.66	4.26	(1.60)
8050 - CENT STER PROCESSING	14.68	15.03	(0.36)
EMERGENCY SERVICES			
EMERGENCY SERVICES	100.81	106.72	(5.91)
RADIOLOGY			
7141 - RADIOLOGY	18.43	19.75	(1.32)
7145 - RADIOLOGY ULTRASOUND	4.64	4.78	(0.14)
7147 - VDI ULTRASOUND	9.16	10.10	(0.94)
7148 - RADIOLOGY OP CLINIC	6.27	5.88	0.38
7149 - BREAST CENTER	24.11	21.44	2.67
7152 - RADIATION THERAPY	12.44	13.31	(0.87)
7160 - NUCLEAR MEDICINE	4.52	4.32	0.20
THERAPIES			
7181 - RESPIRATORY THERAPY	19.15	17.11	2.03
7200 - PHYSICAL THERAPY	26.14	22.56	3.58
7205 - CHILDRENS THERAPY	14.99	12.33	2.66
7211 - OCCUPATIONAL THERAPY	9.33	9.09	0.24
7212 - SPEECH PATHOLOGY	2.93	2.98	(0.05)
7213 - REHAB SERVICES	17.09	25.28	(8.19)
7224 - WOUND CARE ARLEIN	2.75	2.08	0.68

Valley Hospital
Payroll Data: May 17, 2008 YTD (Annualized)
Workload Statistics: May 31, 2008 YTD (Annualized)

Department Description	Worked FTEs	FTEs needed at Max Benchmark	Minimum Staffing Variance
LABORATORY			
7071 - CLINICAL LABORATORY	40.52	33.70	6.82
7076 - PATHOLOGY LABORATORY	3.67	3.21	0.46
7100 - BLOOD	0.02	0.48	(0.46)
SUPPORT SERVICES			
8422 - MATERIAL MANAGEMENT	22.92	23.77	(0.85)
8431 - PLANT MAINTENANCE	36.59	42.22	(5.63)
8434 - SECURITY	16.85	16.56	0.29
8460 - ENVIRONMENTAL SRVS	71.21	40.42	30.79
8465 - LINEN	3.13	5.19	(2.06)
8470 - COMMUNICATIONS	10.10	7.64	2.45
8480 - MAIL PROCESSING	2.31	2.05	0.26
8485 - TRANSLATION SERVICES	1.94	2.04	(0.10)
8490 - HEALTH INF MGMT	48.16	42.68	5.48
ADMIN			
8611 - ADMINISTRATION	7.63	8.83	(1.20)
8630 - MARKETING-COMM AFFAIR	3.88	4.75	(0.87)
8650 - HUMAN RESOURCES	11.30	3.80	7.50
8714 - OUTCOMES MANAGEMENT	19.97	20.38	(0.40)
FINANCE			
8561 - GENERAL ADMITTING	32.47	31.03	1.43
MISC/CLINICS			
8720 - PATIENT CARE SERVICES	15.53	11.55	3.98
7315 - OCCP HLTH SVCS-RENTON	44.53	35.76	8.77
7316 - OCCP HLTH SVCS-AUBURN	16.88	20.09	(3.21)

Evergreen Healthcare
Data: April 30, 2008 YTD (Annualized)

Dept Name	Worked FTEs	FTEs needed at Max Benchmark	Minimum Staffing Variance
NURSING AND INPATIENT SERVICES			
ORTHO, SPINE, NEURO & ONCOLOGY	82.2	74.89	7.28
MEDSURG	99.6	63.60	35.98
PEDIATRICS	9.6	9.53	0.11
PCU-PROGRESSIVE CARE UNIT	45.3	28.24	17.05
NEONATAL INTENSIVE CARE (NICU)	46.1	45.18	0.92
CCA	63.1	55.96	7.17
FAMILY MATERNITY CENTER	154.2	135.64	18.58
CARE MANAGEMENT	22.1	17.21	4.92
NURSING ADMINISTRATION	9.8	9.39	0.37
EMERGENCY SERVICES			
EMERGENCY ROOM	86.2	67.12	19.09
SURGICAL SERVICES			
SURGERY	38.0	42.94	-4.97
PRE-POST ANESTHESIA CARE UNIT	20.5	15.32	5.13
PRE ANESTHESIA CLINIC	9.1	7.11	2.00
ANESTHESIOLOGY	2.8	3.08	-0.27
CENTRAL STERILIZING & PROCESS	15.6	8.53	7.03
RADIOLOGY			
ULTRASOUND	6.4	6.61	-0.20
CT SCANNING	11.9	15.61	-3.69
RADIOLOGY	15.4	19.05	-3.61
MRI	4.8	8.01	-3.17
ELECTROCARDIOLOGY	1.3	1.27	-0.01
NUCLEAR MEDICINE	4.5	4.30	0.21
EPC ULTRASOUND	6.3	5.60	0.70
RADIATION ONCOLOGY	12.1	6.51	5.64
RADIATION ONCOLOGY-PRO FEES	1.9	1.63	0.25
CLINICAL SUPPORT			
PHARMACY	42.1	39.82	2.33
EPC PHARMACY	7.9	6.14	1.78
THERAPIES			
REHABILITATION THERAPIES	36.6	36.42	0.19
RESPIRATORY CARE	19.0	17.02	1.96
NUTRITION THERAPY	4.3	2.77	1.55
CARDIOLOGY			
CARDIAC CATH	8.2	7.38	0.86
ANGIOGRAPHY	4.6	4.81	-0.20
CARDIAC HEALTH CENTER	5.3	4.68	0.63
ECHOCARDIOLOGY	2.8	2.87	-0.10

Evergreen Healthcare
Data: April 30, 2008 YTD (Annualized)

Dept Name	Worked FTEs	FTEs needed at Max Benchmark	Minimum Staffing Variance
LABORATORY			
PATHOLOGY LAB	4.8	3.63	1.18
MICROBIOLOGY LAB	12.9	14.93	-1.99
LABORATORY	35.7	31.74	3.93
LABORATORY-POINT OF CARE	1.8	1.37	0.39
LABORATORY OUTREACH	28.9	28.87	0.06
SUPPORT SERVICES			
CAFETERIA	10.7	19.22	-8.54
DIETARY	24.9	13.77	11.11
FOOD SERVICES	42	50.82	-8.56
LAUNDRY & LINEN	4.1	5.11	-0.99
ADMINISTRATION			
VOLUNTEER PROGRAM	3.1	1.31	1.78
ANSWERING SERVICE	6.3	6.25	0.07
OP CLINICS			
RADIOLOGY-EMG CANYON PARK	0.0	0.23	-0.23
CONTINENCE CENTER	1.5	0.97	0.57
PARKINSON CENTER	5.2	1.34	3.85
REDMOND IMAGING CENTER	4.4	2.01	2.39
MS CENTER	6.7	3.24	3.49
SENIOR HEALTH SPECIALISTS	15.0	5.78	9.24
SLEEP CLINIC	9.3	9.67	-0.38
MAMMOGRAPHY	19.1	24.17	-5.02
DIABETES CENTER	2.6	0.61	2.03
CONTINENCE CTR-PRO FEES	0.3	0.32	-0.01
OB HOSPITALISTS	2.9	0.65	2.26
WOODINVILLE URGENT CARE, EMG	4.2	3.02	1.15
MS CENTER-PRO FEES	2.2	2.28	-0.06
SLEEP CLINIC-PRO FEES	1.4	1.57	-0.19
PARKINSONS-PRO FEES	3.9	3.65	0.28
EMG, DUVALL	9.5	5.11	4.36
EMG, CANYON PARK	10.1	5.69	4.44
SR HEALTH SPECIALISTS-PRO FEES	6.2	7.01	-0.82
EMG, SAMMAMISH	12.7	7.98	4.71
REDMOND URGENT CARE, EMG	10.4	9.27	1.16
EMG, KENMORE	13.6	9.82	3.78
EMG, REDMOND	18.2	12.95	5.22
EMG,FAMILY MEDICINE OF REDMOND	21.6	14.28	7.28
EMG, WOODINVILLE	22.0	16.21	5.81
HOSPITALIST-PRO FEES	15.4	15.53	-0.12
MFM-PERINATOLOGY	26.7	6.67	20.05
PLAZA PHARMACY	2.1	1.30	0.79
PALLIATIVE CARE	3.1	0.70	2.42
CONGESTIVE HEART FAILURE OP CL	1.3	0.83	0.47
ANTICOAGULATION CLINIC	10.8	11.79	-0.96
EMG CENTRAL OFFICE	24.6	23.23	1.42

Steven Hospital
Data: April 30, 2008 YTD (Annualized)

Department	Worked FTEs	FTEs needed at Max Benchmark	Minimum Staffing Variance
NURSING AND INPATIENT SERVICES			
5 West	47.05	42.80	4.25
PCU	38.19	32.65	5.54
8W Oncology	37.49	30.93	6.56
9W Psychiatry	22.90	19.82	3.08
ICU/CCU	37.53	37.01	0.52
Nursing Office	10.45	10.17	0.28
Case Management	17.21	16.95	0.25
SURGICAL SERVICES			
Surgery	25.92	31.61	-5.69
Day Surg Unit	11.84	6.82	5.03
Endoscopy	7.08	5.28	1.80
Recovery	6.05	4.62	1.43
Special Procedures	9.68	8.91	0.77
Surgery Eye Center	2.63	2.29	0.34
Anesthesiology	1.85	1.41	0.44
EMERGENCY SERVICES			
Emergency Svcs	58.89	50.59	8.30
LABORATORY			
Microbiology	9.42	7.54	1.88
Blood Bank	0.80	0.63	0.17
LabCore	20.18	20.73	-0.55
LabOutreach	8.49	8.44	0.05
CLINICAL SUPPORT			
Pharmacy	19.33	19.02	0.31
Hadfield's Rx	31.09	29.59	1.50
SUPPORT SERVICES			
Finance	10.81	14.40	-3.58
Human Resources	7.39	6.10	1.28
Patient Registration	23.30	21.33	1.97
Purchasing	11.36	5.99	5.37
Telephone svcs	6.36	8.42	-2.07
Patient Accounts	20.54	18.92	1.62
Health Info Mgmnt	20.89	20.95	-0.06
Transcription	0.46	0.82	-0.36
Food Svcs	24.93	30.51	-5.58

Steven Hospital
Data: April 30, 2008 YTD (Annualized)

Department	Worked FTEs	FTEs needed at Max Benchmark	Minimum Staffing Variance
THERAPIES			
Speech Path	2.86	2.98	-0.12
Occup Therapy	2.73	2.75	-0.02
Echo	2.06	2.16	-0.10
Physical Therapy	10.03	8.18	1.85
Cardiac Rehab	0.72	0.51	0.22
RADIOLOGY			
Neurology	0.95	0.40	0.55
Radiology	13.19	17.54	-4.35
Radiology Admin	17.75	19.61	-1.86
Ultrasound	6.37	3.43	2.94
CT	5.41	7.46	-2.05
MRI	3.44	1.47	1.97
Radiology at SP	0.26	0.27	0.00
Ultrasound SP	1.48	1.81	-0.33
Mammography SP	9.05	10.12	-1.07
Respiratory Care	10.58	9.99	0.60
OP CLINICS			
Wound Healing Inst	6.12	6.42	-0.30
Vein Clinic	1.17	0.10	1.07
8W Outpatient	1.00	3.35	-2.35
Psych Pro Svcs	2.11	2.53	-0.43
St Intern Med sup	16.63	7.41	9.23
ADMINISTRATION			
Information Svcs	16.06	12.34	3.72
Administration	8.26	7.34	0.91
Volunteers	2.71	2.61	0.11
Phys Rel/ Recruit	2.63	2.32	0.31
Community Educ	4.82	5.58	-0.76
Marketing/ PR	0.80	0.73	0.06
MISC			
Nutrition Svcs	2.17	1.70	0.48
St Intern Med Phys	4.33	3.70	0.63
Birth & Family Supp	24.41	22.92	1.50
Sound Wm's Care	19.21	14.63	4.58
Sound Wm's billing	3.58	3.05	0.53
SPD	9.77	7.64	2.13

Appendix F

Recommendations for the Washington State Legislature

Legislative Recommendation 1 – The Washington State Legislature should amend state law to explicitly limit gifts and compensation to physicians from vendor representatives (see Issue 14)

Background and criteria

Across the nation, relationships between doctors and vendors may have an influence on what products and services doctors choose to offer their patients. Doctors' decisions may be influenced by gifts or other financial incentives such as royalties related to product development or payments for speaking, training or travel. For municipal officers,[15] these arrangements are covered by the Revised Code of Washington (RCW) 42.23.030 (Interest in contracts prohibited — Exceptions) and RCW 42.23.070 (Prohibited Acts), which both prohibit a municipal officer from receiving benefits related to any contracts or related to the officer's services as such officer, respectively. Even though most, if not all, physicians would not be considered a municipal officer, hospitals should make sure these relationships are disclosed and do not adversely impact patient care. The state of Massachusetts has passed a law to promote cost containment, transparency and efficiency in the delivery of quality healthcare that addresses some of the issues noted here (see Massachusetts Chapter 268C of Senate Bill Number 411).

RCW 42.23.070 defines prohibited acts. It states in part:

> "(2) No municipal officer may, directly or indirectly, give or receive or agree to receive any compensation, gift, reward, or gratuity from a source except the employing municipality…"

Massachusetts Senate Bill Number 411, Chapter 268C limits vendors from giving physicians gifts. It states in part:

> "No pharmaceutical manufacturer agent shall knowingly and willfully offer or give to a physician or a member of a physician's immediate family, and no physician shall knowingly and willfully solicit or accept from any pharmaceutical manufacturer, gifts of any value at any time."

Effect or potential effect

Doctors may knowingly or unknowingly be biased to a vendor's products and services because of financial benefit to themselves. This may put the hospital at financial risk from patient lawsuits and the quality of patient care may suffer.

[15] According to RCW 42.23.020, "'Municipal officer' and 'officer' shall each include all elected and appointed officers of a municipality, together with all deputies and assistants of such an officer, and all persons exercising or undertaking to exercise any of the powers or functions of a municipal officer." In the case of public hospital districts, it is most likely this definition would not apply to any physicians practicing medicine within the confines of the public hospital district.

Appendix G

Other observations outside the audit scope and objectives

Procurement observations

Hospitals districts' processes over excluded vendors (i.e., vendors for which no reimbursement will be made by Medicare and Medicaid) are inadequate.

The Office of Inspector General (OIG) maintains a database of excluded persons and entities online at http://oig.hhs.gov/fraud/exclusions.asp. Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans. Federal healthcare programs, including Medicare and Medicaid, will not make payments for any products or services provided by an excluded individual or entity.

None of the three public hospital districts checks the OIG list prior to adding vendors to the approved vendor list. Testing performed on a selection from each hospital's list of vendors paid in 2007 produced no exceptions when compared to the OIG list. **Evergreen**, however, does perform a check of the OIG list via Accounts Payable before paying vendors.

Management has not established controls to prevent the use of excluded vendors.

Hospitals should prevent OIG-excluded vendors from being added to their approved vendor list. Failure to comply could result in loss of reimbursement from federal healthcare programs such as Medicare and Medicaid.

The hospital districts do not properly control capital purchase orders to prevent unauthorized or inappropriate purchases

Capital purchases are added to the accounting books as capital assets. These are typically low-volume, high-dollar transactions. Capital purchase orders require significant approvals, often including approval by the Board of Commissioners, due to the dollars and accounting implications involved with capital purchases. The accounting implications refer to the fact that capital purchases will be recorded as assets and depreciated in future years. Thus, capital assets can impact earnings for many years through depreciation expense, which reduces income. In some years, capital purchases may be far greater than other years (e.g., during a hospital expansion project). For record-keeping purposes, approval documentation for capital purchases should be filed with the capital purchase order.

Our observations at all three hospitals revealed inadequate approvals for capital purchases. **Evergreen** and **Valley** have purchase policies related to capital purchase orders; however, testing showed that those levels were inconsistently being followed. **Stevens** is currently developing policies for capital purchase orders. Additionally, in relation to record-keeping, approval documentation at Valley was not filed together with the purchase order.

Purchasing approval levels are not consistently being followed. Inconsistent adherence to approval levels is not currently being reviewed regularly. At **Stevens**, policies do not yet exist for personnel to follow.

The lack of adequate purchasing controls may lead to inappropriate or unauthorized purchasing activity and inappropriate or inaccurate accounting classifications.

Employee communication observations

The hospital districts use employee satisfaction surveys effectively

Employee satisfaction surveys provide valuable feedback and team-building opportunities for the hospital. Hospitals ideally should conduct employee satisfaction surveys at least every other year. After conducting the survey, results are presented to the staff and staff are asked to work together to develop organizational/departmental action plans to improve. After a sufficient time has passed, a follow-up survey will be conducted to mark progress and identify new opportunities, and the process repeats.

All three public hospital districts demonstrated leading practices in this area. Although **Evergreen** has not conducted an employee satisfaction survey since 2003, it is currently developing a survey for this year. The reason Evergreen has not conducted a survey since 2003 is leadership did not feel it could respond to any outcomes in a timely manner due to ongoing initiatives.

The hospital districts have employee suggestion programs in place

Employee suggestion programs can be formal or informal because the most important point is to develop a culture of trust with management in which employee ideas are encouraged and the strong ideas are evaluated and used by the hospital. Other ideas are developed by management and staff into strong ideas when possible. It is important employees receive appropriate and timely feedback to encourage new ideas in the future and recognition when their ideas are used.

All three public hospital districts demonstrated leading practices in this area.

The hospital districts have operational compliance hotlines

A compliance hotline is a phone number employees can call anonymously to report activities or practices they believe do not meet the standards for ethics, privacy, etc. Although compliance hotlines are used infrequently across the industry, they are an important aspect of the fourth element in the Office of Inspector General's Compliance Program Guidance for Nursing Facilities. The fourth element deals with developing effective lines of communication. All three districts introduce the compliance hotline during new employee orientation, and each year employees take a mandatory follow-up course. Valley even encourages usage by having its CEO record the greeting on the hotline. Management at all three public hospital districts believes there is a low frequency of usage due to their culture, which allows open, two-way communication between management and staff.

All three public hospital districts demonstrated leading practices in this area.

The hospital districts have established service excellence teams

Service excellence teams, or something similar, from across departments are assembled to improve patient/customer satisfaction through getting together and sharing ideas across departments and service areas. These teams provide a formal avenue for employee feedback and suggestions to be discussed and forwarded up to management when appropriate. Typically, membership cuts across departments and levels within the organization to bring a broad experience to the team. Examples of the different teams include Leadership, Measurement, Communications, Standards and Rewards and Recognition.

All three public hospital districts demonstrated leading practices in this area.

Certain hospital districts do not use formal management rounding and CEO forums to interact with employees

Management rounding is the practice of management walking through the departments to informally interact with employees. The goals of rounding are to get to know the employees, let the employees know management cares for and appreciates their efforts, find out what is and is not working well and to open the lines of communication between levels. Rounding should be embraced by executive staff and a

rounding schedule should be maintained to ensure it takes place at least monthly and across all departments.

A second method to provide direct communication to the employees is through CEO forums, formal events in which employees have an opportunity to ask direct questions of the CEO in an open forum and to obtain current information about the hospital. CEO forums should be held frequently enough to have strong participation, but not so often the enthusiasm is lost, and feedback generated at the forums should be communicated to all employees.

At **Valley**, management is expected to round to (or walk through and visit with the employees) in their areas of responsibility on a weekly basis, but a formal schedule is not maintained. As part of this process, issues from rounding are included in status reports and those status reports are included in annual evaluations. The employee survey conducted by Ernst & Young indicated at least 50 percent of the respondents indicated they have seen management rounding at least once a month. Valley schedules CEO forums two times a year and creates flyers and posters to identify the top two or three employee issues from the forums and how they are being addressed.

At **Evergreen**, management rounds regularly in their areas of responsibility by visiting their departments and interacting with the employees. In addition, managers who provide support services visit and interact with their internal customers regularly. However, some members of upper management do not round outside their areas of responsibility and there is no formal rounding schedule maintained. The employee survey conducted by Ernst & Young indicated at least 50 percent of the respondents indicated they have seen management rounding at least once a month. Evergreen does not schedule CEO forums.

Management rounding schedules are not formalized and may not include areas outside a manager's normal area of responsibility. CEO forums have not been scheduled at Evergreen.

Employees may not feel as comfortable interacting with managers and management may not benefit from the same level of feedback and candor from employees.

Stevens has a leading practice by giving senior leadership an official rounding schedule where every department is visited during every quarter. Middle management rounds on a monthly basis by visiting departments and interacting with the employees. In addition, support service departments (materials management, IT, etc.) visit with their internal customers on a regular basis. As part of this process, rounding logs are maintained. The employee survey conducted by Ernst & Young indicated at least 50 percent of the respondents indicated they have seen management rounding at least once a month. Stevens schedules CEO forums four times a year and reported nearly 50 percent attendance at its most recent CEO forum.

Employee feedback

Exhibit G-1: Feedback methods

QUESTION: What methods are available to you and you feel comfortable using to provide feedback/suggestions to management/HR (check all that apply)?	Evergreen	Stevens	Valley
Email	33	17	21
Face to face discussion	32	17	18
Voicemail	20	13	16
Suggestion box	10	2	4
Union representative	8	4	5
Representative committee	6	1	4
Hotline	4	1	6
Other/No Response	2	1	3
Total	115	56	77
Respondents	38	22	24
Methods per Respondent	3.0	2.5	3.2

Exhibit G-2: Most common feedback methods

QUESTION: What is the most common method used to provide feedback/suggestions to management/HR?	Evergreen	Stevens	Valley
Email	26	6	13
Face to face discussion	7	11	4
Voicemail	3	3	3
Representative committee	1	0	1
Suggestion box	1	0	0
Union representative	0	0	1
Hotline	0	0	0
Other/No Response	0	2	2
Total	38	22	24

In general, employees stated the communication at their hospital is good to very good, with the average response more favorable for communicating with Human Resources and direct supervisors than with upper management in terms of availability, timeliness and quality of response. Overall, Valley's employees were the most satisfied with upward communication.

Exhibit G-3: Satisfaction ratings

Employee Internet Survey Findings - Satisfaction Ratings			
Question	Evergreen	Stevens	Valley
How would you rate the methods to communicate with upper management (VPs, Sr. VPs, COO, CEO, CFO,	3.05	3.09	3.55
How would you rate the average quality of upper management's response to communicated issues?	3.00	2.82	3.43
How would you rate the timeliness of upper management's response?	2.95	2.86	3.46
How would you rate your manager's/supervisor's availability to meet confidentially to discuss important	3.55	3.45	3.54
How would you rate your manager's/supervisor's typical response to these discussions?	3.35	3.18	3.63
How would you rate Human Resources' availability to meet confidentially to discuss important issues?	3.31	3.43	3.71
How would you rate Human Resources' typical response to these discussions?	3.08	3.35	3.79
How would you rate the other methods available to communicate with Human Resources?	3.38	3.50	3.67
How would you rate the timeliness of Human Resources' response?	3.38	3.35	3.71

Scale
Excellent = 5, Very Good = 4, Good = 3, Fair = 2, Poor = 1

Appendix H

Public hospital districts' responses to audit findings

The following sections were prepared by the public hospital districts in response to the final audit report. The responses from each public hospital district include only those issues that pertain to their individual district. The responses were added to Appendix H unedited.

Official Response to the Performance Audit of Public Hospital Districts from King County Public Hospital District 1 – Valley Medical

Valley Medical Center

October 23, 2009

Brian Sonntag
Washington State Auditor
Insurance Building
Post Office Box 40021
Olympia, WA 98504-0021

Dear Mr. Sonntag:

Valley Medical Center (VMC) appreciates the opportunity to respond to the State's performance audit report on the three largest public hospital districts in the State of Washington.

The performance audit provides an opportunity to identify areas where VMC may be able to improve its performance, as well as recognize the best practices that VMC already has in place, particularly in relation to nursing and administrative staffing, nursing productivity, and budgeting. We appreciate the recognition that during the course of the audit, ***no*** potential cost savings were found to be attributable to VMC in any of the four main audit areas.

As you will see outlined below in our responses, we value the recommendations provided by the auditors. Some of the recommendations VMC had already self-identified and addressed. In addition, VMC has already implemented or is in the process of implementing many of the recommendations that were identified throughout the process and within this report.

VMC also appreciates the professionalism of both the State Auditor's Office (SAO) and Ernst and Young's staff throughout the audit engagement. We remain committed to sustaining a collaborative relationship with the State Auditor's Office during future audits and hope that our comments below about the overall audit timelines and process are taken in that context.

Overall Audit Timelines and Process

VMC was officially notified that a performance audit of the three largest public hospital districts was to occur in October 2007. The formal entrance with the SAO and Ernst and Young was conducted on March 18, 2008. Fieldwork was completed on the original audit areas by the end of June 2008. Audit issues were discussed during the course of the audit. Our understanding, based upon communications with the auditors, was the performance audit report was to be completed and issued by the end of 2008.

We periodically inquired through the second half of 2008 as to the audit's status and when we would receive a draft of the report. SAO and Ernst and Young both promptly responded to our inquiries, but stated repeatedly they could not provide an estimated date when we would see the report as it was undergoing technical review.

On February 3, 2009, approximately 7 months after the original field work was completed, we were officially notified by SAO that the contract with Ernst and Young had been amended to perform additional audit procedures at each district, and those

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procedures were specific to the CEO's executive compensation. That notification, on Tuesday, February 3, 2009, was the day after VMC's Board of Commissioners approved a resolution related to the CEO's employment contract.

Field work on the executive compensation area of the audit commenced in March 2009. During the entrance conference, the auditors confirmed they had not conducted a performance audit on executive compensation of any other governmental entities. Four of the five Board members expressed concern at that time directly to the SAO about the protracted timeframes related to the report release.

Field work was completed by the end of April 2009. For the next 4 months, we received no communication from the auditors on the status of the draft report, other than when we specifically inquired as to if there were any additional questions. In August 2009, SAO notified us the report was undergoing continued technical review and Ernst and Young came back onsite to perform additional audit work.

In September 2009, SAO notified us of their intention to schedule exit conferences by the end of the month to discuss the draft report even though we had not yet received the draft. SAO also notified us some of the timeframes for review and responses were being compressed and were shorter than what had been communicated to VMC throughout the audit process.

We received the *draft* of this report on September 23, 2009, nearly 15 months after field work was completed on the first four audit areas, and nearly 5 months after field work was completed on the additional audit area of executive compensation. This was our first exposure to the written report and our first exposure to any issues that may have been discovered related to executive compensation.

We understood, from consistent communication from SAO, that VMC would have 10 working days to factually verify the contents of the draft audit report. Our factual verification was due back by October 7, 2009.

On September 25, 2009, the draft of the audit report was electronically distributed by the SAO to our Board of Commissioners for review as well. On the same day, the SAO has acknowledged releasing a draft of this report as a professional courtesy to a state senator who does not represent VMC's district and, in fact, represents the district of one of VMC's closest competitors.

In turn, on September 25, 2009, this ***draft*** report, which VMC had received less than 48 hours earlier and not yet had the full opportunity to review for factual integrity or provide our feedback to the auditors, was provided to the media. We do not know who provided this draft to the media. Our Board had received the report only an hour earlier so they had no opportunity to review the draft either prior to being contacted by the media.

We learned of that distribution only when the media directly contacted us.

The draft report contained both factual demographic errors as well as omissions. In addition, inconsistent comparatives were utilized between the three hospital districts as it relates to some key executive compensation benchmarks that fundamentally changed the comparatives.

While the majority of factual errors appear to have been remedied in the final report, VMC's management and four of five VMC's Board members have expressed serious concern on why a draft report that had not yet been factually reviewed by VMC would have been distributed in this manner.

Our consistent understanding throughout this audit process, and what was repeatedly communicated to us throughout the audit from the auditors, was that VMC would be afforded the ability to review the draft report for factual verification prior to the release of the report into the public domain.

In our opinion, the actual process that SAO used was not consistent with what VMC has experienced in prior year audits or what had been represented to us.

As several of our Board members stated to SAO during the exit conference, we remain troubled as to why this draft report was released in this fashion, as the final report would have been (and will be) released within several weeks in any case.

We continue to be confused on why an audit that took over 15 months to draft (from field work date to draft report date) would need or require such compressed timeframes for issuance and that this compressed report release date coincides with election timelines. Given this chain of events, it is reasonable for the President of the Board and others involved to be concerned that these outside factors were related to the timing of the report release.

Issue 1 – Recommendation

> *"Valley… should develop easy to understand financial and quality of care information, such as medication errors and patient falls, to post on their websites (instead of developing financial statistics, they could choose to post their financial statement)."*

We concur that financial and operational information should be readily available to the taxpayers of our District and, in fact, it is currently available. Monthly financial and statistical information is now posted on our website, as are our yearly audited financial statements. Quality of care data is available on our website through our link with the Joint Commission. That link has been available through our tab on *Accreditation* as well as under the *Quality and Patient Safety* tab.

Issue 2 – Recommendation

> *"Valley…should consider initiating programs similar to Evergreen to strengthen ties with the community.*

Valley Medical Center has an impressive monthly health screening and health education calendar that is sought out by the District residents. Participation in the workshops, screenings, flu shot, and educational programs allow on-going opportunity for community feedback. Thirty years ago Valley Medical Center developed a program specific for seniors in our community, Golden Care. That program has grown to over 18,000

members who routinely participate in two-way communication with the District. Many of our health programs and operational methods have been modified over time based on the input of the residents through Golden Care; e.g. hours and days of operation for our primary care clinics.

VMC is planning to launch a similar program targeted for our young families in the district. This program will be launched in early 2010, communicating first with the thousands of families who have had children delivered in Valley's Birth Center. We look forward to the opportunity to more directly encourage two-way communication with parents and young adults in our District.

VMC, of course, continues to rely on input from the 400+ volunteers who are community residents who actively volunteer in our hospital and clinics on a weekly basis. They are never hesitant to offer insights and suggestions for improvements in our delivery of care and communication with our residents.

We are interested to learn more about the formal Community Advisors program at Evergreen which is cited as a leading practice in this Report. We are open to exploring anything and everything that helps engage our residents in their knowledge and access of their local District hospital system.

Issue 3 – Recommendation

> *"Valley…should update their patient consent forms. The form updates should include patient consent to having vendor representatives or non-hospital staff members present and for their participation in patient procedures. The forms should also disclose financial relationships noted in Issue 14 below. The hospitals should require vendors to provide immunization records if they will be visiting patient care areas and should set stricter standards for vendors who work in sterile areas such as the operating room."*

We concur. Valley Medical Center will modify its patient consent forms to include vendor representatives or non-hospital members' presence during patient procedures. VMC will require these non hospital staff/vendor representatives to provide evidence of an initial two-step screening for Tuberculosis. An optional annual re-screening will be encouraged but not required for non hospital/vendor staff who are visiting patient care areas or areas with sterile areas/cores.

Issue 4 – Recommendation

"Valley should:

- *Given the stated compensation philosophy, affirm that performance warrants annual cash compensation that is above the 75th percentile and reconfirm appropriateness of mix between fixed and variable pay.*
- *Reevaluate the need for annual and recurring payment of retention benefits.*
    - *Reassess the risk that the CEO will voluntarily leave his position with Valley given his long tenure with the hospital and the current economic environment.*

- *Since the current benefit runs through 2013, the Board should assess whether the value of the non-competition provision is still commensurate with the consideration being paid under the retention plan."*

As it relates to VMC's stated compensation philosophy, the Board felt this retention benefit was key to maintain CEO continuity while VMC undertook substantial on-site capital improvements, recruited a number of key senior executives in anticipation of a near term change of the CEO, and continued to take steps to preserve VMC's financial health in an increasingly competitive marketplace for health services, including competition from nearby private as other as other publicly supported hospitals. In fact, as recently as February 2009, the Board reevaluated the need to retain the CEO and extended his contract for an additional year.

To that end, the Board establishes goals for the CEO for each year to reflect the importance of the initiatives mentioned above, among others. The CEO's incentive compensation is predicated on achieving the Board-designated goals, which are reviewed each year and are modified by the Board, as they deem appropriate. This review is not perfunctory. Most recently, in 2009, the Board did not pay out any incentive compensation related to 2008 goals.

We are in consensus that re-evaluation of the annual performance is important. As part of the CEO's annual performance evaluation, which is typically conducted before the end of the year, the Board will be reviewing the legalities of the CEO's employment and compensation agreements, and will receive and review reports from external compensation specialists, who have been tasked with evaluating current market conditions.

According to Appendix C.2, "Competitive Market Analysis," the CEO's 2009 compensation is at less than the 25th percentile's market consensus for Hospital System CEOs. In 2 of the last 11 years (18%), there was no incentive payment earned by the CEO. During that timeframe, the average incentive paid out has been 23.7%, which is less than the maximum achievable, and less than what the auditors state in this report is the standard benchmark (40%).

Issue 5 – Recommendation

"Valley should avoid similar provisions in future contracts."

The reasons the Board permitted such a payment to the current CEO are unlikely to be equally applicable to a successor CEO. Therefore, we believe we will not see similar provisions in the future.

As it relates to the payment of the retirement benefit, and as is stated in the Cause of this Issue, the Board knew and understood that the early payment of retirement benefits was not typical. They believed there was good business reason for the decision and that the decision could be understood only when considering the unique circumstances surrounding the current CEO's employment and compensation arrangements. In fact, the Board is very pleased that in early 2010, the Emergency Service Tower will open and provide significantly enhanced emergency room and related services to our District.

The Board believes that CEO continuity was key to the successful delivery of this service and many others to the District.

Issue 6 – Recommendation

"Valley[2] should:

- *Review Resolution 778, the employment agreement and the Supplemental Executive Benefit Plan to determine the appropriate funding amounts.*
- *Conduct a legal analysis to determine whether compensation amounts in excess of the Supplemental Executive Benefit Plan and Resolution 778/the employment agreement should be recovered. Extend the legal analysis to review the appropriateness of the 2008-2013 retention benefits*
- *Establish review protocols to avoid future funding mistakes.*

[2] After Valley management was informed of this issue, the CEO issued a directive to the Treasurer of the District to conduct a full investigation, including obtaining new legal representation other than those involved in 2003."

We appreciate the auditors acknowledging in footnote 2 the action that VMC has already taken. We concur with the auditor's recommendations and believe we are already in the process of implementing them.

As referenced, once the inconsistency in documentation was communicated to the CEO, his response was unilateral and immediate. On October 12, 2009, the CEO issued a directive to the Treasurer of the District to conduct a full investigation on these inconsistencies and to report the results directly to the Board President. That investigation has already commenced. The CEO has also instructed the Treasurer to obtain new legal representation for the District to perform the legal analysis of this investigation other than those involved in 2003.

In addition, the CEO, upon learning of the inconsistency between documents, has taken the precautionary step of also unilaterally funding the maximum amount of the inconsistency into a separate bank account as a safeguard while the investigation is ongoing. While the legal drafting errors were not caused by the CEO or the Board of Commissioners, the CEO has taken this step to avoid even the appearance of any impropriety.

Issue 7 – Recommendation

"Valley should:

- *Reevaluate the necessity of including additional goals that do not result in an incentive reward and annually review the goals with monetary awards associated to ascertain if they support the key objectives of the hospital.*

- *Review the relationship between performance and payout under the annual incentive plan on an annual basis to confirm the goals are set at a level to drive performance levels that warrant maximum payouts."*

We appreciate the auditors' recommendations. We concur that goals should be established to drive performance and goals should be reevaluated each year. The Board annually establishes the incentive goals. As noted in the Cause, the Board believes all of the Board-established goals are relevant and related to the key-objectives of the hospital, and those that are not directly linked to incentive rewards are utilized by the Board during the CEO's annual performance review and in conjunction with merit increases to base salary.

As was previously mentioned, but is relevant to this issue as well, in 2 of the last 11 years (18%), there was no incentive payment earned by the CEO. During that timeframe, the average incentive paid out has been 23.7%, which is less than the maximum achievable, and less than what the auditors state in this report is the standard benchmark (40%).

Issue 14 – Recommendation

"Valley…should require that vendors log their visits….All three public hospital districts should develop policies requiring the disclosure of outside compensation and financial relationships on an ongoing basis for hospital employees. Additionally, hospitals should set policy to explicitly limit gifts and/or samples and require all employed physicians and staff to complete an annual confirmation that they have complied with applicable policies….All three hospitals should either update or create policies explicitly prohibiting the acceptance of any gift, compensation, gratuity, or reward by anyone who could be considered a municipal officer…"

We concur with the recommendation that vendors should log their visits, and they do so at VMC, as was noted within the "condition." We will be expanding the logs, as the auditors recommend, to include gifts and/or samples and the value of those gifts.

For those individual physicians with whom we have specific contractual arrangements, as well as for employed physicians and our management team, we do require annual disclosure of potential conflicts of interests, including disclosure of financial relationships with vendors or potential vendors. This process has been in place since 2000 and has been strengthened in 2009.

Issue 15 - Recommendation

"Valley…should strengthen their existing value analysis processes to prevent them from being bypassed."

We concur, as the auditors acknowledge, that we have a well-defined value analysis team, and we also concur that there is the ability to strengthen our internal processes. A new Director of Materials Management was hired in mid-2009; one of the new Director's tasks is to enhance our existing value analysis team and associated processes.

Issue 16 – Recommendation

> *"Valley…should adopt a consistent policy for managing consigned inventory. That policy should include a formal process for tracking inventory movements and should tie directly to a patient's medical record as a requirement for payment. Categorize items in their consignment inventory and document any changes to agreed inventory levels in writing with vendor representatives. Periodically reconcile consigned inventory records to actual inventory and follow up on any discrepancies."*

We concur. During the audit, we were in the process of implementing a perpetual inventory system, which also provides appropriate internal controls and tracking of the consigned inventory. Policies related to consigned inventory are being written in conjunction with the perpetual inventory implementation and deployment, which is slated to go live in November 2009.

Issue 17 – Recommendation

> *"Valley…should develop an approval matrix that covers both electronic and paper purchases….these limits should be established on an individual or departmental basis rather than a blanket dollar-based approach. This matrix should be enforced electronically wherever possible…."*

We concur and appreciate the auditors noting in the "condition" that VMC was already in the process of implementing an electronic requisitioning system, with varying levels for all departments, during the audit. Currently, the majority of dollars spent through the purchasing departments are done through the electronic requisition process and departmental thresholds have been established. The authorization matrix is enforced electronically by our purchasing system. We also have a process in place for manual transactions with varying authorization thresholds as well. Nearly all transactions require at least Vice President-level authorization.

Issue 18 – Recommendations

> *"Valley should focus on improving the physical security of inventory, especially inventory containing potentially sensitive and/or valuable products or information. Inventory levels should be aggressively monitored using a report that highlights inventory that is not used or used infrequently, where possible. Signature policies should be uniform for all deliveries."*

We concur. As mentioned in our response to Issue 16, during the audit, we were in the process of implementing and deploying a perpetual inventory system. That system aggressively monitors established par levels of inventory stock and will be producing a daily benchmarking report on inventory levels to the Director of Materials Management and the CFO. The perpetual inventory system also has appropriate internal controls that should address inventory that may contain potentially sensitive information.

VMC does have signature policies in effect; however, the Director of Materials Management is in the process of ensuring we have an enhanced, consistently-utilized and reviewed signature policy for all deliveries.

Issue 19 Recommendations

> *"Valley should develop a more comprehensive approach to documentation and reporting by the project managers, including more detailed, formalized reports to document critical issues, budget status, change orders, and schedule performance weekly. The VP of Facilities should also use a more formalized, standardized report to capture financial status, schedule status, change orders, and critical project issues."*

We concur. The VP of Facilities is now requiring and receiving more formalized, detailed reports from the project managers. The VP of Facilities is also designing a more formalized, standardized report that will be provided to the Building Committee each month.

Issue 20 Recommendations

> *"Valley's recommendations include contractually requiring contractors to use Prolog to derive the benefits described by project managers consistently across projects. Valley should also consider implementing Primavera software on at least one workstation to facilitate a more detailed analysis of schedules for all major activities."*

We partially concur. VMC does contractually require contractors to use software to derive the benefits as noted in the recommendation; however, we were not requiring the software to be specifically *Prolog*. We have now established a policy that requires all publicly bid construction projects with construction costs in excess of $2,000,000 to have contract language that requires the use of *Prolog*.

We concur with the recommendation of implementing Primavera software. We had not done so in the past due to the cost of obtaining Primavera and the perceived cost-benefit. However, we were able to obtain a basic version of Primavera at a reasonable price and VMC's project managers are now utilizing the software on specific construction projects.

Issue 21– Recommendations

"Valley should establish a formal change order classification system that is standard across all projects and can be easily accessed by all members of its project teams. The log should track change order number, brief description, amount, contingency source (owner or contractor), total value of changes, dates (submitted/approved/rejected), status (approved/approved with changes/rejected), time impact (days), delay to critical path (days), responsible parties, and the root cause of the change. Valley's project managers should maintain their own formal logs of change orders for all projects in a standard format that includes all the elements mentioned previously."

We partially concur. As the auditors note in the "Condition," the Surgery Project did have a formal change classification system for change orders. All of VMC's construction projects have a formal change order classification that is standard and can be accessed by all members of its project teams. The log, however, did not include all of the elements mentioned in the recommendation. We will be supplementing our current change classification system documentation with the additional elements mentioned above that are not already included.

Conclusion:

Once again, thank you for the opportunity to comment on this performance audit. We believe a performance audit can be an important tool for any organization.

We also thank you for acknowledging our accomplishments in the "Commendations" sections of the audit report. We believe we are Best Practice in the administrative areas of nursing and staffing administration, nursing productivity, and budgeting. This performance audit confirmed those Best Practices, as well having no potential cost savings attributed to VMC.

We believe these best practices are a reflection on our operational and financial strength and illustrates our commitment to quality patient care for our residents every day.

Sincerely,

Rich Roodman,
Chief Executive Officer

Paul Hayes, RN
Executive VP, COO

Larry Smith,
Chief Financial Officer

Jeannine Grinnell,
Treasurer

Official Response to the Performance Audit of Public Hospital Districts from King County Public Hospital District 2 – Evergreen Healthcare

EVERGREEN
HEALTHCARE

October 14, 2009

Mr. Brian Sonntag
Washington State Auditor
Washington State Auditor's Office
3200 Capitol Boulevard S.W.
P.O. Box 40031
Olympia, Washington 98504-0031

Dear Mr. Sonntag:

Thank you for this opportunity to formally respond to the performance audit of public hospital districts. We are constantly striving to be more accountable and improve the quality of healthcare we deliver. Evergreen welcomes the audit team's suggestions of ways to become more efficient and cost-effective. During the audit we worked closely with the audit team and appreciate the professionalism, commitment, and partnership exhibited by both your staff and the audit contractor, Ernst and Young.

We agree with most of the recommendations in the audit report. Since the original audit field work was completed last year, we have already implemented many of the recommendations and are working diligently on others. We also appreciate the Auditor's recognition of the excellent work Evergreen had already accomplished prior to the audit. Specifically, the audit commended Evergreen for our:

- Community Advisors program that engages the community in advising the hospital on important decisions
- Patient consent form revision project
- Formal position control system
- Management of consignment inventory
- Weekly monitoring of construction project costs through the Weekly Activity Report and weekly meetings
- Requirement by contract for contractors to submit full schedule updates monthly in order to be paid for their work to verify the contractor has met certain benchmarks required in the contract before being paid.

We have enclosed our detailed response to all of the issues that were identified in the audit pertaining to Evergreen. In our response we have indicated which recommendations have already been implemented as well as those that we are still working to complete. We will report our progress on the incomplete items to the Evergreen Board of Commissioners at future public board meetings as well as in our annual reporting to your office until those recommendations are complete.

Sincerely,

Steven E. Brown, FACHE
Chief Executive Officer
Evergreen Healthcare

Enclosure

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This document was prepared in response to the final audit report provided to King County Public Hospital District #2 (Evergreen). This response includes only those issues that pertain to Evergreen. For clarity purposes, we have listed the SAO findings and recommendations in bold text and Evergreen's response in normal text.

Issue 1 – Two hospital districts do not provide easily accessible financial, quality and operations information to citizens

Recommendation: Valley and Evergreen should develop easy-to-understand financial and quality of care information, such as medication errors and patient falls, to post on their websites (instead of developing financial statistics, they could choose to post their financial statements).

Evergreen Response (KCPHD No. 2): We agree that transparency and accountability to our constituents is important and we are working to provide more detailed information on our website. Since the audit field work, we have added quality information from HealthGrades to our current website. In November we will be transitioning to a new website which will include additional information such as Core Measures and HCAHPS data with links to those actual websites, as well as, monthly financial data.

Issue 3 – Hospital Districts do not notify patients of vendor participation in patient care and track vendor immunizations

Recommendation: Valley, Evergreen and Stevens should update their patient consent forms. The form updates should include patient consent to having vendor representatives or non-hospital staff members present and for their participation in patient procedures. The forms should also disclose financial relationships noted in Issue 14 below. The hospitals should require vendors to provide immunization records if they will be visiting patient care areas and should set stricter standards for vendors who work in sterile areas such as the operating room.

Evergreen Response (KCPHD No. 2): Evergreen had already begun work on a new patient consent form prior to the audit and this project was noted by the audit team as a potential model for the other hospital districts. We have since completed our redesign of the patient consent form and it now includes disclosure if a healthcare industry representative will be present during the procedure. We are currently transitioning providers to the new form—this will be complete by the end of the year.

We also agree that it is important to know the immunization status of vendors who have patient contact and/or work in sterile areas. We were in the process of implementing a vendor credentialing system at the time of the audit field work last year. This implementation has been completed and includes a requirement for vendors in patient care areas to submit immunization records.

Issue 8 – The incentive plan is very subjective with numerous performance goals related to the incentive payout appearing to be part of a CEO's normal job duties

Recommendations: Evergreen should redesign the annual incentive plan to include:

- Fewer performance goals.
- Each goal should have objective, measurable results identified.
- The results should be linked to monetary rewards.

Evergreen Response (KCPHD No. 2): We acknowledge that the current CEO incentive plan includes a large number of performance goals. Many, but not all, of these goals are already tied to objective, measurable results. The Board of Commissioners and CEO will review this recommendation prior to development of 2010 performance goals.

Issue 9 – The CEO's employment contract and the incentive plan do not specifically address incentive payments upon termination, including resignation, death, disability or retirement

Recommendation: Evergreen should consider modifying the CEO employment contract or the annual incentive plan to define payouts when the CEO leaves the hospital's employment.

Evergreen Response (KCPHD No. 2): The CEO employment contract currently limits severance compensation, if and when applicable, to a designated number of months (based on length of employment) of the CEO's base salary. By definition in the contract, base salary does not include incentive compensation. Nevertheless, the Board of Commissioners and CEO will review if greater clarity is needed or would be helpful in determining if and when incentive compensation must be paid in the event that the CEO's employment is terminated.

Issue 11 – Ineffectively managing hospital personnel leads to overstaffing and underutilization, creating additional costs

Recommendations: Evergreen should define the financial analysts' roles with department managers to:

- Assist in daily monitoring of productivity, including dual accountability with department managers.
- Assist in monitoring costs.
- Assist in analyzing and identifying root causes related to productivity management (e.g., scheduling imbalances, ineffective use of overtime).
- Include in the monitoring process target salary and nonsalary costs per unit of service as an additional measure to evaluate departmental management effectiveness.
- Schedule joint meetings with managers and members of senior leadership to review productivity and expenses.

Evergreen Response (KCPHD No. 2): We agree that we can formalize the role of the financial analysts to ensure consistency in how they work with the management team and increase their involvement in certain areas. Currently, this team works with many of our managers to manage costs on a monthly and/or daily basis including budget preparation and review of financial statements and productivity analysis. Finance is currently working on a revision of the variance reporting process which will include formalizing the financial analysts' role in this process and accountability to senior leadership. The financial analysts' involvement in daily productivity will also be formalized as part of the rollout of the new process discussed below.

Recommendations: Evergreen should also establish:

- An employee monitoring system for productivity and staffing that is standard across all departments and has the ability to report information daily with initial focus on nursing and other clinical departments, but adding all departments in a progressive manner.
- Training so managers and senior leadership can effectively use the monitoring system and standard reporting processes to review productivity measures.
- Productivity metrics for all departments based upon budgetary needs of the hospital (all departments should be viewed as variable in terms of staffing even though some departments may not vary staff on a consistent, daily basis).

Evergreen Response (KCPHD No. 2): Since the field audit, we have implemented an employee monitoring system for nursing departments that includes daily, weekly, and monthly productivity and staffing information. All of the nursing managers and their senior leadership have been trained and are using the standard reports on a daily basis. Next steps will be to develop a plan to roll this out to other clinical departments, and eventually to all departments.

We agree that all departments should have productivity metrics and Finance will work to identify appropriate metrics for those departments that don't currently have one.

Issue 12 – The hospital districts' monthly budget review processes lack precision and discipline to allow management to make timely, fact-based decisions regarding staffing costs

Recommendations: Evergreen and Stevens should use consistent budget analysis templates district-wide. The Finance department and division vice presidents should provide input on the format and content. The districts should consider the following elements:

- Number of patients treated and revenue compared to budget
- Hours per unit of service
- Salaries per unit of service
- Non-labor costs per unit of service
- Variance explanations
- Plans for correction

Evergreen Response (KCPHD No. 2): We agree that greater consistency across all hospital departments would be beneficial. Evergreen has had two templates for variance analysis, one for clinical and one for non-clinical departments, which are published each month for managers to use. This template includes; number of patients treated compared to budget, salaries per unit of service, non-labor costs per unit of service, variance explanations and plans for correction. Finance is currently revising a monthly variance analysis report in PeopleSoft and creating a new policy which will include expectations of management and senior leadership to ensure consistency of use and format.

Potential cost savings and other effects – nursing and administrative staffing

- Recommendations: Evergreen could experience cost savings around $5,225,000 over a five-year period by reducing agency hours to 2.0 percent of productive hours, assuming the staffing mix and wage rates remain relatively stable.

Evergreen Response (KCPHD No. 2): We appreciate the auditors bringing this to our attention last year. Since that time, nursing leadership has worked aggressively to reduce staffing expenses, particularly due to overtime and agency use. An operational dashboard was created and is now used for capacity planning, allowing managers to make changes in staffing levels every 4 hours based on actual and anticipated census on each unit. Overtime usage has decreased 50% and use of agency personnel has also decreased significantly. We no longer use any day to day agency staff and use of travelers (longer term agency) has been restricted to critical care and the emergency department. Our agency hours as a percent of productive hours in 2009 are 1.75%. These changes resulted in a decrease of 15-20 FTEs in nursing and savings of approximately $4.6 million.

Issue 14 –The hospital districts lack policies requiring physician disclosure of outside compensation and financial relationships on an ongoing basis, which can potentially affect the selection and cost of medical supplies.

Recommendations: Valley, Evergreen and Stevens should require that vendors log their visits, including:

- Date of visit,
- Vendor and representative information,
- Destination department,
- Person visiting,

- Gifts and/or samples, and
- Value of gifts and/or samples given.

All three public hospital districts should develop policies requiring the disclosure of outside compensation and financial relationships on an ongoing basis for hospital employees. Additionally, hospitals should set policy to explicitly limit gifts and/or samples and require all employed physicians and staff to complete an annual confirmation that they have complied with applicable policies. The confirmation should also require disclosure of outside compensation, which may create a real or perceived conflict of interest (e.g., physician speaking or consulting fees, travel, royalty payments). All three hospitals should either update or create policies explicitly prohibiting the acceptance of any gift, compensation, gratuity or reward by anyone who could be considered a municipal officer according to RCW 42.23.020.

We recommend the Washington Legislature amend state law to explicitly limit gifts and compensation to physicians from vendor representatives; Massachusetts Chapter 268C of Senate Bill Number 411 could provide some guidance.

Evergreen Response (KCPHD No. 2): As mentioned above in issue 3, Evergreen subscribes to a vendor credentialing system and now requires vendors to register with the hospital and log their visits, including the above information. We are currently working with the vendor credentialing service to make the gifts & samples fields mandatory.

We also recently implemented a requirement for all management staff and physicians in leadership positions to submit an annual conflict of interest attestation, which includes disclosure of outside compensation that may create a real or perceived conflict of interest. We plan to revise our gifts policy to explicitly prohibit acceptance of any gift, compensation, gratuity or reward by municipal officers.

Issue 15 – Hospitals are not completely limiting the use of products not approved for purchase to contain costs

Recommendation: Valley and Evergreen should strengthen their existing value analysis processes to prevent them from being bypassed. Evergreen should contractually limit payments for products that are not approved prior to use to discourage the vendors from attempting to bypass the value analysis process.

Evergreen Response (KCPHD No. 2): We agree that it is important to ensure that our value analysis processes are not being bypassed. However, many of our purchasing contracts are part of a group purchasing agreement and we don't have the ability to alter those agreements to include a contractual limit for non-approved products. We do, however, include this language in our Vendor policy and all vendors are required to read and sign that they agree to abide by it. Some of our newer contracts do include a capped flat amount paid for products. As contracts are revised, this language will be added to the terms and conditions.

Issue 17 – The hospital districts have not established appropriate approval levels over the purchase of medical supplies

Recommendation: Valley, Evergreen and Stevens should develop an approval matrix that covers both electronic and paper purchases. As different departments and individuals will have varying needs for spending authorities (e.g., a requester in the operating room will require different thresholds than someone in a clerical function), these limits should be established on an individual or departmental basis rather than a blanket, dollar-based approach. This matrix should be enforced electronically wherever possible, and manually prior to the creation of a purchase order where it is not. Exception reports should be reviewed regularly.

Evergreen Response (KCPHD No. 2): We have updated our approval matrix for use with both paper and electronic purchase orders. This matrix is checked by purchasing prior to the issuance of a purchase order and by accounts payable for non-purchase order vouchers prior to issuance of a check. We are also currently working on an improved work flow process for electronic requests that will automate much

of this for electronic requisitions. While our approval matrix is based on blanket thresholds for dollar amounts, the matrix does include notations of departments and/or individuals with exceptions due to the unique needs of their departments.

Issue 18 – The Hospital Districts' inventories are not managed effectively

Recommendations: Evergreen should review physical security policies, procedures and practices hospital-wide. In addition, a review of specific item placement and the number of varieties of similar products should be performed to further reduce risk and supply expenses.

Evergreen Response (KCPHD No. 2): We agree that there was potential for improvement in this area. Following the field audit, we reviewed our physical security policies, procedures and practices and implemented some changes. We are continuing this review to identify additional enhancements we can make to our physical security. We also agree that our inventory in certain areas includes a number of varieties of similar products. This presents a challenge since the variety is based on physician preference. We are, however, working with our physicians to identify opportunities for consolidation.

Issue 20 – Hospital contractors are not required to use specific software programs for schedule and progress reporting, resulting in less effective oversight

Recommendation: Contractually require their construction contractors to submit electronic reports in formats readable using the hospitals' project management software. This common communication platform will allow critical information to be shared more broadly and efficiently. It will also help the hospitals perform a more detailed analysis of schedules, including sequencing, duration and float, for all major activities.

Evergreen and Stevens should contractually require their contractors to submit schedules in a Microsoft Project format on small works projects. If Evergreen plans to stop outsourcing the construction management function on larger projects in the future, then it should consider investing in Primavera software so that its project coordinators can learn to review and analyze Primavera schedules electronically to verify logic, sequencing, durations, etc.

Evergreen Response (KCPHD No. 2): Evergreen's Construction Management staff agrees that good project management software can facilitate communication between the owner, design team and the contractor. However, the contracting community has not universally accepted a sole source for construction management software. Evergreen is evaluating a number of different platforms including for example, Primavera, Prolog, and e-Builder to determine if the various platforms can communicate easily with each other. This evaluation will help Evergreen to understand the affects of requiring contractors to submit electronic reports in a particular format. It is important to understand whether such a requirement will negatively affect the competitive environment of the public bid process.

Currently, Evergreen's standard contract requires submission of a contract schedule in Microsoft Project.

Issue 21 – The hospital districts do not analyze the root cause of change orders, which may result in recurring budget/cost overruns on construction projects

Recommendation: Evergreen should continue to improve monitoring of smaller projects by developing additional processes and training programs focused on management of small projects. Evergreen should also enhance its change classification system to allow for analysis of root cause and owner versus contractor-initiated changes across all projects.

Evergreen Response (KCPHD No. 2): On May 17, 2005, the District enacted formal policies and procedures governing the Change Order Review Committee. The committee tracks and reviews all changes on projects with a budget of $500,000 or more. Evergreen agrees that tracking and reviewing changes on smaller projects is also important. Consequently, Construction Management staff began implementing this recommendation shortly after the audit team completed their fieldwork last year. Evergreen employs a "Change Classification System" and the root causes are identified for internal processing by Construction Management staff and prior to submission to the Change Order Review

Committee. Construction Management staff meet weekly to discuss ways to more effectively manage projects and control of project scope and change is a high priority.

Official Response to the Performance Audit of Public Hospital Districts from Snohomish County Public Hospital District 2 – Stevens Hospital

The document summarizes the **Stevens Hospital** management responses and action plans to the recommendations made by Ernst and Young (E&Y) in the referenced report. The responses are organized by issue number as referenced in the E&Y report, with the specific recommendation shown by E&Y and then the Stevens Hospital response and action plan.

Issue #1-– ***Two hospital districts do not provide easily accessible financial, quality and operations information to citizens***

E&Y Commendation
Stevens' Board of Commissioners meets in an open public meeting at least monthly. A standing agenda item is Board review of the monthly financial and operational results. Recently, Stevens began posting monthly financial and operational information on its website. These are the same reports presented at monthly Board meetings. Also, the most recent set of audited financial statements is posted on the website, along with internal quality data and links to external websites (Centers for Medicare & Medicaid Services, Joint Commission) that provide information about the quality of care and outcomes.

Stevens Hospital Response
Stevens is please that E&Y recognized that we provide leading practices in this area to the citizens it serves. Over the past two years, the management has worked diligently to develop ways to communicate via meetings, town halls, and the internet with the people in the community that it serves.

Issue #2 – ***Two hospital districts could enhance community outreach efforts by establishing community advisor programs, which allow citizens from the district to participate in the operation of the public hospital district***

E&Y Recommendation
Valley and **Stevens** should consider initiating programs similar to Evergreen to strengthen ties with the community.

Stevens Hospital Response
The management reviewed the program at Evergreen and decided for the current time, that it would not be cost effective to implement such a program. The Evergreen program includes the use of a full time dedicated employee to coordinate the program and organize the various activities and presentations. Stevens will continue to increase it presence in the community by holding town hall meeting and visiting with the various other city governments (at their council meetings) and fire district one on a periodic basis to update them on the activities and programs at Stevens and to solicit input.

Issue #3 – Hospital Districts do not notify patients of vendor participation in patient care and track vendor immunizations

E&Y Recommendation
Valley, Evergreen and Stevens should update their patient consent forms. The form updates should include patient consent to having vendor representatives or non-hospital staff members present and for their participation in patient procedures. The forms should also disclose financial relationships noted in Issue 14 below. The hospitals should require vendors to provide immunization records if they will be visiting patient care areas and should set stricter standards for vendors who work in sterile areas such as

the operating room. **Evergreen's** current patient consent form revision project could be used for guidance at **Valley** and **Stevens**.

Stevens Hospital Response
Stevens will be updating its patient consent forms, using Evergreens project for guidance, over the next three months. The materials management department will be updating its policies to ask vendor staff that visit patient care areas to comply with the hospital's immunization policies.

Issue #10 – Several of the annual incentive plan performance measures were exceeded during the prior year or significantly exceeded in the current year, indicating that the goal-setting process may result in goals that are not sufficiently challenging to warrant additional compensation

E&Y Recommendation
Stevens should:

- Review the relationship between performance and payout under the annual incentive plan on an annual basis.
- Review goals from year to year to assess the increase in the degree of difficulty in attaining the various performance levels.

Stevens Hospital Response
Stevens has reviewed the relationship between the incentive goal and the actual performance of the prior year in setting the targets for each goal. In all cases for 2008, the goal target was set at a higher level. In 2009, there were two exceptions: (1) days of cash on hand was set at the same level as 2008, because a conscious decision that the institution would maintain the same cash levels in order to invest more heavily in equipment and technology and (2), for 2009 operating income and inpatient admits were targeted at reduced levels due the significant impact of the financial crisis and recession that started in October 2008. It should be noted that the payout of the award for 2007 was only 44% and estimated payout so far through August 2009 for 2009 is 52%. The three year average (2007-2009) is 62%, which is below benchmark guideline of 66% for such plans.

E&Y Commendation
Stevens' annual incentive plan is well-structured with defined performance metrics and goals. Each metric is objective and measurable with weightings assigned to emphasize importance. It also appears that the performance goals can change annually in order to reflect the hospital's evolving priorities

Stevens Hospital Response
The hospital is pleased that E&Y has recognized the well structured nature of the plan and the emphasis on the performance goals can change as priorities change.

Issue #11 – Ineffectively managing hospital personnel leads to overstaffing and underutilization, creating additional costs

E&Y Recommendation
Stevens should:

- Determine if accountants assigned to departments are capable of analyzing staffing and productivity; if not, develop tools and training to provide the accountants with that capability.
- Establish expectations that the accountants support daily department analysis of trends in overtime, agency use, problem solving with the manager (e.g., is the manager scheduling equitably from day to day?) and help the managers analyze costs.
- Perform a cost-benefit analysis and select one of the following:
  - Re-establish the DPMS tool.
  - Upgrade Kronos to include Visionware (which is no longer sold as an add-on product, but is integrated into a package).
  - Leverage the data available from Kronos and develop tools internally to use that data.

Departments with greater variable workloads (e.g., nursing, clinical services, dietary, transport) should be the initial focus.

In the short term, **Stevens** should perform the following:

- Determine which currently available Kronos reports are most valuable to managers in managing and understanding their labor costs.
- Provide these reports to managers along with training on how to use and access them.
  - Senior leadership should follow up with managers regarding their use of reports and solicit feedback

Stevens Hospital Response

The hospital budget manager, assistant controller and the Director of Finance are assigned the responsibility of helping departments to monitor and analyze their productivity. We believe that the use of these personnel has been effective and beneficial. The higher volume departments use a daily spreadsheet tool to help them monitor their productivity. This has been developed specific to each department and has been reviewed with the finance staff noted above. In addition, FTE levels are monitored every two weeks with the bi-weekly FTE report and monthly with the MOR report and review process. Hospital management does not feel that a formalized, sophisticated computer program for daily monitoring of productivity is needed.

Issue #12 – The hospital districts' monthly budget review processes lack precision and discipline to allow management to make timely, fact-based decisions regarding staffing costs

E&Y Recommendation

Stevens should use consistent budget analysis templates district-wide. The Finance department and division vice presidents should provide input on the format and content. The districts should consider the following elements:

- Number of patients treated and revenue compared to budget
- Hours per unit of service
- Salaries per unit of service
- Non-labor costs per unit of service
- Variance explanations
  - Plans for correction

Stevens Hospital Response

Stevens has a consistent and well developed template to present and analyze monthly the results that encompasses all of the elements of the E&Y recommendations with the exception of a variance documentation and plan of correction template. Explanations for variances are provided by the cost center manager at the monthly MOR along with plans of correction, which are written. Hospital management will consider the use of and feasibility of having a standard variance documentation template for written documentation of variances and plans of corrections.

Issue #13 – Lack of position control at Stevens allows departments to potentially hire in excess of budget, resulting in additional costs

E&Y Recommendation

Stevens should:

- Create a formal position control based on the budgeted FTEs by department.
  - Ensure Human Resources conducts a review of the budgeted position control listing prior to posting a position, and the department manager and the appropriate vice president should review the need of the requested position based on the departmental volume and workload

Stevens Hospital Response

Stevens does have a formal position control system as part of the FTE requisition process using the "position mangers" software system that includes formal department manager and VP approval. Such

approvals do take into account changing workload of the department. HR Management will be instituting a review of the FTE levels that are documented in the HR system with the budgeted FTE levels supplied by the Finance Department as an additional check, and will alert the respective manager and VP to any unaccounted variance.

Potential cost savings and other effects – nursing and administrative staffing

E&Y Recommendation
Based on the above findings for Evergreen and Stevens, opportunity exists to reduce labor costs through improved management of staffing and productivity. Due to agency nurses receiving a higher hourly rate than staffed nurses (often more than double), agency nurses should be the first to have their hours reduced when staffing management improves. **Stevens** could experience cost savings around $3,195,000 over a five-year period by reducing agency hours down to 2.0 percent of productive hours [currently at 2.4%], assuming the staffing mix and wage rates remain relatively stable

Stevens Hospital Response
Stevens' agency rate use is on the low side of the benchmark (5% or less) for hospitals of similar size in an urban environment with significant nursing and other clinical staff shortages. The majority of the agency use is for agency staff with long term contracts to fill assignments that cannot be filled with salaried staff or are for temporary situations caused by leaves of absences of salaried staff. After considering the fact that agency staff do not receive benefits or paid time off, the cost of an agency staff member is very close to a salaried staff person. The use of agency is also warranted, since under the union agreements, the hospital would potentially need to pay overtime and double-time by asking current staff to be scheduled for extra shifts beyond their assigned FTE commitment. The calculations of a savings of $3,195,000 over 5 years (which is approximately $600,000 per year) by reducing agency use from 2.4% to 2.0%, could result in un- safe staffing levels in specific departments.

Starting in September, 2009, Stevens is undertaking a benchmarking staffing and cost comparison program process over the next eight months (Action O-I, a Thompson Reuters efficiency benchmark service for community hospitals) to benchmark performance for 2009 at the department level for efficiency, productivity and cost. This program will allow us to compare our selves to a large representative data base of hospitals, with similar size and operating characteristics at the department level. With the results, we will then develop and implement plans where there are potential opportunities.

Issue #14 –The hospital districts lack policies requiring physician disclosure of outside compensation and financial relationships on an ongoing basis, which can potentially affect the selection and cost of medical supplies.

E&Y Recommendation
Valley, Evergreen and **Stevens** should require that vendors log their visits, including:

- Date of visit,
- Vendor and representative information,
- Destination department,
- Person visiting,
- Gifts and/or samples, and
- Value of gifts and/or samples given.

All three public hospital districts should develop policies requiring the disclosure of outside compensation and financial relationships on an ongoing basis for hospital employees. Additionally, hospitals should set policy to explicitly limit gifts and/or samples and require all employed physicians and staff to complete an annual confirmation that they have complied with applicable policies. The confirmation should also require disclosure of outside compensation, which may create a real or perceived conflict of interest (e.g., physician speaking or consulting fees, travel, royalty payments). All three hospitals should either update or create policies explicitly prohibiting the acceptance of any gift, compensation, gratuity or reward by anyone who could be considered a municipal officer according to RCW 42.23.020.

We recommend the Washington Legislature amend state law to explicitly limit gifts and compensation to physicians from vendor representatives; Massachusetts Chapter 268C of Senate Bill Number 411 could provide some guidance.

Stevens Hospital Response
Stevens does have a vendor log that is maintained by the materials management department that includes the first four items above recommended by E&Y. Stevens will add the two additional items to the log.

Stevens does have a conflict of interest policy and disclosure process for employees and salaried physicians signed at time of employment that covers the recommendations by E&Y for disclosure; however, such acknowledgement of this policy and indication of any disclosures is not required annually; Stevens will implement such process annually.

Issue #15 – Hospitals are not completely limiting the use of products not approved for purchase to contain costs

E&Y Recommendation
Stevens should continue to develop its value analysis process and monitor its effectiveness once it is fully operational. This development could be aided by collaboration with Evergreen and Valley to learn from their processes, especially relative to the timeliness of review**.**

Stevens Hospital Response
Stevens in January 2009 updated and revamped its value analysis process and committee to increase its effectiveness and gain better compliance. To date, the value analysis process has been very effective and compliance has increased prior to the change.

Issue #16 – Certain hospital districts do not properly manage consigned inventory to prevent unnecessary costs

E&Y Recommendation
Valley and **Stevens** should:

- Adopt a consistent policy for managing consigned inventory.
- The policy should include a formal process for tracking inventory movements and should tie items directly to a patient's medical record as a requirement for payment.
- Categorize items in their consignment inventory and document any changes to agreed inventory levels in writing with vendor representatives.
  - Periodically reconcile consigned inventory records to actual inventory and follow up on any discrepancies

Stevens Hospital Response
Stevens in August 2008 established a formal policy and procedures for managing consigned inventory that addresses the above E&Y recommended elements.

Issue #17 – The hospital districts have not established appropriate approval levels over the purchase of medical supplies

E&Y Recommendation
Valley, Evergreen and **Stevens** should develop an approval matrix that covers both electronic and paper purchases. As different departments and individuals will have varying needs for spending authorities (e.g., a requester in the operating room will require different thresholds than someone in a clerical function), these limits should be established on an individual or departmental basis rather than a blanket, dollar-based approach. This matrix should be enforced electronically wherever possible, and manually prior to the creation of a purchase order where it is not. Exception reports should be reviewed regularly.

Stevens Hospital Response
Stevens has a system of delegated authority that requires the department manager to indicate which individuals in the department can use the electronic requisition system to order routine supplies. Manual requisition of supplies requires the authorized signers indicated by the department manager or the manager themselves and these requisitions are reviewed by the materials management buyers for compliance 100%, with any discrepancies escalated appropriately. All capital items require the use of the capital expenditure form which requires operational VP and CFO approval 100% of the time, besides department manager approval. Stevens hospital management feels the current controls are adequate, but will initiate a formal policy and procedure to document the practices and protocols in place.

E&Y Recommendation
Stevens should immediately correct the segregation of duties issue mentioned above by eliminating the treasurer/senior accountant's administrative IT access to the Lawson application.

Stevens Hospital Response
This was an oversight that was not brought to our attention in September 2009; however, the situation was corrected when the treasurer retired in early 2009, and the current treasurer does not have this access.

Issue #18 – The Hospital Districts' inventories are not managed effectively

E&Y Recommendation
Stevens demonstrated few issues with respect to physical security of its inventory locations. Inventory control, however, could be improved, especially in nursing units relative to the storage of pharmaceuticals in medication rooms and drug dispensing machines. **Stevens** should focus on inventory and control procedures in nursing units and the physical security of inventory items.

Stevens Hospital Response
The hospital implemented a new pharmacy dispensing system in April 2009 ("Accudose") and has revamped its pharmacy control and reconciliation procedures as a result. All nursing personnel have been trained and are following the new procedures. In addition, additional training and compliance monitoring of nursing personnel for physical security of partially used drugs has been established.

Potential cost savings and other effects – procurement and inventory management

E&Y Recommendation
Based on the above issues for all three public hospital districts, opportunity exists to reduce costs as well as to reduce risks that have the potential to create additional cost. Issues related to inventory management, especially those related to excess inventory, have implications in both potential loss and risk of expired product being used in the delivery of patient care.

In considering all of the issues above, Ernst & Young subject matter professionals determined the recommendations cannot be directly tied to any specific cost savings. However, a high-level analysis does indicate all three public hospital districts show room for improvement in managing their supply expenses. A 2008 supply chain study conducted by the Healthcare Financial Management Association (HFMA) reported hospitals performing at the top 25th percentile spent $180 on supplies per adjusted patient day. By following the above recommendations, each of the hospitals should be able to narrow the gap between their spending level and the HFMA benchmark. As a point of reference, supply spending at each hospital was calculated as shown below:

- Valley's annual medical supply expense of $36 million calculates to approximately $190 per adjusted patient day.
- Evergreen's annual medical supply expense of $35 million calculates to approximately $245 per adjusted patient day.
- Stevens' annual medical supply expense of $16.5 million calculates to approximately $228 per adjusted patient day.

Stevens Hospital Response
The hospital compares favorably (1st or 2nd quartile) in almost all benchmark supply indicators as shown in the "Operations Advisor/Supply Focus" report (2008-2009 YTD produced by Premier GPO; Stevens is a member of such GPO). Stevens is working to improve in a number of areas to achieve first quartile performance in all areas.

Issue #19 – The hospital districts' monitoring and reporting processes could be improved to enhance project management and improve project performance

E&Y Recommendation
Stevens should continue developing more formalized processes around construction monitoring and reporting. Stevens should also enhance its reporting by using a more robust, yet streamlined, summary report for each project that captures key budget data, schedule information, change orders and critical issues. This type of reporting will become more important as Stevens takes on larger, more complex projects.

Stevens Hospital Response
Stevens now has in place more formal reports and programs to monitor and report on construction projects. The hospital invested in Prolog software in anticipation of larger, more complicated projects. This is used to track the numerous smaller projects currently underway as well.

Issue #20 – Hospital contractors are not required to use specific software programs for schedule and progress reporting, resulting in less effective oversight

E&Y Recommendation
Evergreen and **Stevens** should contractually require their contractors to submit schedules in a Microsoft Project format on small works projects.

Stevens Hospital Response
For larger projects (lasting more than one month) Stevens will require its contractors to submit monthly schedule updates.

Issue #21 – The hospital districts do not analyze the root cause of change orders, which may result in recurring budget/cost overruns on construction projects

E&Y Recommendation
Stevens should continue to develop controls to better define the scope early in the project life cycle and to prevent scope creep during construction.

Stevens Hospital Response
Tighter construction control and administrative oversight by the Construction Manager has been implemented on construction projects. This will limit "scope creep" and unnecessary change orders.

Issue #22 – One hospital district does not require timely updates to construction schedules, which may result in an inability to identify project delays and related costs

E&Y Recommendation
Stevens' contracts do not require contractors to submit their schedules both electronically and in hard copy format. However, the small projects undertaken by Stevens often have total durations less than one month. Although Stevens currently has minor capital activity, its future activity is anticipated to increase significantly and these reports will assist in monitoring.

Stevens Hospital Response
Contract language will be added to the documents for larger projects (over 1 month in duration) to require monthly schedule updates.

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