Washington Healthcare News®

wahcnews.com

Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 6, ISSUE 10 OCTOBER 2011

Health Care Reform Update: Insurance Exchanges and Insurer Risk Standards

By Daniel W. Fisher
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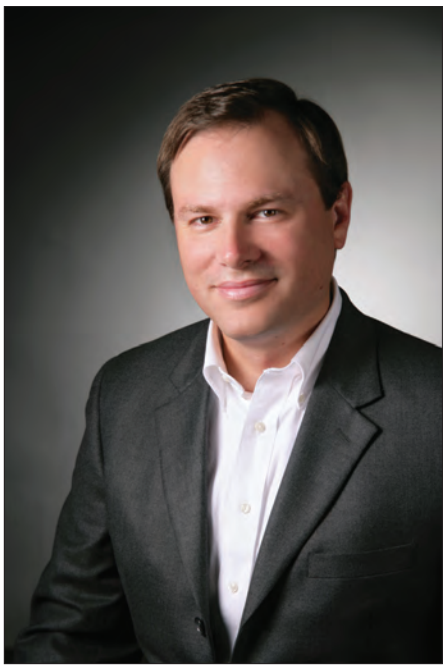

The Patient Protection and Affordable Care Act (PPACA) requires that by January 1, 2014, states operate health insurance exchanges to provide a competitive marketplace where individuals and small businesses may purchase affordable private health insurance coverage. It's a colossal undertaking that also assumes the political willpower continues after the next presidential election. Even so, there is a lot to learn and much at stake right now for healthcare providers and employers of all sizes here in Washington State. In my opinion, the foundation of PPACA is not the constitutionally challenged individual mandate to purchase coverage, but the success or failure of Accountable Care Organizations and the State Insurance Exchanges. With recent rules published, the Exchanges are currently getting most of the attention.

According to the Department of Health and Human Services (HHS), the Exchanges will make it easier to compare health plan options, receive answers to health coverage questions, determine eligibility for tax credits for private insurance or public health programs and enroll in suitable health coverage. Individuals and small employers with up to 100 employees will be eligible to participate in the Exchanges, though until 2016, states can limit employers' participation to businesses with up to 50 employees. Beginning in 2017, states may allow businesses with more than 100 employees to participate in the Exchanges. Causing additional confusion are the commercial "exchanges" already in play in some states – Washington included – that do not fall under these rules.

On July 11, 2011, HHS offered two notices of proposed rule-

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making: (1) Establishment of Exchanges and Qualified Health Plans, and (2) Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. The first notice sets standards for establishing the Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange and certifying health plans for participation. The second notice attempts to ensure premium stability for plans and enrollees in the Exchanges. Since I have yet to see anything affordable about health reform, it is the premium risk adjustments that I find most troubling.

HHS is accepting public comments on the proposed Exchange guidance for 75 days to learn from states and other stakeholders how the rules can be improved. More information from HHS on the Exchanges is available at: www.healthcare.gov/law/provisions/exchanges/index.html.

The Exchanges' greatest challenges will be the same as those for health insurers and self-funded employers: cost control, assigning risk and premium stability. Healthcare coverage in the Evergreen State, like most states, is provided through a divergent collection of public, commercial, and employer self-insured plans. In 2014, with an Exchange and perhaps a Federal Basic Health program, the complexity increases.

Where someone will end up depends on many factors:

- Whether the person is employed
- The size of the person's employer
- Whether their employer self-insures, joins an association healthcare plan, or foregoes coverage altogether
- The amount of the person's household income
- The cost of plans offered in and out of the Exchanges
- An individual's decision on if and when to seek coverage

Such variables make cost and enrollment predictions for the Exchanges nearly impossible. The goal, of course, is to provide universal access to coverage and care at an affordable cost for every resident, something the current health insurance market does remarkably well for some while leaving others

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out in the cold.

Despite the complexity and wildly differing incentives of the many stakeholders, the Washington State Health Benefit Exchange must be ready by mid-2013. Many other public and private exchanges may come into play in the months and years following. Planning is underway in Olympia with a $23 million federal grant, and coordination with a Joint Legislative Select Committee that started meeting in July.

The countdown is on. The State Health Benefit Exchange must start signing up health insurance plans by 2013 or the federal government will take over the project.

The Washington Health Care Authority placed responsibility for the organizational design of this complicated enterprise in the hands of Molly Voris. Her first challenge? To manage a new federal grant of $23 million to fund the start up, of which about $19 million will go to designing the information system. So what does this all mean?

Establishment of Exchanges & Qualified Health Plans

According to HHS, the proposed guidance gives states significant flexibility to build Exchanges.

Exchange Functions

The Exchanges are to provide a competitive marketplace for affordable health insurance, including:

- Certifying, recertifying and decertifying health plans to be offered in the Exchange, i.e. QHPs
- Assigning ratings to each QHP based on quality of coverage and price
- Providing information to consumers on QHPs in a standardized format
- Operating a website and toll-free hotline to offer QHP comparison information and to allow eligible consumers to apply for and purchase coverage
- Determining eligibility for the Exchange, tax credits, cost-sharing reductions for private insurance and public health coverage programs and helping individuals enroll in those programs

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- Determining when individuals are exempt from the requirement to maintain health insurance and granting approvals to individuals for hardship or other exemptions

- Establishing a "Navigator" program to help consumers assess and make choices about their health coverage options and coverage

- Implementing outreach and education programs

- Complying with oversight and program integrity requirements

Qualified Health Plans (QHPs)

Health plans offered through the Exchange must be certified as QHPs. Certification has two components. First, the Exchange must determine whether the health plan meets the minimum standards outlined in the proposed guidance, which include marketing, network adequacy and health plan service area. In some cases, states can choose to implement these standards beyond the minimum outlined in HHS's proposed guidance.

Second, the Exchange must determine whether offering a given health plan through the Exchange is in the interest of individuals and small business. Exchanges may choose among one of several strategies for making this determination:

- utilize an "any qualified plan" strategy for certifying QHPs in its Exchange, whereby an Exchange would certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements;

- undertake a competitive bidding or selective contracting process, and limit QHP participation to only those plans that ranked highest in terms of certain Exchange criteria; or

- negotiate with health insurance issuers on a case-by-case basis. Here, the Exchange would request a health insurance issuer, upon meeting the minimum certification standards, to amend one or more specific health plan offerings to further the interest of the Exchange participants.

Enrollment Process and Navigators

All Exchanges will use the same enrollment periods and application forms to reduce administrative burden for consumers and health insurance issuers. Questions will be answered via websites, toll-free call centers and in-person offices. Navigators, not brokers or agents, will reach out to employers and employees, consumers and self-employed individuals to conduct public education activities, to raise awareness about QHPs, distribute impartial information about QHP enrollment, premium tax credits and cost-sharing reductions, assist consumers in selecting QHPs, and (I'm not making this up) provide information in a manner that is culturally and linguistically appropriate.

Small Business Health Options Program (SHOP)

Beginning in 2014, a Small Business Health Options Program (SHOP) will provide a way for small employers to offer their employees a choice of health plans like those offered by Chambers of Commerce association plans and larger employers. According to HHS, SHOP reduces a small employer's burden by finding QHPs, providing information on pricing and benefits, enrolling employees and consolidating billing.

Standards related to Risk Adjustment, Reinsurance & Risk Corridors

To help protect health insurance issuers offering coverage through an Exchange against risk selection and market uncertainty, PPACA established three programs to begin in 2014. The risk adjustment program will transfer excess payments from plans with lower risk enrollees to plans with higher risk enrollees, thereby ending the incentive for issuers to avoid the sick and market only to the healthy. It will be very interesting to follow how insurers respond to these transfer payments. The reinsurance program requires all health insurance issuers, and third-party administrators on behalf of self-insured group health plans, to make contributions to a nonprofit reinsurance entity to support high risk individuals. Washington State has had such a program for years. The risk corridor program creates a mechanism for sharing risk between the federal government and QHP issuers.

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Barriers to Care Removed, but State Obstacles Still in Place: The Future of Telemedicine in Washington State

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In early May of this year, the Centers for Medicare and Medicaid Services ("CMS") removed a giant obstacle in provision of telemedicine services. Recognizing that its rules and regulations regarding telemedicine services were "duplicative and burdensome,"[1] CMS amended its Conditions of Participation ("CoPs"), implementing a new credentialing and privileging process for physicians and practitioners providing telemedicine services. But what these changes mean for practitioners and medical facilities in Washington is yet to be seen.

Background

Before the new telemedicine credentialing and privileging process became effective, a small hospital was faced with the onerous task of privileging what could be dozens of specialty physicians and practitioners providing telemedicine services to its patients from larger medical centers. Before the CMS revisions, the CoPs for hospitals and critical access hospitals ("CAHs") required that the governing body of a hospital or CAH make privileging decisions based on recommendations from its medical staff.[2] Before issuing a recommendation, the medical staff was required to examine the credentials of candidates for medical staff membership.[3] This process applied to all practitioners at the hospital – including physicians and practitioners who provided radiology reads and telemedicine services over video teleconferencing.

Over the years, the credentialing and privileging of telemedicine providers has created tension between CMS and the Joint Commission. The Joint Commission took a more lenient stance, allowing the practice of "privileging by proxy"[4] under which the "originating site" (the site where the patient is located at the time the service is provided) was allowed to accept the credentialing and privileging decisions of the "distant site" (the site where the practitioner providing the professional service is located) under special circumstances. CMS, however, disagreed with this approach. After years of direct conflict with CMS, the Joint Commission revised its privileging standards to bring them into compliance with the CoPs. After nearly a decade of tension, however, it appears that the two entities are now becoming more closely aligned. With CMS's revisions to

the CoPs, the Joint Commission has again adopted a more flexible approach to the credentialing and privileging of telemedicine providers.[5]

Breaking Down Barriers

The revised CoPs now allow hospitals and CAHs to rely on the credentialing and privileging decisions of either Medicare-certified hospitals or other telemedicine entities, regardless of whether they are Medicare-certified hospitals. In order to rely on these entities, however, the hospital or CAH must have a written agreement with the distant-site facility that meets certain requirements.

If a hospital or CAH engages the services of a medical entity not certified by Medicare ("distant-site telemedicine entity"), the hospital or CAH must take an additional step. Besides maintaining a written agreement, the hospital or CAH must also ensure that the distant-site telemedicine entity furnish services only in a manner that enables the hospital or CAH to comply with all applicable CoPs for the contracted services.[6]

Application Within Washington

Without changes in Washington's current statutory scheme, it is difficult to determine to what extent medical facilities will fully appreciate CMS's relaxed telemedicine credentialing and privileging process. Under Washington law, hospitals have a duty to request certain information from a physician seeking privileges.[7] This information includes a number of items, such as the reason for any discontinuation of privileges, pending professional misconduct proceedings or professional malpractice actions, and the substance of any findings in any medical misconduct or malpractice action, to name a few.[8] The hospital must also seek similar information from any other hospital where the physician maintains, or had maintained, privileges.[9] By requiring this inquiry, however, the benefits of CMS's revised credentialing and privileging process are negated.

Conclusion

With CMS's removal of "unnecessary barriers" in the telemedicine arena, CMS is hoping that the relaxed credentialing and privileging requirements will ultimately improve the quality of patient care,[10] all the while allowing hospitals to conserve resources while maintaining an adequate breadth of specialty services. Though these objectives are worthwhile, it is difficult to know what impact this more lenient process will have within Washington. For hospitals to take full advantage of the new regulations, the Washington State legislature, the Department of Health, or both will likely have to act.

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Notes:

[1]Medicare and Medicaid Programs: Changes Affecting Hospitals and Critical Access Hospital Conditions of Participation: Telemedicine Credentialing and Privileging, 76 Fed. Reg. 25,550, 25,551 (May 5, 2011).

[2]*See* 42 C.F.R. § 482.12(a)(2); 42 C.F.R. § 482.22(a)(2).

[3]42 C.F.R. § 482.22(a)(2).

[4]76 Fed. Reg. 25,550.

[5]The Joint Commission, "Medical Staff," *in Comprehensive Accreditation Manual for Hospitals: The Official Handbook* 13.01.01 (Mar. 2011).

[6]42 C.F.R. § 482.22(a)(4); 42 C.F.R. § 485.616(c)(3).

[7]RCW 70.41.230.

[8]RCW 70.41.230(1).

[9]RCW 70.41.230(2).

[10]76 Fed. Reg. 25,550.

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How efficient and affordable the Exchanges will be is yet to be seen.

Source: Department of Health and Human Services

Dan Fisher is CEO of EmSpring Corporation, an employee benefits firm with an emphasis on health insurance and self-funded medical plans, benefits and plan design, HR and integrated payroll technology. He is also a Washington Society of CPAs past president and a benefits broker since 1989. You can reach Dan at 877-550-0088 or dan.fisher@emspring.com. For more about EmSpring, visit www.emspring.com.

In the Belly of the Beast - Industry Trends and Opportunities

By Darryl Price
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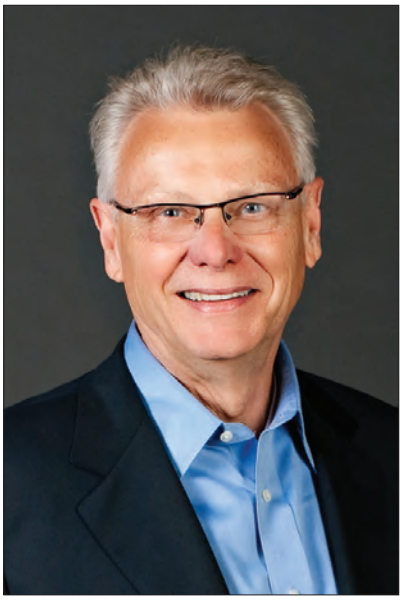

After twenty plus years in the belly of America's healthcare system beast, I am skeptical but not cynical. I no longer look for or believe that there is a silver bullet that will "fix" healthcare. The system is just too complex and fragmented. It's hard to see how there could be a lever that, when pulled, will align all the practices, incentives and systems into a unified model of care and funding.

I do believe, however, that when individuals become engaged in managing their own health, the industry has a better chance of managing the system. In this column, I attempt to find and showcase those trends and opportunities that I believe can actually make a difference and move us toward creating a healthier world and community along with a sustainable healthcare system.

Like many of you, I was transfixed by the events of the "Arab Spring." Apart from the human drama, which remains gripping, the role that mobile technology and social media played in enabling these dramatic events awakened me to the potential of these potent new tools.

I saw how powerful mobile technology had become. How it connected individuals and created the platform for change. As with most dramatic change, the outcome is difficult to predict but the power mobile technology played in enabling it is certain.

The question this phenomenon sparked in me was this: Could mobile technology enable the badly needed communication across the healthcare system? Could it connect the people, providers and carriers by providing the platform for change? Could it also enable a revolution in healthcare?

Mobile technology, more than any technology or tool I've seen, meets people where they are, on their terms, in their day-to-day lives. It travels with them, becomes their lifeline to the people, information and transactions that are important to them. And this opportunity for personal connection is increasing exponentially. A recent Neilson study projected that one in two Americans with cell phones will have a smartphone by Christmas 2011. In 2008, that number was only one in ten. In just three years smartphone ownership went from 10% to 50% of cell phone owners, a group which is itself growing. The opportunity to connect people, providers and carriers through mobile technology is now.

Slalom Consulting is a leader in mobile technology and has been for many years, across many industries. Our excitement about the far-reaching effects mobile technology can have in healthcare was galvanized most recently by a project with Group Health. As Justin Jarrett, Slalom Consulting's Project Manager on this project, expressed it, "We were delighted to be the technology partner for Group Health Mobile. But, more than the technology, what excited our team was the opportunity to make a patient's life easier. The outcome exceeded our expectations. The business strategy and member input drove the technology, as it should; allowing us to deliver benefit immediately to people when they needed it."

Group Health iPhone members

now have a healthcare system in their pocket. They can quickly schedule appointments, check wait times, view lab results, self-diagnose symptoms, call the consulting nurse, access their medical records, and participate in a host of other activities that will help them manage their health…all from the convenience of their smartphone. No need for embarrassing phone calls from a cubicle or taking time off to make healthcare arrangements or tracking down your last tetanus shot.

We are seeing this effect across the industry as clients incorporate mobile technology into their efforts to engage people both clinically and in their business dealings. Locally, Slalom Consulting worked with SonoSite, the world leader in point-of-care ultrasound devices, to better connect to the new tech-savvy generation of medical professionals. Through a "pull" strategy application, SonoAccess, they now stream educational videos to customers and prospects via their iPhones. The videos offer expert guidance on ultrasound techniques, video case studies, a gallery of clinical imagery, and even a reimbursement guide. It was so successful that the CIO migrated SonoSite's sales force to iPhones to enable on-the-spot demos.

Mobile technology is enabling change worldwide by connecting individuals to each other and to issues that are important to them. Across delivery systems and carriers there is one constant – the people. Sometimes those people are patients, sometimes health plan members, and sometimes providers. Even the most skeptical sees the potential mobile technology presents for engaging these individuals across our fragmented system. Who knows-- the one constant in that fragmented system may be the individual and their smartphone.

Darryl Price is the Healthcare Practice Leader for Slalom Consulting. With twenty plus years of executive experience in healthcare, Darryl brings a keen understanding of the healthcare business and the technology solutions that drive success. Darryl can be reached at darrylp@Slalom.com.

Slalom Consulting is a national business and technology consulting firm that helps companies drive enterprise performance, accelerate innovation, enhance the customer experience, and increase employee productivity. To learn more visit www.Slalom.com.

Health Reimbursement Accounts or Health Savings Accounts: Which One is Right for Your Employees?

By Jessica Rothe, MBA
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and

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In today's competitive marketplace, where budgets are stretched thin, employers want cost effective alternatives to a traditional medical plan. Companies understand that employees have historically enjoyed relatively robust medical plans that offer coverage with little to no out of pocket cost. However, with the rising costs for coverage under a traditional medical plan employers are increasingly modifying medical plan coverage to achieve greater cost savings by implementing High Deductible Health Plan ("HDHP") designs where employees pay less in premiums, but have higher deductibles and out of pocket costs.

HDHP Plans are growing in popularity amongst employers looking to maximize their employee benefit dollars; however, employees generally see HDHP plans as a benefit take away, since they do have to shoulder more of their own medical expenses. To combat this negative perception employers often elect to offset the cost-shift by funding all or a part of the deductible back to the employee through either a Health Reimbursement Arrangement ("HRA") or a Health Savings Account ("HSA"). When deciding which of these options to implement, the employer must consider a wide variety of factors, particularly when contemplating an HSA.

Health Reimbursement Arrangements ("HRA")

The basic concept of a HRA is that the employer provides funds which are used to reimburse the employee for qualified medical expenses incurred by them or their tax dependents. No employee funds are involved, and the money that is not used to pay eligible expenses remains property of the employer.

HRAs offer maximum flexibility to the employer to design and structure the amount per employee available for reimbursement, along with what expenses are eligible for reimbursement. Additionally, the employer can decide if they wish to allow a carryover right for any un-used funds or not.

The employer also has significant flexibility in designing and structuring the underlying HDHP plan. First dollar benefit designs are permitted and a full Flexible Spending Account (FSA) can be offered alongside the HRA, which is not the case with an HDHP/HSA paring.

HRA's are attractive not only for their design flexibility, but also because they appeal to diverse economic and age demographics within the employer's workforce. Employees like HRA's since the employer is essentially paying for some or all of the deductible. HRAs are a great addition when the employee compensation level is such that disposable income might not be sufficient to absorb the full HDHP deductible costs. HDHP/HRA's easily coordinate with other insurance coverage that employees or their dependents might carry, including Medicare, so regardless of the age of the participant population everyone can benefit from the HRA.

Drawbacks to HRAs are that the employer must ensure that sufficient funds are available to cover the amounts allocated to the HRA, even though the money might not actually be reimbursed, which does require additional accounting

involvement and reconciliation. Additionally, since it is employer funds, employees don't have as much incentive to spend those dollars wisely as they do when it is their money on the line.

In comparison with HSAs, HRAs are generally regarded as offering the best opportunity for control, flexibility, and work well with both younger and older employees.

Health Savings Accounts

Unlike HRAs which are legally considered medical plans, a Health Savings Account (HSA) is a tax-favored bank account, that is in the name of the employee and all funds deposited into it by Employer and/or Employee are immediately property of the employee. Due to the fact that the all monies deposited into the HSA are non-taxable, the government has strict regulations surrounding the amount of funds per year that may be deposited, and how the money is used. To ensure that the account is not used as a end-run around paying taxes, the underlying HDHP plan must follow strict design parameters in order to deemed qualified for bundling with an HSA.

Since the HSA is a bank account, once funds are deposited into the account the employer's obligation is complete and the responsibility resides solely with the employee on the use of the funds. Employees like the fact that the money is theirs to either spend or save depending on their given situation. A relatively healthy person with low claim experience can effectively allow funds to build up in that account and then can utilize it as another source of retirement income. Due to some of the tax complexities involved with funding and utilizing HSAs, these type of arrangements work best in workplaces with highly educated, well compensated, white collar employees who generally have the sufficient levels of disposable income to fund their deductibles.

One of the nuances to HDHP/HSA plan design requirements is that in order for the employee to be eligible to make contributions or receive funds in their HSA, the employee and their covered dependents cannot have any other form of insurance coverage in effect other than another qualified HDHP plan. This requirement means that HDHP/HSA plans may work best in companies who have relatively younger workers who are less likely to have other coverage in ef-

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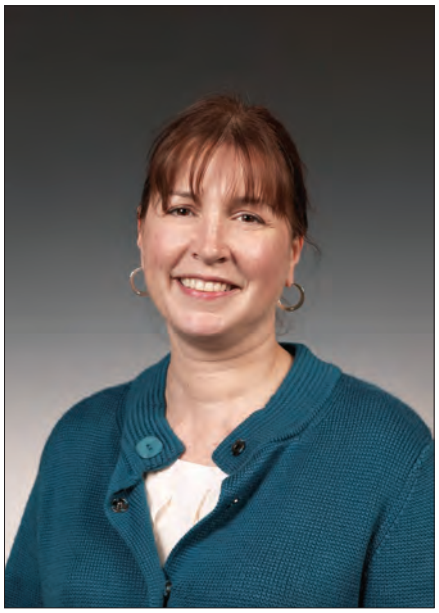
Mobile App Connects Group Health Members to Care

By Gwen O'Keefe, M.D.
Chief Informatics Officer
Group Health



People use their iPhones to find a Starbucks, fight off Angry Birds, and book flights. Now Group Health members can use their smartphone to better manage their health care needs.

Group Health has launched an iPhone app that does a whole lot more than provide the usual health tips. Those of our more than 660,000 members who use iPhones – and a lot of them do – will have the ability to do everything from review medical records to check how long the wait time is for a prescription pick-up. Soon we'll extend this same capability to Android-based smart phones.

At Group Health, we've always believed that the right technology can make health care more effective and affordable. That's why we were among the first health care providers to give members secure Web-based access to medical records, a step we took a decade ago. We've been on the leading edge in the use of electronic medical records, with EpicCare EMR. And we're one of five leading health care providers in the United States that have formed a consortium to work on new ways to securely exchange electronic health data.

What we have consistently found is that when our members have plenty of information, they make better decisions about their health care needs. For Group Health, that has resulted in both lower per-member costs than other health care providers, and in better medical outcomes for members.

The new mobile app takes that approach to making health care information accessible and useful, and rolls it out in a way that reflects how our members live today. We know we live and work in a tech-savvy state, and this gives people with mobile devices one more way to use them. Smartphone use is growing so rapidly that in a few years more people will use them to access the Internet than those using PCs. Clearly this is the wave of the future.

The new Group Health app achieves several business goals for us. Most importantly, of course, it promotes better health by connecting members and their health care providers in a new and innovative way. But it also helps bond members to Group Health by creating a convenient and preferred tool they can use to connect with us. It also helps us reach a growing segment of the population that may have a smartphone, but not a PC.

Our patients' input was a key ingredient in enabling Group Health to offer the right services and features. We heard they want to save time and get answers quickly, and we built the following features to meet and exceed their expectations:

- **My Care** – This offers a direct link between Group Health members who receive care at one of Group Health's 25 medical centers, to their medical records and caregivers. Users can securely log in to view their medical records, make an appointment, email their doctor, check lab test results, and more.

- **Symptom Checker** – Got a headache, a sore ankle, an upset stomach? App users can take advantage of the Symptom Checker to get quick information about the possible causes

of a health problem, and whether it's urgent or is apt to disappear in a day or two.

- **Consulting Nurse** – Our members can call or send secure messages to Group Health's Consulting Nurse Service, any time of the day or night.
- **Locations** – Group Health members can use this feature to find the nearest Group Health medical center. If they have their smartphone's GPS location service turned on, the Locations service will vector them to the nearest clinic.
- **Wait Times** – How long until my prescription is ready, or my lab results are in? Wait Times has the answer.
- **Settings** – Members can set up the app with their preferred clinic, login information, and more.

Group Health members who want to try the new mobile app can do so simply by using their iPhone to browse to ghc.org/mobile. They'll automatically be asked if they wish to download the app. The mobile app also can be found on iTunes or in the Apple App Store. An Android version of the mobile app is due out later this September.

The Group Health mobile app already is proving popular with our members. More than 7,000 members have downloaded it, and on average we have 750 active Group Health users each day. One member wrote on iTunes "Finally - health care that I can manage from my phone."

I think our mobile app is a big step in our efforts to improve our members' engagement in their care decisions. It's one more way that we're empowering our members and giving them the tools they need for better health.

Dr. Gwendolyn B. O'Keefe has been with Group Health Cooperative in Seattle as both the Medical Director for Informatics and the Executive Director of Care Delivery IT services since 2009. She was recently named CMIO for Group Health. She is a general internist practicing in one of Group Health's Seattle-based clinics.

Contact Dr. O'Keefe through twitter @gwendolynokeefe.

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fect. Workforces that tend to have older workers who are nearing retirement or Medicare entitlement, or whose employees have other impermissible coverage in effect will either have to drop their other coverage, or they will be prohibited from utilizing the HSA. This can have a very negative impact on employees and their dependents, so careful analysis of workforce demographics must be considered prior to implementing an HSA.

In comparison with HRAs, HSAs are generally regarded as having the best opportunity for consumer engagement, cost control, and works well in environments that have a young healthy workforce that has higher compensation levels.

When done right the implementation of either a HRA or an HSA can be a wonderful complement to a HDHP medical plan and can be viewed as a positive benefit for both the employee and the employer. However, when implemented without a thorough analysis of the demographics of the employee population, the fundamental requirements and regulations involved, and the level of administrative involvement required by the employer; the outcome can have a negative impact on both the employer and their employees. HRA and HSA are both great options to enhance a HDHP medical plan, but it is critical that employers carefully consider the pros and cons to each option and select the one that best fits their organization.

Jessica Rothe, MBA has over 6 years experience in the employee benefits field, and is the Supervisor of Compliance Services at HMA. She is responsible for legislative compliance for HMA, and with her team in conjunction with each client's legal counsel, provides compliance assistance to HMA clients as well.

Lita Swanson has over 25 years experience in the employee benefits field and is the Manager of Consumer Directed Healthcare at HMA.

Healthcare Management Administrators (HMA), is a third party benefits administrator based in Bellevue, WA. HMA currently administers over 600 benefits plans and offers self-insured employers a full complement of benefit products and services. Contact: proposals@accesstpa.com or 800.869.7093.

Providence & TGBa Team on LEAN Design: Chehalis Family Medicine

By Nora Haile
Contributing Editor
Washington Healthcare News

Always an efficient operation in its own right, Taylor, Gregory, Broadway Architects (TGBa) recently worked with Providence Medical Group to take their design process to a truly LEAN level. The healthcare-centric TGBa teamed with the Providence Office of Operational Excellence (OE) to design a 6,000 sf medical home clinic for Chehalis, Washington. Providence selected Chehalis as a result of a service demand analysis. According to Erik Emaus, DO, CPE and Chief Executive of Providence Medical Group in Southwest Washington, "We found Lewis County to be relatively underserved for primary care." With two primary care providers currently providing care, eventually there will be four to serve at the clinic.

Chehalis Family Medicine espouses the team-based care model of a medical home and also incorporates an RN specialist role, which focuses on care management, helping to coordinate care for complex chronic disease management. "Historically seen in hospitals to assure a good transition from hospital to home, we believe a similar role is needed in the primary care model," he explained. "It's proactive care and improves the health of the entire community."

To develop the medical home's design, TGBa's Gina Dais and Kent Gregory explained the 3P (project preparation process) process.

Clinic "On-stage" Area

Clinic "Off-stage" Area

"About 15 people got together for a 3-day work session. All stakeholders were involved - physicians, administrators, clinical staff and the OE (which led it)," Gregory said. "We started with clinic data such as the existing performance and what the goals were in terms of flow and through-put." An intense process discussion and discovery followed, and at the end of the three days, they had a complete design concept. He continued, "The method let us accomplish in three days what can typically take over three weeks for a clinic of equivalent size."

The "winning" floor plan resulted from the people who provide the care. The teams, encouraged to work through how they did things, then used flow diagrams to depict processes, streamlining constantly. As Dais explained, "Part of 3P included asking 'Why' five times. Each time clinical staff said they did a certain task followed by another step, we'd all ask 'Why' until the essentials emerged."

Gregory elaborated, "The challenge was, as always, with human nature – we only know what we've been doing. We needed to wipe the slate clean and think of the way it could be. We concentrated on a flow that produced the outcomes they wanted – the best way for patients and staff to move through the clinic. It was highly collaborative and created strong buy-in." He and Dais emphasized that TGBa was there for support. "The users and stakeholders became the true designers of the space," they agreed.

Emaus was enthusiastic about the clinic and the 3P design process. "For our care teams, the 3P process ensures respect of their input and the fact they will rely on the building to best serve patient needs," he said. "It turns healthcare into a team sport and provides a more cost effective, quality driven, and safe care experience."

The clinic, a build-out of an existing Arts & Crafts style structure, has a circular flow that allows patients to enter and move smoothly through the care experience – exam, lab or x-ray – before exiting at the end of the loop. The design team used visual elements and warm tones for a secure, welcoming feeling. However, as Gregory verbally drew a picture of the implemented design, the clear focus was on care delivery rather than aesthetics, though those had distinctive purposes as well. "The model was for on-stage and off-stage areas," he described. "We used subdued, natural colors

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< TGBa, from P17

and materials and indirect lighting for onstage, and more brightly lit, office-like décor for the offstage areas." They implemented elements like pass-through doors that allow staff to visually check and then to restock room supplies without entering the onstage area and disrupting patient care.

As Providence's Emaus explained, "Exam rooms have two entrances. The patient enters the onstage care area and is met by care team members entering from the offstage area." The offstage area features cubicles and workspaces where physicians and clinical staff take care of administrative tasks. It's a far cry from the traditional pods and office layout with common-use hallways. Emaus particularly likes it. "The traditional layout actually isolated us," he said. "I called it 'practicing alone together' because other than time with the patients, our interaction, and therefore social support, with the rest of the care team was minimal."

Emaus praised TGBa's engagement. "They were with us every step of the way. We wanted to create a physical expression of our intent that healthcare delivery be a team-based sport that's cost effective and meets the needs of the community. They were attentive, responsive and creative – true philosophical partners."

For more information on TGBa, visit www.tgbarchitects.com or call 425-778-1530.

Washington Healthcare News

wahcnews.com — *Articles, Interviews and Statistics for the Healthcare Executive*

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

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President - Franciscan Foundation

(Tacoma, WA)

Job Summary:

This is a key senior management job with responsibility for fostering a culture of philanthropy for the Franciscan Health System (FHS) to generate funding/charitable giving in support of the immediate and long-range goals of the organization and for providing strategic oversight and direction for all Franciscan Foundation programs and activities. Work includes: 1) formulating, developing and implementing objectives, initiatives and policies to support fund-raising activities, ensuring program and fiscal accountability; 2) establishing long-term partnerships and strengthening existing relationships with the corporate/foundation sector, and building broad-based community awareness/support; 3) ensuring that systems are in place to assess/maximize overall performance, and to meet ethical standards and legal/regulatory requirements; 4) evaluating Foundation performance in relation to objectives, and implementing changes to effect continual improvement, and 5) managing a professional staff engaged in the full range of development activities. Works requires considerable expertise in building effective relationships that are often based on the application of strong persuasion and negotiation skills. Knowledge of fund development (including a wide variety of effective funding strategies/programs) and a proven track record of strategic philanthropic marketing, portfolio management and working collaboratively with governance Boards is also required. This position requires a high degree of professionalism and an ability to interact with a variety of internal and external entities/individuals to significantly increase the visibility of the Franciscan Foundation and to attract key top-level donors and prospects. An incumbent also works collaboratively with the FHS Leadership (e.g. President/CEO, hospital COOs) and trustees in developing/marketing/implementing a philanthropic strategic plan to drive significant growth in grants and charitable giving (e.g. major/deferred gifts, endowments, capital campaigns, etc).

Qualifications:

Bachelor's degree in a field related to the duties of the position, and a minimum of ten years of directly-related work experience (e.g. development/fund-raising, marketing/client relationships), including four years in a management/executive capacity. Work experience in a non-profit and/or healthcare-related environment is preferred. Juris doctorate degree or Master's degree in a field related to the duties of the position is preferred. Certification by the Association for Healthcare Philanthropy (AHP) as a Certified Fundraising Executive (CFRE) is strongly preferred. Certification by the AHP as a Fellow (FAHP) is desirable.

To learn more and apply: Visit **www.fhshealth.org/jobsearch.aspx** and search for **President - Franciscan Foundation, Requisition Number 1100011674.**

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Nurse Manager, ICN

(Santa Rosa, CA)

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To apply, please e-mail your resume to **barbara.darling@stjoe.org** or apply online to Job Requisition #338978 at **www.stjosephhealth.org**. For additional information, please contact Barbara Darling, Recruiter at 707-522-1505. Principals only, no agencies or recruiters please.

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